

Physicians Professional Liability Insurance Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Verify that all requested explanations and documents are attached, including current declarations page and policy, CV and currently valued loss runs.

- Please complete this form electronically or type/print clearly and answer all questions.
- If you do not purchase Prior Acts Coverage from us you will not have coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.
- If your specialty is Pain Management, Neurosurgery or Bariatric Surgery you will need to complete an additional procedure questionnaire.

ACCOUNT INFORMATION

1. Applicant Name			
Other Names Used			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Degree / Title			
Birth Date (MM/DD/YYYY)			
Federal DEA #			
National Practitioner ID #			
2. Home Address	Street:		
	City:	State:	Zip:
	County:		
	Phone:	Fax:	
	Email:		
3. Principal Office Address	Street:		
	City:	State:	Zip:
	County:		
	Phone:	Fax:	
	Email:		
	Website:		
4. Other Office Address	Street:		
	City:	State:	Zip:
	County:		
	Phone:	Fax:	
	Website:		

5. Type of Practice (check all that apply):

Individual (solo) Unincorporated Individual (solo) Corporation Partnership

Member of Multi-Person Corporation or Association Employee of: _____

Other (describe): _____ Independent Contractor of: _____

6. List Federal Taxpayer Identification Number(s) and name(s) of Corporate entity(ies):

Entity: _____

Entity: _____

7. Please list names of all other partners, stockholders, associates, independent contractors and employed physicians. (Indicate status of each and provide proof of coverage for each).

Name: _____ Carrier: _____ Current Limits: _____

FINANCIAL AND EXPOSURE DETAILS

8. List all states where the Applicant is licensed:

State: _____ License # _____

State: _____ License # _____

State: _____ License # _____

9. Medical Specialty: _____ % of practice: _____

Sub-Specialty: _____ % of practice: _____

10. Are you American Board Certified in your Specialty? Yes No

Name of Specialty Board(s): _____

Date of Certification: _____ / _____ / _____

11. Are you American Board Certified in your Sub-Specialty? Yes No

Name of Specialty Board(s): _____

Date of Certification: _____ / _____ / _____

12. If you are a foreign medical graduate, are you certified by the Educational Commission for Foreign Medical Graduates? Yes No

13. Have you ever failed any Board Certification testing? Yes No

If "Yes" please explain: _____

14. Attestation

If the answer to any of the following is "Yes," please give full details (including dates) on a separate sheet of paper:

- a. Have you ever been or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? Yes No
If "Yes," provide copies of all accusations, decisions, consent orders, etc.
- b. Has or is your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? Yes No
- c. Have you ever had privileges at any hospital or other institution denied, reduced, revoked, restricted or suspended? Yes No
- d. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics or any other substance abuse, sexual addiction, anger management issues, or any mental or emotional disorder? Yes No
- e. Have you ever been arrested, indicted, pled guilty to, or been convicted of any crime other than minor traffic violations? Yes No
- f. Has your membership in any professional society or association ever been refused, censured, suspended or revoked? Yes No
- g. Do you currently have or have you ever had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine? Yes No
- h. Are you currently or have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform your professional duties? Yes No
- i. Has any physician, patient or insurance plan ever filed a complaint against you with any Medical Association/Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau? Yes No
- j. Have you ever been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)? Yes No

15. Training

Medical School: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Internship:

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Type of Residency: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Fellowship Training /Type: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Additional Medical Specialty training	<u>Type</u>	<u>Dates</u>
<u>Location</u>		

