

Travelers Casualty and Surety Company of America
Hartford, Connecticut

NOTICE: ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE AGAINST "INSUREDS" DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS "DEFENSE EXPENSES", AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY "CLAIM" UNLESS DUTY-TO-DEFEND COVERAGE HAS BEEN SPECIFICALLY PROVIDED HEREIN.

GENERAL INFORMATION

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

Agency	Code	Agent Name/License Number	Policy Number

Applicant Information:

Name of **Applicant**: _____

Year **Applicant's** Business Was Established: _____

Street Address: _____

City, State, Zip: _____

Website Address: _____

Description of **Applicant's** Operations: _____

Does the **Applicant** now have tax exempt status under the United States Internal Revenue Code? Yes No

Is the **Applicant** a subsidiary of a foreign parent? Yes No

Does the **Applicant** currently file, or do they anticipate in the next 6 months filing, any documents with the Securities and Exchange Commission, or similar foreign authority regarding any equity or debt securities? Yes No

Subsidiary Information and 50% or more owned joint ventures under management control:

Name	% Owned	Year Started	Description of Operations	Entity Type*
	%			
	%			
	%			

*Entity Types: FP = For-Profit (other than Partnership) NP = Non-Profit GP = General Partnership LP = Limited Partnership
LLC = Limited Liability Company To enter more information, please attach a separate page or an organization chart

CONTACT INFORMATION FOR RISK MANAGEMENT SERVICES

The policy for which this application is made includes Risk Management Plus+ OnlineSM, a loss prevention program. Please provide the name and contact information for the individuals responsible for overseeing Financial and Human Resource matters for access to the program. This service is not, and should not be, considered a substitute for competent legal counsel. Any recommendations should be reviewed with appropriate legal counsel before implementation.

HR Contact: _____ HR Contact Email: _____

Title: _____ HR Contact Phone: _____

Chief Financial Officer: _____ CFO Contact Email: _____

Preferred Title: _____ CFO Contact Phone: _____

FINANCIAL INFORMATION

Note: Omit this section if the Applicant is required to submit a separate financial statement as directed in the Required Attachments section.

Please indicate the following as it relates to the Applicant's fiscal year end (FYE): <i>(please indicate negative figures with "(" or "-", as appropriate)</i>	Most Recent FYE (Month/Year) /	Prior FYE (Month/Year) /
1. Current Assets		
2. Total Assets		
3. Current Liabilities		
4. Long Term Debt		
5. Retained Earnings/Fund Balance (Accumulated Deficit/Fund Deficit)		
6. Net Equity/Net Assets (Deficit Equity)		
7. Revenues		
8. Net Income (Net Loss)		
9. Is the Applicant currently, or has it been in the past 24 months, in violation or has it amended any debt covenant? If "Yes", please attach an explanation	Yes	No

EMPLOYEE INFORMATION

1. Locations of **Applicants** and Number of Employees* for Each:

State or Foreign Country	# of Locations	Full Time Employees		Part Time Employees	
		As of Date of Application	12 Months Ago	As of Date of Application	12 Months Ago

*Employees include Leased, Temporary and Seasonal Employees and Volunteers
To enter more information, please attach a separate page to the application

2. Please provide the following turnover figures for each of the last three years:

	20__	20__	20__
Voluntary Terminations	_____	_____	_____
Involuntary Terminations	_____	_____	_____
Layoffs	_____	_____	_____
Number of employees compensated less than \$50,000 annually:	_____		
Number of employees compensated more than \$100,000 annually:	_____		

3. Maximum number of employees at any one point during the previous 12 months for the following classifications (regardless of whether they are full or part time):

Labor Unions	Independent Contractors	Temporary	Leased	Seasonal

4. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:

- | | | |
|---|-----|----|
| a. Any actual or proposed merger, acquisition, or divestiture? | Yes | No |
| b. Any creation of a new business, subsidiary or division? | Yes | No |
| c. Any registration for a public offering or a private placement of securities? | Yes | No |
| d. Any reorganization or arrangement with creditors under federal or state law? | Yes | No |
| e. Any branch, location, facility, office, or subsidiary closings, consolidations or layoffs? | Yes | No |

If any of the above questions were answered "Yes", please attach an explanation, including the timing, the essential terms of the event, arrangement, and the surrounding circumstances

HUMAN RESOURCES

- | | | |
|--|-----|----|
| 1. Does the Applicant have a Human Resources department?
Number of HR employees: | Yes | No |
| 2. Are individuals who handle Human Resources functions, both in HR department and locally, formally trained on HR matters? | Yes | No |
| 3. Does the Applicant have an employee handbook which has been reviewed by legal counsel? | Yes | No |
| 4. Does the Applicant utilize an employment application? | Yes | No |
| 5. Does the employment application or employee handbook contain "Employment at Will" language? | Yes | No |
| 6. Does the employment application contain an "Equal Employment Opportunity" statement? | Yes | No |
| 7. Please indicate whether the Applicant has formal written policies and procedures related to the following and indicate whether employees sign and acknowledge receipt and understanding: | | |

