HEALTHCARE ORGANIZATIONS AND PROVIDERS LIABILITY INSURANCE

NEW BUSINESS APPLICATION

PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDE CLAIMS MADE AND REPORTED COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR AN APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. READ THE POLICY AND THIS APPLICATION CAREFULLY AND CONTACT YOUR PROVIDER WITH ANY QUESTIONS.

Instructions:

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.

- Currently valued carrier loss runs for the previous seven (7) years
- Schedule of physicians/residents/interns for whom coverage is requested
- Risk Management/Quality/Safety Plan(s)
- Most recent accreditation survey report with response to any deficiencies cited
- Most recent CMS/state licensing survey with response to any deficiencies cited
- Current audited or accountant-prepared financial statements with notes
- Copy of Medical Staff By-Laws

For Self-Insured Programs:

- Trust financial agreement
- Bank statement of trust fund
- Description of claims handling
- Trust coverage wording
- Recent actuarial review

GENERAL INFORMATION

1. Applicant Legal Name:

2. Mailing Address: Street: ______________________________
   City: ______________________ State: __ Zip:_____-____
   County:____________________ Website:____________________

3. Applicant's Legal Structure
   ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC
   ☐ Other: ______________________________

4. Tax Status
   ☐ For Profit – Private ☐ For Profit – Publicly Traded ☐ Not for Profit
   ☐ Governmental Fed. Tax ID# __-_______

5. Type of Risk (check all that apply)
   ☐ Acute care hospital
   ☐ Behavioral health hospital
   ☐ Rehabilitation hospital
   ☐ Chemical dependency/substance abuse facility
   ☐ Senior living/LTC facility
   ☐ Accountable care organization
   ☐ Critical access hospital
   ☐ Long term acute care hospital (LTAC)
   ☐ Children's Hospital
   ☐ Research Hospital
   ☐ Specialty Hospital: _______________
   ☐ Other: ____________________

6. Number of years in operation: _____ years Number of years under current ownership: _____ years

7. Please indicate accreditation(s)/certification(s) held by the Applicant:
   ☐ The Joint Commission (TJC)
   ☐ American Osteopathic Association (AOA)
   ☐ College of American Pathologists (CAP)
   ☐ Magnet Status (ANCC)
   ☐ Det Norske Veritas Health Care (DNV)
   ☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
   ☐ Clinical Laboratory Improvement Amendment (CLIA)
   ☐ Other: ____________________

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8. List all states where the Applicant is operating and providing services:

9. Are all facilities licensed by the State's in which they operate? ☐ Yes ☐ No

10. Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency? ☐ Yes ☐ No
    If "Yes", please provide details: ____

11. Does the Applicant have any operations outside of the United States of America? ☐ Yes ☐ No
    If "Yes", please provide details: ____

12. Is the Applicant owned, controlled or managed by another entity? ☐ Yes ☐ No
    If "Yes", please provide details: ____

13. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to:
    a. Merge, acquire or consolidate with another entity? ☐ Yes ☐ No
    b. Sell or divest another entity or facility? ☐ Yes ☐ No
    c. Discontinue any operations or services? ☐ Yes ☐ No
    d. Enter into any new business activities or services (including new procedures or products being offered)? ☐ Yes ☐ No

    If "Yes", describe the essential terms of each such transaction: ____________________________________

14. Has the Applicant entered into any joint ventures or limited partnerships? ☐ Yes ☐ No
    If "Yes", describe the essential terms of each such transaction: ____________________________________

15. Please list below all subsidiaries, including a description of operations, relationship to the Applicant, ownership and retroactive date.

Name & Address	Description of Operations	Relationship	Ownership %	Retroactive Date

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

16. Does the Applicant own, operate or manage any business or facilities other than the operations described in this Application? ☐ Yes ☐ No
    If "Yes", please provide details, including name of entity and the Applicant's ownership interest/management role: ____________________________________

17. Does the Applicant provide or participate in any teaching programs? ☐ Yes ☐ No
    If "Yes", please describe the type of programs: ____________________________________

18. Are the programs hospital-sponsored? ☐ Yes ☐ No
    If "Yes", please provide the name of the sponsoring institutions: ____________________________________

19. Does the Applicant require proof of health care professional liability insurance for students/residents/interns? ☐ Yes ☐ No

20. Does the Applicant utilize integrated, electronic medical records for:
    a. Inpatient services? ☐ Yes ☐ No
    b. Outpatient services? ☐ Yes ☐ No
       If "Yes", are integrated, electronic medical records utilized in all locations? ☐ Yes ☐ No

