Munich RE

MUNICH RE SPECIALITY INSURANCE
APPLICATION
ALLIED HEALTH FACILITY PROFESSIONAL & GENERAL LIABILITY

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 producer with any questions.

INSTRUCTIONS:

- Carefully review and fully answer each of the following questions completely.
- Complete the application in its entirety. Don't leave any question unanswered. If a question does not apply to you, state N/A.
- If additional space is needed to answer any questions fully, attach a separate page.
- This application must be completed, dated and signed by a principal or officer of the business.

Please attach the following:

The items requested below are to be submitted with this application before a quotation can be developed and released.

1. Completed separate supplemental application(s) for each class of business that you are requesting coverage.
2. Copy of facility license for each location
3. Current CMS or state health department inspection report for each location, if applicable
4. Minimum (5) years recently valued (3 months) loss history, including the current year for each coverage being requested.
5. Most recent accrediting agency report (TJC, CARF, AAAHC, AAAASF, etc.), if applicable.
6. Most recent CPA prepared and audited financial statement.
7. Copy of marketing materials/brochures.
8. List of all entities, subsidiaries, joint ventures, etc. requested to be included for coverage under the proposed insurance. Include name, address, description of operations, relationship, date acquired, ownership percentage and retroactive date.

SECTION I. GENERAL INFORMATION

Identify the type(s) of Allied Health Facilities seeking insurance (mark all that apply):

☐ Abortion Service Centers ☐ Ambulances ☐ Behavioral Health Service Centers ☐ Blood Banks
☐ Cancer Treatment Centers ☐ Cardiac Catheterization Centers ☐ College/Student Health
☐ Community Health Centers ☐ Development Disabled Rehabs ☐ Dialysis Centers ☐ Emergicenters
☐ Employee Health Centers ☐ Endoscopy Centers ☐ Eye Banks ☐ Health Departments ☐ Home Health Care
☐ Hospice Care ☐ Imaging Centers ☐ Intraoperative Monitoring Company ☐ Laboratories
☐ Lithotripsy Centers ☐ Med Spas ☐ Medical Registries ☐ Optical Centers ☐ Pharmacies
☐ Rehabilitation Centers ☐ Retail Clinics ☐ Schools ☐ Sleep Centers ☐ Substance Abuse Centers
☐ Surgical Centers ☐ Telemedicine Company ☐ Urgent Care Centers ☐ Wound Care Centers
☐ Weight Loss Centers

Indicate the number of patients by age group: < 18 yrs. of age:_____ 18-54 yrs. of age:_____ 55 yrs. of age+:_____

REQUESTED EFFECTIVE DATE: **LIST STATES WHERE APPLICANT PROVIDES SERVICES**:

☐ New Applicant ☐ Renewal (If Renewal, POLICY NUMBER):_____

1. Employers Federal Tax ID #(FEIN): _____
2. Corporate/Parent Name (d/b/a): _____

Corporate Address: _____

City: _____ State: _____ Zip Code: _____

3. Website: _____

4. Contact Person: _____ Title: _____

E-mail: _____ Phone #: _____ Fax #: _____

5. Number of years the organization is in operation: _____ Number of years under current ownership: _____

6. Number of years under current management company (if applicable): _____

Name of Management Company: _____

7. Does the Applicant provide management services to other entities for a fee? ..... ☐ Yes ☐ No

8. Revenue:

Historical (past 5 years) annual gross revenues	Year
(current year annual gross revenues	
(projected 12 mo. annual gross revenues)	

9. Applicant is (check all that applies):

☐ Profit ☐ Individual ☐ Accredited by TJC ☐ Accredited by AAAHC
☐ Non-Profit ☐ Partnership ☐ Accredited by CARF ☐ Accredited by AAAASF
☐ Governmental ☐ Corporation ☐ Accredited by other: List
☐ Joint Venture

10. If the Named Insured owns or manages multiple facilities, are all facilities governed by the same corporate policies and procedures?..... ☐ Yes ☐ No

11. Are there state licensing requirements for the facilities?..... ☐ Yes ☐ No

If yes, has the state conducted an inspection of facilities? (please submit with application)..... ☐ Yes ☐ No

12. Has the organization's or any of the facility's/location's licenses been suspended, revoked or placed on probation in the past seven years?..... ☐ Yes ☐ No

13. Has Medicare or Medicaid Certification been suspended or revoked in the last seven years? ..... ☐ Yes ☐ No

14. Has a state or federal agency fined any facility within the past seven years? ..... ☐ Yes ☐ No

15. Has the organization had substantiated allegations of financial fraud/abuse or physical/sexual/verbal or any other form of abuse?..... ☐ Yes ☐ No

16. Within the past 5 years 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. Offer any new business activities or services? ..... ☐ Yes ☐ No

(If "Yes" to any of the above, please attach a description for each transaction.)

