EUCLID
EXEC

DOWNSIZING SUPPLEMENTAL APPLICATION

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.

1. Name of **Applicant**: _____

2. How many employees have been affected by the reduction in force in the past 12 months? (Please provide dates of terminations & numbers of employees impacted by date.) _____

_____

3. How many employees are expected to be affected in the next 12 months? _____

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

_____

_____

_____

Attach a separate sheet if necessary.

5. Has (or will) the **Applicant** articulated the business reasons for the reduction in force, documented those reasons and communicated them to management? Yes☐ No☐

6a. Does the **Applicant** have a written plan outlining the criteria to be used in selecting employees to be laid off? Yes☐ No ☐

6b. If Yes, has that plan been reviewed by counsel? Yes☐ No ☐

6c. If Yes, when was that plan last updated? _____

7. 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☐

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8a. Have (or will) laid off employees be asked to sign waivers or releases? Yes☐ No ☐

8b. If Yes, have the waivers or releases been reviewed by counsel? Yes☐ No ☐

9. Does (or will) the **Applicant** provide outplacement services to laid off employees? Yes☐ No☐

10. Does (or will) the **Applicant** provide severance packages to laid off employees? Yes☐ No☐

I. REQUIRED ATTACHMENTS

- Most recent annual financial statement

II. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL, HEAD OF HUMAN RESOURCES, GENERAL COUNSEL OR OTHER OFFICER ACCEPTABLE TO EUCLID EXEC) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY EUCLID EXEC. 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, Officer, Head of Human Resources or General Counsel)

Name (Printed or Typed) _____ _____

Title _____

Date _____

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

Producer Signature _____

Producer Name (Printed/Typed) _____

Agency Name _____

Agency Code _____

License Number _____