21. Does the Applicant have any technology updates planned in the next 12 months? ☐ Yes ☐ No
    If "Yes", please provide details: ____________________________________

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22. Does the Applicant use E-prescribing? ☐ Yes ☐ No
23. Does the Applicant utilize Computer Physician Order Entry (CPOE) that includes prescribing error detection and override alerts? ☐ Yes ☐ No
24. Does the Applicant utilize telehealth (eICU, teleradiology, etc.)? ☐ Yes ☐ No
    If "Yes", please provide details: ________________________________
25. Are clinical research studies performed? ☐ Yes ☐ No
    If "Yes" i) is IRB approval obtained? ☐ Yes ☐ No
    ii) Who obtains consent from study participant(s)? ________________________________
26. Does the Applicant participate in a patient safety organization? ☐ Yes ☐ No

CURRENT AND REQUESTED COVERAGE

Please note that requested coverage is not automatically provided. The policy, if issued, will determine actual coverage.

27. Requested Policy Period: -
28. Retroactive Date:
29. Coverage Requested (select all that apply): ☐ Primary ☐ Excess
    ☐ Deductible ☐ SIR requested: Each claim: $__________ Aggregate: $__________
    Primary limits of liability requested: Each claim: $__________ Aggregate: $__________
    Excess limits of liability requested: Each claim: $__________ Aggregate: $__________
30. Self-Insured Retention:
    a. What coverage(s) does the SIR apply: ________________________________
    b. Limits of coverage provided by SIR: ________________________________
    c. Do defense expenses erode the limit: ________________________________
    d. Is there a dedicated trust: ________________________________
    e. Who handles claims within the SIR: ________________________________
    f. Which law firm provides defense coverage: ________________________________

31. Current coverage:

	PL	GL	EBL	Excess	Auto	EL
Carrier:						
Policy Period:	-	-	-	-	-	-
Limits (Occ./Agg.):	$ /	$ /	$ /	$	$ CSL	$
Deductible/SIR:	$	$	$	$	$	$
Claims-Made/Occurrence:	☐ CM ☐ Occ	☐ CM ☐ Occ	☐ CM ☐ Occ	☐ CM ☐ Occ	☐ CM ☐ Occ	☐ CM ☐ Occ
Retro Date:						
Years with Carrier:						

32. Describe any additional insureds to be included, description of operations, their interest and required coverage:

Name & Address	Description of Operations	Interest	Coverage Desired
			☐ PL ☐ GL
			☐ PL ☐ GL
			☐ PL ☐ GL
			☐ PL ☐ GL

33. **MISSOURI RESIDENTS – DO NOT ANSWER THIS QUESTION.**
    Has any professional liability insurer ever cancelled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant or any other entity for which coverage is requested? ☐ Yes ☐ No
    If "Yes", please provide details: ________________________________

EXPOSURE DETAILS

34. Please provide the following information: Total number of licensed beds: _____

	Projected Next 12 Months	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year
Inpatient Services (Number of Occupied Beds)					
Acute Care Beds					
Long-Term Acute Care Beds (LTAC)					
Bassinets/Cribs					
Pediatric Beds					
ICU Beds					
CCU Beds					
NICU Beds					
Behavioral Health Beds					
Rehabilitation Beds					
Hospice Beds					
Substance Abuse Beds					
Swing Beds					
Skilled Nursing Care Beds					
Residential/Assisted Living Beds					
Independent Care Beds					
Inpatient Surgeries and Deliveries					
Total Number of Inpatient Surgeries					
Total Number of Deliveries (including C-Sections and VBACs)					
Number of C-Sections					
Number of VBACs					
Outpatient Services (Do not include Lab, X-Ray, and Radiology Units)					
Emergency Department Visits					
Urgent Care Visits					
Outpatient Clinic Visits					
Outpatient Surgeries (include colonoscopies and endoscopies)					
Physician Office Visits					
Home Health Care Visits					
Rehabilitation Visits (occupational, speech and physical)					
Behavioral Health Visits					
Other (describe):					

Physicians

35. Is the Applicant requesting employed physicians, residents or interns be included in the proposed health care professional liability insurance? ☐ Yes ☐ No

If "Yes", please attach a schedule which includes physician name, specialty, PGY year (if applicable), and retroactive date.