<p>16. Do you perform surgery:</p> <p>a. In your office? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>b. In any other non-hospital facility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="padding-left: 20px;">If "Yes" list the names and type of facilities:</p> <p style="padding-left: 20px;">List the surgical procedures you perform in your office or other non-hospital facility:</p> <p>c. Is general anesthesia administered in any of the above non-hospital facilities? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="padding-left: 20px;">If "Yes," by whom?</p>		
<p>17. Do you treat or review the treatment of prison inmates? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If "Yes:"</p> <p>a. What percentage of your practice? _____ %</p> <p>b. Please explain and provide facility names:</p> <p>c. Is insurance provided by the above facility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>		
<p>18. Do you practice as a professional or amateur sports team physician? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If "Yes,"</p> <p>a. What percentage of your practice? _____ %</p> <p>b. Describe duties, team names and type of sport:</p>		
<p>19. Do you perform medical legal evaluations? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If "Yes,"</p> <p>a. What percentage of your practice? _____ %</p> <p>b. For whom?</p>		
<p>20. Do you treat or consult on patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If "Yes:"</p> <p>a. What percentage of your practice? _____ %</p> <p>b. Where?</p>		

21. Are you associated in any capacity with, or do you have a financial relationship (ownership, investment or compensation) with, any of the following:

a. Any health care facility having bed and board accommodations? Yes No

b. Any surgicenter, clinic, urgent care center, foundation, blood bank, laboratory, abortion clinic, birthing center, physical, occupational or speech-language therapy services, radiology/imaging services, radiation therapy services, durable medical equipment/supplies, prosthetic or orthotic devices/supplies, home health services, or outpatient prescription drugs? Yes No

If "Yes" to either of the above, are you:

Owner (whole or part) Executive Officer Director of Ancillary Services Dept.
 Administrator Medical Director Committee Member
 Other (describe):

c. Any other medically related business enterprise? Yes No

If "Yes," please explain:

22. Are you a physician with teaching responsibilities? Yes No

If "Yes:"

a. Please explain:

b. Is insurance coverage provided by this institution or facility? Yes No

23. List all facilities (i.e. hospitals, surgicenters, etc.) where you are currently on staff and show percentage of work in each facility:

<u>Facility Name</u>	<u>City</u>	<u>State</u>	<u>Type of Privileges</u>	<u>% of Work</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

24. Are you a Hospitalist? Yes No

If "Yes," at what facilities?

25. Do you:

a. Work in any emergency room? Yes No

If "Yes," is it required solely to maintain staff privileges? Yes No

b. Provide any Locum Tenens services? Yes No

c. "Moonlight" at any facilities? Yes No

d. Provide any services at a hotel, spa or health club? Yes No

e. Provide pre or post-operative care or follow-up for any bariatric surgery patients? Yes No

If "Yes," percent of practice? _____%

If "Yes," to any of the above, please explain:

26.	Do you treat patients in any nursing home, skilled nursing facility or assisted living center? If "Yes:" a. What percent of practice? _____ % b. Do you treat patients other than your own? _____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No												
27.	What percentage of your practice involves the treatment of chronic pain management with medications only? _____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No												
28.	As part of your practice do you diagnose, treat, care for or consult with patients regarding the use of medical marijuana? If "Yes," please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No												
29.	Are you associated with any clinics that dispense medical marijuana? If "Yes" please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No												
30.	Are you a medical director of any facility? If "Yes," what facility? If "Yes, provide evidence of coverage for each facility.	<input type="checkbox"/> Yes <input type="checkbox"/> No												
31.	Do you perform consultations outside the state of your primary office address, including but not limited to, the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (tele-medicine or internet medicine) or do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? If "Yes:" a. What percentage of your practice? _____ % b. Identify all states in which such patients reside:	<input type="checkbox"/> Yes <input type="checkbox"/> No												
32.	Do you treat patients who reside outside the state of your primary office address? If "Yes" what percentage of your practice? _____ % What states?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
33.	Do you have any other practice outside of what you are applying for coverage? If "Yes," a. Name of practice: _____ b. Name of Carrier: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No												
34.	List all locations where you have practiced in the last 10 years (include time period, group name and address). <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>Group Name</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Street/City/State</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>During Years</u></th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </tbody> </table>	<u>Group Name</u>	<u>Street/City/State</u>	<u>During Years</u>										
<u>Group Name</u>	<u>Street/City/State</u>	<u>During Years</u>												