SECTION II. COVERAGE INFORMATION

17. Coverage Requested: (expand the table with additional rows as needed, or attach separate page)

PRIMARY	Effective Date	Retroactive Date	Limits Per Occ/Agg	Deductible/SIR
Professional Liability				
General Liability				
Employee Benefits Liability				
Other (describe):				

EXCESS	Effective Date	Retroactive Date	Limits Per Occ/Agg	Deductible/SIR
Professional Liability				
General Liability				
Employee Benefits				
Auto Liability				
Employers' Liability				
Other (describe):				

18. Current Coverage: (expand the table with additional rows as needed, or attach separate page)

PRIMARY	Carrier	Effective Date	Occ. or Claims Made	Retro Date	Limits Per Occ/Agg	Deductible or SIR	Premium
Professional Liability							
General Liability							
Employee Benefits Liability							
Other (describe):							
EXCESS	**Carrier**	**Effective Date**	**Occ. or Claims Made**	**Retro Date**	**Limits Per Occ/Agg**	**Deductible or SIR**	**Premium**
Professional Liability							
General Liability							
Employee Benefits Liability							
Auto Liability							
Employers' Liability							
Other (describe):							

19. Has any insurer canceled or declined to renew professional liability coverage (**Missouri Residents Do Not Answer**)? ..... ☐ Yes ☐ No

    If yes, please explain: _____

20. Neither the Applicant nor any individual or entity proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows: (If none, state so): _____

It is agreed that with respect to the immediately preceding question, if any such fact, circumstance, situation, transaction, event, act, error, or omission exists, then such fact, circumstance, situation, transaction, event, act, error, or omission and any claim, proceeding or action arising therefrom is excluded from the proposed coverage.

SECTION III. FACILITY EXPOSURE INFORMATION
(Please complete the Supplemental Application for each location)

21. **Services Provided**: Indicate all services provided by your facilities, giving requested information for each classification. Information given should include projected numbers for the next 12 months. "Visits" are defined as the number of times each patient enters your facility for healthcare related services. "Beds" are defined as the average number of occupied beds. "Revenue" is the amount generated from sale of goods and services.

(A) Facility Type	Current Year Gross Revenues	Projected 12 Months Gross Revenues
Laboratory, includes Sleep Center		
Lithotripsy Center		
Optical Establishment (Eye Care)		
Organ/Tissue Bank		
Pharmacy		
Research		
Telemedicine Company		
Wound Care Center		
X- Ray/Imaging/MRI		
Other (*please describe*)		

(B) Facility Type	Current Year # of Visits	Projected 12 Months # of Visits	# of overnight Beds
Abortion Clinic			
Cancer Treatment Center/Non-Radiological			
Cardiac Catheterization Center			
College/University Health Center			
Community Health Center			
Dialysis Center			
Emergicenter			
Employee Health Center			
Endoscopy Center			
Health Department			
Hospice Care			
Intraoperative Monitoring Company			
Medical Spa			
Mental Health – Counseling			
Mental Health – Crisis Management			
Mental Health – Substance Abuse			
Rehabilitation – Cardiac			
Rehabilitation – Development Disability			
Rehabilitation – Physical/Occupational			
Rehabilitation – Trauma – Therapy			
Rehabilitation – Trauma – Transitional Living			
Rehabilitation – Trauma – Skilled Medical			
Retail Clinic			
Surgical Center - Single Specialty Please specify:			
Surgical Center – Multi-Specialty			
Urgent Care Center			
Weight Loss Center (Bariatrics)			
Other (*please describe*)			

(C) Facility Type	Current Year FTE's	Projected 12 months - FTE's
Home Care Agency		
Medical Registries		
Other (*please describe*)		

(D) Facility Type	Current Year number of donations	Projected 12 months - number of donations
Blood/Plasma Banks		
Other (*please describe*)		

(E) Facility Type	Current Year Annual Gross Revenue	Projected 12 Months Gross Revenue	Current Year Annual Payroll	Projected 12 Months Annual Payroll	Current Year # of Runs	Projected 12 Months # of Runs
EMT/Ambulance						
Other (*please describe*)						

22. A proposed physician/surgeon would only be covered under the policy in his/her capacity as a medical director for activities relating to administration of the facility.