Allied Health Care Providers

36. Please provide the number of health care professionals described below who are employed by or work under the control of the Applicant:

Advanced practice registered nurses _____
Physician assistants _____
Podiatrists _____
Psychologists _____
Surgical assistants _____
Other (describe)________________: _____

Hiring/Credentialing

37. Total number of medical staff: Board Certified: % Board Eligible: %

38. Are midlevel practitioners (advanced practice registered nurse, certified registered nurse anesthetist, physician assistant) full members of the medical staff (governed by medical staff bylaws)? ☐ Yes ☐ No

39. Are midlevel practitioners credentialed using the same processes as physicians? ☐ Yes ☐ No

40. Is final credentialing for staff members approved by a formal credentialing committee prior to granting staff privileges? ☐ Yes ☐ No

41. Are privileges provisional for at least six (6) months for all new staff members? ☐ Yes ☐ No

42. Are medical staff re-credentialed at least every 2 years? ☐ Yes ☐ No

43. Are criminal background checks required? ☐ Yes ☐ No

If "Yes", at which level: ☐ County ☐ State ☐ Federal

44. In the past 5 years, has any member of the medical staff had his/her appointment to the medical staff or privileges revoked, restricted or suspended? ☐ Yes ☐ No

If "Yes", please explain: ________________________________

45. Please indicate all of the screening/hiring procedures used for professionals and others who provide patient care services for the Applicant's operations.

a. Verification of educational background ☐ Yes ☐ No
b. Verification of previous employers/employment history ☐ Yes ☐ No
c. Verification of personal references ☐ Yes ☐ No
d. Verification of any pending license suspensions or revocations, or any pending disciplinary action by other facilities ☐ Yes ☐ No
e. Require information on any professional liability or work related claims that have previously been made against any individual ☐ Yes ☐ No
f. Require information on an allegations of sexual abuse or molestation previously made against any individual ☐ Yes ☐ No
g. Drug/alcohol testing ☐ Yes ☐ No

46. Does the Applicant's by-laws require physicians to carry healthcare professional liability insurance? ☐ Yes ☐ No

If "Yes", what limits are required (Each Occurrence/Aggregate): $_______ / $_______

47. Are employees required to complete appropriate annual training/competencies? ☐ Yes ☐ No

48. Does the Applicant require all foreign trained physicians to be certified by the Education Council for Foreign Medical School Graduates? ☐ Yes ☐ No

Specialty Areas

49. **Obstetrics:**

a. Indicate the minimum professional liability limits required for OB/GYNs: $_______ / $_______

Are such limits: ☐ Separate per provider ☐ Shared among all providers

b. List who has privileges to perform vaginal deliveries C-Sections, and VBACs:

Specialty	Privileges for Deliveries	Privileges for C-Sections	Privileges for VBACs
Obstetrician	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Family Practitioner	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other:______________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

c. Are all physicians providing OB services board certified or eligible? ☐ Yes ☐ No

If "No", please explain: ________________________________

d. Do midwives practice at the Applicant's facility? ☐ Yes ☐ No

If "Yes", are they supervised by an obstetrician? ☐ Yes ☐ No

Do they deliver babies in a home setting? ☐ Yes ☐ No

e. What is the service level of the nursery: ☐ Level 1 ☐ Level II ☐ Level III

f. Are obstetricians, family practitioners, physicians, midwives required to maintain continuing education in electronic fetal monitoring (EFM) with validated competency in EFM interpretation as part of the credentialing, privileging and re-credentialing process? ☐ Yes ☐ No

g. Are all labor and delivery nurses and physicians required to successfully complete an approved course in EFM? ☐ Yes ☐ No

h. Is continuous EFM performed on all patients in active labor? ☐ Yes ☐ No

i. Does the Applicant have any off-site birthing centers? ☐ Yes ☐ No

j. Is an obstetrician on the premises twenty-four (24) hours per day? ☐ Yes ☐ No

If "No", what is the maximum time for arrival to the hospital: _____ minutes

k. Can emergency C-sections be performed in less than 30 minutes? ☐ Yes ☐ No

l. Is there a process in place to review and measure obstetric/neonatal-specific practice, quality of care and outcomes that adhere to the professional standards of AAP/ACOG/AWHONN? ☐ Yes ☐ No

If "No", please explain: ________________________________

m. Is the Applicant a regional referral center for newborns requiring intensive care for high risk pregnancies? ☐ Yes ☐ No

If "No", does a written procedure exist for transferring all high-risk mothers and/or babies? ☐ Yes ☐ No

50. **Surgery:**

a. Indicate the minimum professional liability limits required for surgeons: $_______ / $_______

Are such limits: ☐ Separate per provider ☐ Shared among all providers

b. Are all physicians doing surgery board certified or eligible? ☐ Yes ☐ No

If "No", please explain: ________________________________

c. When are sponge, needle and instrument counts performed (OB, surgical and other procedures)?________________________________

d. Are any of the following performed at the Applicant's facility?

