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***Fiduciary Liability***

***Employer Securities Supplemental Application***

**Travelers Casualty and Surety Company of America**

**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 IS SPECIFICALLY PROVIDED.**

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

## I. GENERAL INFORMATION

Name of **Applicant**: _____

1. Name of Employee Stock Ownership Plan (ESOP) or any other plan(s) holding employer securities:

_____

_____

2. Date and reason the plan holding employer securities was established:

_____

_____

3. If the plan is an ESOP, is it leveraged? Yes ☐ No ☐
*If Yes, provide the date, terms and reasons for loan as well as the names of any parties selling shares to the ESOP and list any guarantors of the loan:*

_____

_____

4. Complete the following table to show the relationship of the amount of stock owned by the plan compared to the total number of employer stock shares outstanding:

| Year | Total Shares Outstanding | # of Shares Owned by Plan | Value ($) Per Share | % Owned By Plan |
|---|---|---|---|---|
| Current Year | | | $ | % |
| 1st Prior Year | | | $ | % |
| 2nd Prior Year | | | $ | % |
| Year Established | | | $ | % |

5. Is an independent valuation of the stock completed annually? Yes ☐ No ☐
*If Yes, please provide the name of the entity that performed the valuation and list any other relationships that the entity has with the plan or the **Applicant** including, but not limited to, providing accounting, consulting or banking services:*

_____

_____

6. When the plan was created, did it replace an existing employee benefit plan that was terminated? Yes ☐ No ☐
*If Yes, please provide complete details including names and dates regarding distribution of assets, notices and promises to participants and acceptances by the participants:*

7. Does the plan have a trustee that is not otherwise affiliated with the **Applicant**? Yes ☐ No ☐
*If Yes, please provide the name and title of all independent trustees:*

8. Does the plan have representation on the **Applicant's** Board of Directors? Yes ☐ No ☐
*If Yes, please provide the name and title of the board representative(s):*

9. Does the plan include a provision for pass-through voting and tendering of allocated employer securities held by the plan and "mirrored" voting and tendering of unallocated employer securities held by the plan? Yes ☐ No ☐
*If No, please provide an explanation:*

10. Please describe any financial transactions involving assets of the plan over the last 3 years, or anticipated in the next 12 months impacting more than 10% or over $250,000 of the plan's total assets:

## II. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the **Applicant** or are obtained by the Company from any public source, including the Internet*):

- Most recent stock valuation report
- Plan financial statement for each Employee Stock Ownership Plan (ESOP) or any other plan(s) holding employer securities

## III. 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.

## IV. 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.

## V. SIGNATURE SECTION

**THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, TRUSTEE 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 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, IN ALL STATES OTHER THAN NC 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 THEREWITH, IN ISSUING THE POLICY.**

**ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.**

| | |
|---|---|
| Signature of **Applicant's** Authorized Representative (Partner, Principal, Trustee or Officer) | Name (Printed) |
| Title | Date |

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

| | | |
|---|---|---|
| Producer Signature | Producer Name (Printed) | |
| Agency Name | Agency Code | License Number |