Medical Director Name	Current Insurance Carrier	Limits	Effective date of policy	Employee/Contractor	Hrs/mo

23. Other Health Care Professionals. Indicate the number in each category **AND** full-time and part-time

Type of Professional	Employees (Full Time/Part Time)	Contractors (Full Time/Part Time)	Volunteers (Full Time/Part Time)
Dentists			
Emergency Medical Technicians			
Nurse Anesthetists			
Nurse Midwives			
Nurse Practitioners			
Occupational Therapists			
Oral Surgeons			
Pharmacists			
Physical Therapists			
Physician Assistants			
Psychologists			
RNs/LPNs/LVNs			
Social Workers			
Technicians			
Other (define)			

24. Written requirements the following providers carry Professional Liability Insurance - Please indicate the limits required.

	Yes	No	Limits
Physicians			
Surgeons			
Oral Surgeons			
Dentists			
Pharmacists			
Nurse Anesthetists			
Nurse Midwives			
Nurse Practitioners			
Physician Assistants			
Other (define)			

25. Are Certificates of Insurance obtained and updated annually for all professional services that are contracted? ..... ☐ Yes ☐ No

26. Is there a written formal credentialing policy in place that includes verification of contracted and employed staff for certifications, criminal background checking, sex offender status, abuse and neglect registry checking, employment history and clinical competency?..…….. ☐ Yes ☐ No

27. Does the organization obtain driving records/MVRs on employees assigned to drive vehicles? ..... ☐ Yes ☐ No

28. Please provide physical facility information:

Address/Occupancy	Square Footage	Age	Type of Construction	# of Floors	Type of Fire Protection*	Clinical or Administrative

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

29. Does the organization conduct periodic evacuation drills?..... ☐ Yes ☐ No

If "Yes," which departments and how often? _____

30. Does the organization conduct periodic fire drills? ..... ☐ Yes ☐ No

If "Yes," how often? _____

31. Does the organization have a written Emergency Management Preparedness Plan? ..... ☐ Yes ☐ No

If "Yes," please provide a copy.

32. Is new construction and/or abatement ☐ contemplated or ☐ pending? ..... ☐ Yes ☐ No

If "Yes," please explain:

33. Has the organization identified and developed back-up systems for the loss of essential utilities, supplies, equipment, etc? ..... ☐ Yes ☐ No

If "No," please explain: _____

34. Indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

35. Do you sell/lease durable medical equipment or products to patients or others in connection?..... ☐ Yes ☐ No

If yes, please complete the following information:

Total Annual Sales: $ _____

Total Annual Lease/Rental Receipts: $ _____

Please provide product brochures and a list of items and their total annual sales and leases.

_____

Have any of the products that you distribute ever been recalled?..... ☐ Yes ☐ No

36. Do you provide preventive maintenance or repairs on medical equipment leased to others?..... ☐ Yes ☐ No
If yes, please provide details: _____

SECTION IV. RISK & CLAIMS MANAGEMENT INFORMATION

37. **RISK MANAGEMENT**

a. Please indicate who is responsible for the organization's risk management program.

Name: _____ Title: _____

How long in this role? _____

b. Who does this individual report to? _____

c. Does this individual have responsibilities other than risk management? ..... ☐ Yes ☐ No

If "Yes," please describe: _____

d. Are all incident reports reviewed by this individual and the medical director? ..... ☐ Yes ☐ No

e. Do all contracts for clinical services include mutual hold harmless and indemnification agreements? ..... ☐ Yes ☐ No

If "No," describe the contracted services where these provisions do not exist: _____

f. Do all contracts for clinical services contain minimum Professional Liability insurance requirements for the other party? ..... ☐ Yes ☐ No

If "Yes," what is the minimum amount required? $_____ Each Professional Incident / $_____ Annual Aggregate

If "No," describe the contracted services where this provision does not exist: _____

g. Is an electronic medical records system (EMR) fully integrated at all sites? ..... ☐ Yes ☐ No

If "No," what is the plan for full integration? _____

h. Does the organization have a formal Just Culture Program? ..... ☐ Yes ☐ No

i. Does the organization require an arbitration agreement be signed by all patients? ……. ☐ Yes ☐ No

j. If anesthesia is provided, is all anesthesia services provided by a Board-Certified Anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA)? ……. ☐ Yes ☐ No

38. **CLAIMS MANAGEMENT**

a. Who, within the organization, is responsible for claims management activities?

Name: _____ Title: _____

b. Is there a written claims management policy/procedure? ..... ☐ Yes ☐ No

If "Yes," please attach.

c. Does a Third Party Administrator manage claims within the SIR (if applicable)? ☐ Yes ☐ No

If "Yes," please provide name of TPA Firm and Contact: _____

d. Please provide names of defense firms who currently represent you in professional liability matters.