Experimental surgery	☐ Yes ☐ No	Spinal surgery	☐ Yes ☐ No
Neurosurgery (brain)	☐ Yes ☐ No	Cardiothoracic surgery	☐ Yes ☐ No
Weight loss/bariatric surgery	☐ Yes ☐ No	Organ transplantation	☐ Yes ☐ No
Gender reassignment surgery	☐ Yes ☐ No		

51. **Bariatric/Weight Loss Surgery**:

a. Indicate the number of bariatric/weight loss surgeries performed in the last 12 months: _____

b. Indicate the number of years the Applicant's facility has specialized in the care and treatment of bariatric/weight loss patients? _____ years

c. Is there a multidisciplinary team and unit dedicated to the care and treatment of bariatric/weight loss patients? ☐ Yes ☐ No

d. Does the Applicant perform bariatric/weight loss surgery on adolescents (under age 18 yrs.)? If "Yes", how many in the last 12 months? _____ ☐ Yes ☐ No

e. Does the Applicant's bariatric/weight loss program comply with the guidelines from the American Society for Bariatric Surgery? ☐ Yes ☐ No

f. Does the Applicant require physicians to be credentialed specifically for bariatric/weight loss surgery? ☐ Yes ☐ No

g. Are all physicians doing bariatric surgery board certified or eligible? ☐ Yes ☐ No
If "No", please explain: ________________________________

h. Is the Applicant designated a Bariatric/Weight Loss Surgery Center of Excellence? ☐ Yes ☐ No

52. **Anesthesia:**

a. Indicate the minimum professional liability limits required for anesthesiologists: $_______ / $_______
Are such limits: ☐ Separate per provider ☐ Shared among all providers

b. Staffing of the anesthesia department is by: (check all that apply)
☐ Contracted anesthesiologists ☐ Employed anesthesiologists ☐ Residents ☐ Surgeons
☐ Contracted CRNAs ☐ Employed CRNAs ☐ Anesthesia assistants
If contracted, name of contracted group(s): ________________________________

c. Are all physicians doing anesthesia board certified or eligible? ☐ Yes ☐ No
If "No", please explain: ________________________________

d. Are non-physician providers supervised by an anesthesiologist or surgeon? ☐ Yes ☐ No
If "No", please explain: ________________________________

e. Is an anesthesiologist/CRNA on the premises twenty-four (24) hours per day? If "No", what is the maximum time for arrival at the hospital? _____ minutes ☐ Yes ☐ No

f. Is the patient's informed consent discussion documented in the patient's medical record? ☐ Yes ☐ No

53. **Emergency Department:**

a. Indicate the minimum professional liability limits required for ED physicians: $_______ / $_______
Are such limits: ☐ Separate per provider ☐ Shared among all providers

b. Staffing or the emergency department is by: (check all that apply)
☐ Contracted physicians ☐ Employed physicians ☐ Staff physicians
☐ Residents ☐ Nurse practitioners ☐ Physician assistants
If contracted, name of contracted group: ________________________________

c. Are all physicians providing ED services board certified or eligible? ☐ Yes ☐ No
If "No", please explain: ________________________________

d. What level of care does the emergency department provide:
☐ Level I (tertiary) ☐ Level II (comprehensive) ☐ Level III (basic) ☐ Level IV (stand-by)

e. Is the Applicant a dedicated trauma center? ☐ Yes ☐ No

f. Is the emergency department staffed 24 hours a day by a physician? ☐ Yes ☐ No

g. Does the Applicant employ EMS personnel (dispatch, EMT, paramedics, flight crew, etc.)? ☐ Yes ☐ No

54. **Radiology Department:**
   a. Indicate the minimum professional liability limits required for radiologists: $_______ / $_______
      Are such limits: ☐ Separate per provider ☐ Shared among all providers
   b. Staffing of the radiology department is by: (check all that apply)
      ☐ Contracted physicians ☐ Employed physicians ☐ Staff physicians
      ☐ Residents ☐ Nurse practitioners ☐ Physician assistants
      If contracted, name of contracted group(s): ________________________________
   c. Are all physicians providing radiology services board certified or eligible? ☐ Yes ☐ No
      If "No", please explain: ________________________________
   d. Does the Applicant perform interventional radiology procedures? ☐ Yes ☐ No
   e. Does the Applicant or the contracted group provide teleradiology services? ☐ Yes ☐ No
      If "Yes", please provide details: ________________________________
   f. Is there a radiologist on the premises 24 hours a day? ☐ Yes ☐ No

55. **Special Services**:
   a. Ambulance — Number of vehicles: _____
      Number of runs per year: _____
   b. Blood Bank — Number of blood donors (pints): _____
   c. Organ Tissue Bank — Number of organ donors: _____
      Number of organ/tissue donations per year: _____

General Liability Exposure

Please provide a schedule of all locations for which coverage is requested. Schedule should include address, operation type, occupancy and square footage for each such location.

