The term Applicant means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

Name of Applicant: 

1. How many employees have (or will be) affected by the reduction in force? 

2. What are the business reasons for the reduction in force?

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3. Has (or will) the Applicant articulated the business reasons for the reduction in force, documented those reasons and communicated them to management? 

   Yes [ ] No [ ]

4. a. Does the Applicant have a written plan outlining the criteria to be used in selecting employees to be laid off? 

   Yes [ ] No [ ]

   b. If Yes, has that plan been reviewed by counsel? 

   Yes [ ] No [ ]

   c. If Yes, when was that plan last updated? 

5. Has (or will) the Applicant conducted an analysis to determine the impact the reduction in work force will have on members of any protected class? 

   Yes [ ] No [ ]

6. a. Have (or will) laid off employees be asked to sign waivers or releases? 

   Yes [ ] No [ ]

   b. If Yes, have the waivers or releases been reviewed by counsel? 

   Yes [ ] No [ ]

7. Does (or will) the Applicant provide outplacement services to laid off employees? 

   Yes [ ] No [ ]

8. Does (or will) the Applicant provide severance packages to laid off employees? 

   Yes [ ] No [ ]

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I. REQUIRED ATTACHMENTS

- Most recent annual financial statement

II. COMPENSATION NOTICE

**Important Notice Regarding Compensation Disclosure**

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.
### III. FRAUD WARNINGS

**Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island**
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Attention: Insureds in Colorado**
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Attention: Insureds in Florida**
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania**
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

**Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and Washington**
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Attention: Insureds in Oregon**
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**Attention: Insureds in Puerto Rico**
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

### IV. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, HEAD OF HUMAN RESOURCES, GENERAL COUNSEL OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.
Signature of Applicant’s Authorized Representative  
(Partner, Principal, Officer, Head of Human Resources or General Counsel)  

Name (Printed)  

Title  

Date  

V. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):  

Producer Signature  

Producer Name (Printed)  

Agency Name  

Agency Code  

License Number  

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