

**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+ Online<sup>SM</sup> 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 <b>Applicant</b> currently, or has it been in the past 24 months, in violation or has it amended any debt covenant? <u><a href="#">If "Yes", please attach an explanation</a></u>		Yes <input type="checkbox"/> No <input type="checkbox"/>

## 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 <input type="checkbox"/> No <input type="checkbox"/> |
| b. Any creation of a new business, subsidiary or division?                                    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. Any registration for a public offering or a private placement of securities?               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. Any reorganization or arrangement with creditors under federal or state law?               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| e. Any branch, location, facility, office, or subsidiary closings, consolidations or layoffs? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

[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? Yes  No   
 Number of HR employees: \_\_\_\_\_
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:

		<b>Receipt Acknowledged</b>
Zero Tolerance Sexual Harassment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Discrimination	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Equal Opportunity	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disabled Employees and Accommodations	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Grievance Procedures	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pregnancy Leave/FMLA	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Employee Discipline	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Annual Written Performance Evaluation	Yes <input type="checkbox"/> No <input type="checkbox"/>	

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? Yes  No   
[If "No", please attach an explanation describing your procedures](#)
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? Yes  No  [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 <input type="checkbox"/> No <input type="checkbox"/>	
	\$	\$	Yes <input type="checkbox"/> No <input type="checkbox"/>	

## 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 <input type="checkbox"/> No <input type="checkbox"/>					

**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).*