56. Do all of the Applicant's locations meet National Fire Protection Agency building codes? ☐ Yes ☐ No

57. Does the Applicant have any new construction or renovation projects planned for the next 12 months? If "Yes", briefly describe: ________________________________ ☐ Yes ☐ No

58. Does the Applicant have any special events/fund raising planned for the next 12 months? ☐ Yes ☐ No

59. Does the Applicant operate any of the following:
   a. Day care center for children? ☐ Yes ☐ No
      If "Yes", i) Is it open to the public? ☐ Yes ☐ No
      ii) How many children attend daily? _____
   b. Day care center for adults? ☐ Yes ☐ No
      If "Yes", how many adults attend daily? _____
   c. Fitness/wellness center? ☐ Yes ☐ No
      If "Yes", is it open to the public? ☐ Yes ☐ No

60. Does the Applicant have a swimming pool on the premises? ☐ Yes ☐ No

61. Does the Applicant have a heliport/helipad? ☐ Yes ☐ No
   If "Yes", i) Where is the pad located (e.g. parking lot, top of building, etc.)? _____
   ii) Estimated number of landings per year? _____
   iii) Is the helicopter: ☐ Owned ☐ Leased

62. How many vehicles in each of the following categories does the Applicant own or operate?
   Private passenger _____ Service _____ Ambulance _____ Patient transport _____
   Emergency _____ Non-emergency _____ Other (please describe): ______________________

63. Are Employee benefits Self-Administered? ☐ Yes ☐ No
   Number of Employees: _____

Risk Management

64. Is there a written, formalized risk management program? ☐ Yes ☐ No

65. Risk Management Contact	Name/Title:
	Email Address:
	Telephone Number: Ext:

66. To whom does the risk manager report?

Contractual Agreements

67. Does the Applicant lease or rent any equipment from others? ☐ Yes ☐ No
 If "Yes", please provide a description of the equipment: ____________________

68. Does the Applicant sell, rent or donate equipment to others? ☐ Yes ☐ No
 If "Yes", please provide details: ____________________

69. Does the Applicant have any contractual agreements with independent contractors who provide services as its facility? (Please submit a copy of each contract.) ☐ Yes ☐ No
 If "Yes" i) Indicate which services are contracted:
 ☐ Housekeeping ☐ Laboratory ☐ Pharmacy ☐ Laundry
 ☐ Pathology ☐ Other (describe): ____________________
 ii) Are certificates of insurance obtained from all contracted providers? ☐ Yes ☐ No
 If "Yes", indicate the minimum insurance limits required: $_______ / $_______

70. Does the Applicant agree to hold others harmless (indemnify) or assume any liability in any contractual agreement? If "Yes", please provide a copy of the contract. ☐ Yes ☐ No
 Note: Please list any entities required by contract to be included as additional insureds in question 32.

CLAIMS HISTORY

71. During the past seven (7) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐ Yes ☐ No

 If "Yes", please provide the following information for all such claims as an attachment to this Application: dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed).

 NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTINON 71 IS EXCLUDED FROM THE PROPOSED INSURANCE.

72. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such entity, or any such individual has reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

 If "Yes", please attach details to this Application.

 NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 72 IS EXCLUDED FROM THE PROPOSED INSURANCE.

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Applicable in AL, AR, DC, LA, MD, NM, RI and WV

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

*Applies in MD Only.

Applicable in CO

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.

Applicable in FL and OK

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)*.

*Applies in FL Only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*.

*Applies to NY Only.

Applicable in ME, TN, VA and WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits.

*Applies in ME Only.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

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 by 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.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by the Company. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

The Company will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

The Company is authorized to make any inquiry in connection with this Application. The Company's acceptance of this Application of the making of any subsequent inquiry does not bind the Applicant or the Company to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must notify the Company immediately and the Company may modify or withdraw any quotation or agreement to bind insurance.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	
NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.	

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address:	Street: City: State: Zip:
Email Address:	

Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:
NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.	