			Receipt Acknowledged	
Zero Tolerance Sexual Harassment	Yes	No	Yes	No
Discrimination	Yes	No	Yes	No
Equal Opportunity	Yes	No	Yes	No
Disabled Employees and Accommodations	Yes	No	Yes	No
Grievance Procedures	Yes	No	Yes	No
Pregnancy Leave/FMLA	Yes	No	Yes	No
Employee Discipline	Yes	No	Yes	No
Annual Written Performance Evaluation	Yes	No		

- | | | |
|--|--------------------|---------------|
| 8. Have the above policies and procedures been reviewed by legal counsel within the past 24 months? | Yes | No |
| 9. With respect to employee terminations, does the Applicant consult with legal counsel or Human Resources personnel prior to every termination?
If "No", please attach an explanation describing your procedures | Yes | No |
| 10. Please indicate whether the Applicant conducts human resources training, including sexual harassment training for managers and supervisors? | Yes | No |
| 11. What percent of the Applicant's revenue is derived from being a Federal Contractor? | | % |
| 12. Is Applicant a: | General Contractor | Subcontractor |
| If General Contractor, what percentage of jobs require Subcontractors? | | % |

LOSS INFORMATION

Have any employment-related claims, administrative, criminal or regulatory proceedings, charges, hearings, demands or lawsuits been made against the **Applicant** or any entity or person proposed for this insurance during the past three years, whether or not insured, including claims involving employees, temporary, leased employees or independent contractors or ERISA? **If "Yes", please complete the table below**

To the extent that any lawsuit or claim required to be disclosed in response to the question above constitutes a "Claim" as defined by the Policy, such claim was made prior to the policy period requested hereunder and therefore would be excluded from coverage.

Details	Amount Paid for Defense	Amount Paid for Damages	Covered by Insurance?	Corrective Procedures Implemented
	\$	\$	Yes No	
	\$	\$	Yes No	

POLICY OPTIONS

What is the **Applicant's** preference for defense coverage?

Duty to Defend

Reimbursement

Is coverage requested for Third Party claims?

Yes No

CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

Requested Limit (A)	Requested Retention (B)	Requested Effective Date (C)	Coverage Currently Purchased (D)	Expiring Limit (E)	Expiring Retention (F)	Expiring Premium (G)	Current Insurer (H)	Date Coverage First Purchased (I)
			Yes No					

1. If Liability Coverage is currently purchased as indicated in column (D) above, please answer the following question:

As of the Date the **Applicant** first purchased this Liability Coverage, were there any facts, circumstances, or situations which might have resulted in a claim being made against any insured? Yes No

If "Yes", please attach an explanation

(Not applicable if coverage first purchased and continuously maintained more than 3 years prior to this application date)

2. If Liability Coverage is not currently purchased as indicated in column (D) above, please answer the following question:

Are there any facts, circumstances, or situations which could give rise to a claim under the Liability Coverage for which the **Applicant** is applying? Yes No

If "Yes", please attach an explanation

3. With respect to the Liability Coverage being applied for above, if Requested Limit of Liability in Column (A) exceeds the Expiring Limit of Liability in Column (E):

With respect to the higher limits requested, are there any facts, circumstances, or situations which could give rise to a claim under the Liability Coverage for which the **Applicant** is applying? Yes No

If "Yes", please attach an explanation

Without prejudice to any other rights and remedies of the Company, any claim arising from any facts or circumstances required to be disclosed is excluded from the proposed insurance.

REQUIRED ATTACHMENTS

As part of this Application, submit the following documents with respect to the **Applicant**:

- Employee Handbook, if **Applicant** has 500 or more employees
- Most recent EEO-1 report, if **Applicant** has 1,000 or more employees
- Most recent annual financial statement, if policy limit requested is \$3,000,000 or greater
- Construction Supplemental Questionnaire, if **Applicant** is a contractor
- Third Party Supplemental Questionnaire, if **Applicant** requests this coverage option

SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED ST. PAUL TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY ST. PAUL 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 IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE: (1) IN VA AND UT, PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED; AND (2) IN ALL STATES OTHER THAN VA AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED IN CONNECTION WITH THE APPLICATION PROCESS, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Attention: Insureds in AR, CO, DC, FL, KY, LA, ME, NJ, NM, NY, OH, OK, PA, TN, and VA

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 may also be subject to a civil penalty.

(In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation.)

(In Colorado, 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.)

(In 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 or concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.)

(In 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.)

Signature of **Applicant's** Authorized
Representative (President or CEO):

Title:

Name (Printed):

Date:

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the Section and Question Number (e.g., Financial Information, #9).