_____

SECTION V. AUTO LIABILITY INFORMATION (Applicable only for UMBRELLA – N/A for primary coverage)

39. Please check and complete for all that apply:

Vehicle Type	Service Radius (in miles per vehicle)	Number of Urban Use Vehicles	Number of Non-Urban Use Vehicles	Used for Patient Transport?
Private Passenger - Delivery				☐ Yes ☐ No
Private Passenger – Patient Service				☐ Yes ☐ No
Private Passenger - Other				☐ Yes ☐ No
Van (< 8 passengers)				☐ Yes ☐ No

Vehicle Type	Service Radius (in miles per vehicle)	Number of Urban Use Vehicles	Number of Non-Urban Use Vehicles	Used for Patient Transport?
Van (8-15 passengers)				☐ Yes ☐ No
Light Truck - Delivery				☐ Yes ☐ No
Light Truck – Patient Service				☐ Yes ☐ No
Light Truck - Other				☐ Yes ☐ No
Medium Truck				☐ Yes ☐ No
Bus (15-30 passengers)				☐ Yes ☐ No
Bus (> 30 passengers)				☐ Yes ☐ No
Hired & Non-Owned Autos				☐ Yes ☐ No
Other:				☐ Yes ☐ No

SECTION IX. EMPLOYER'S LIABILITY & EMPLOYEE BENEFITS LIABILITY INFORMATION

40. Number of employees: _____

41. Are employee benefits self-administered? ..... ☐ Yes ☐ No

If "No," are they administered by an outside vendor? ..... ☐ Yes ☐ No

If "Yes," what is the name of the vendor? _____

ADDITIONAL DOCUMENTS AND INFORMATION INCORPORATED BY REFERENCE

ALL WRITTEN STATEMENTS, MATERIALS OR DOCUMENTS FURNISHED TO THE **INSURER** IN CONJUNCTION WITH THIS **APPLICATION**, REGARDLESS OF WHETHER SUCH DOCUMENTS ARE ATTACHED TO THE POLICY, ARE HEREBY INCORPORATED BY REFERENCE INTO THIS **APPLICATION** AND MADE A PART HEREOF, INCLUDING WITHOUT LIMITATION ANY SUPPLEMENTAL APPLICATIONS OR QUESTIONNAIRES.

LEGAL NOTICE

BEFORE YOU SIGN THIS APPLICATION, READ THESE NOTICES CAREFULLY AND DISCUSS WITH YOUR BROKER IF YOU HAVE ANY QUESTIONS.

FOR THE PURPOSES OF THIS **APPLICATION**, THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE OF ALL PERSON(S) OR ENTITIES PROPOSED FOR THIS INSURANCE DECLARES THAT THE STATEMENTS IN THIS **APPLICATION**, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE.

THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE AGREES THAT IF THE STATEMENTS AND INFORMATION SUPPLIED ON THIS **APPLICATION** OR INCORPORATED BY REFERENCE CHANGES BETWEEN THE DATE OF THIS **APPLICATION** AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE **INSURER** OF SUCH CHANGES, AND THE **INSURER** MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

SIGNING OF THIS **APPLICATION** DOES NOT BIND THE **APPLICANT** OR THE **INSURER** TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS **APPLICATION** AND ANY INFORMATION INCORPORATED BY REFERENCE HERETO, SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IS INCORPORATED INTO AND IS PART OF THE POLICY.

SHOULD **INSURER** ISSUE A POLICY, **APPLICANT** AGREES THAT SUCH POLICY IS ISSUED IN RELIANCE UPON THE TRUTH OF THE STATEMENTS AND REPRESENTATIONS IN THIS **APPLICATION** OR INCORPORATED BY REFERENCE HEREIN. ANY MISREPRESENTATION, OMISSION, CONCEALMENT OR INCORRECT STATEMENT OF A MATERIAL FACT, IN THIS **APPLICATION**, INCORPORATED BY REFERENCE OR OTHERWISE, SHALL BE GROUNDS FOR THE RESCISSION OF ANY POLICY ISSUED.

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

STATE FRAUD NOTICES

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: 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 AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE **APPLICANT**.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: 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 OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN

INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

FOR THE PURPOSES OF THIS **APPLICATION**, THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE OF ALL PERSON(S) OR ENTITIES PROPOSED FOR THIS INSURANCE DECLARES THAT THE STATEMENTS IN THIS **APPLICATION**, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE.

SIGNATURES

Signed: _____

Date: _____

Title: _____ Organization: _____

(Must be signed by an authorized officer) (Organization's seal)

Producer: _____

License Number: _____

Address: _____

_____