35. How many:

a. Days do you work per week? _____

b. Hours do you work per day? _____

c. How many surgical procedures do you perform each week? _____

36. What is your average weekly patient load? _____

37. What percent of your patients are:

a. Over age 65? _____%

a. Age 18 or younger? _____%

b. Hospitalized patients? _____%

38. Do you or your professional entity employ or contract for the services of any healthcare personnel? Yes No

If "Yes," provide number of each and indicate if coverage (shared limits) is desired for each.
(Note: If employed by an entity, coverage may not be available.)

	Full-Time / Part-Time	# Employed	Is Coverage Desired?	# of Independent Contractors	Are they Insured?
Nurses (RN, LPN, LVN)					
Medical Assistants					
Technicians					
Psychologists					
Physical Therapists					
Physicians Assistants**					
Nurse Practitioners**					
CRNA's**					
Nurse Midwives**					
Other (describe):					
Other (describe):					

**If employed or contracted, please submit a written explanation of practice and procedures performed, along with certificate of course completion and license number. Provide proof of insurance if insured elsewhere. If coverage is desired, please complete an Allied Personnel Professional Liability Insurance Application for each.

39. Do you advertise your medical practice? Yes No

If "Yes:"

a. In what states?

b. List medium(s) and frequency of each:

c. Provide copies of advertisements that you are currently using or have placed in periodicals, yellow pages, on flyers, handouts, etc. and any scripts being used for voice or film media.

40. Do you use experimental devices or drugs or do you perform experimental procedures or therapy in treatment or surgery or are you a principal investigator for any clinical trial? Yes No

If "Yes:"

a. Provide details:

b. Are the protocols IRB approved? Yes No

c. Are you involved or do you participate in non-IRB approved clinical research trials? Yes No

If "yes," please provide full details on separate sheet and include supporting documents.

41. Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule? Yes No

If "Yes," have you implemented procedures to comply with the HIPAA Privacy Rule? Yes No

42. Has your practice (e.g. specialty, procedures or practice environment) changed in the last five years? Yes No

If "Yes," please explain:

E. Surgical Procedures	# Performed		# Assisted		Home Deliveries Other Non-Hospital Deliveries (explain):				
	Past Year	Next Year	Past Year	Next Year					
Adenoidectomy					VBAC				
Anal Fissure					Other (describe):				
Anal Fistulectomies									
Any surgical procedure involving cutting into or within the abdominal cavity, chest cavity, orbital cavity, spine or facial sinuses					<input type="checkbox"/> None of the above				
Any surgical procedures on malignant lesions except for diagnostic purposes					F. Urological Procedures	# Performed		# Assisted	
Amputations						Past Year	Next Year	Past Year	Next Year
Appendectomies					Any cutting into or on the kidney, ureter or bladder				
Aspiration of Cyst of Breast					Aspiration of Hydrocele				
BCIR					Circumcisions				
Biopsies					Orchiectomy				
If "Yes," explain types:					Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)				
Cholecystectomies - Open					Prosthetic Implants				
Chymopapian Injections					Sex Change Surgery				
Hemorrhoidectomies					Treatment of Torsion of the Testicle				
Hernioplasties					Vasectomy				
Herniorrhaphy (Inguinal or Femoral Only)					Other (describe):				
Laparoscopic Cholecystectomies					<input type="checkbox"/> None of the above				
Mastectomy					G. Anesthesia Procedures:	# Performed		# Assisted	
Mastoidectomy						Past Year	Next Year	Past Year	Next Year
Minor Office Surgery					Acupuncture				
Myringotomy					If "Yes," for anesthesia?				
Nasal Polypectomy					Caudal				
Operations within the middle or inner ear					Digital Block				
Organ Transplants					General				
If "Yes," explain:					Intravenous Anesthesia				
Otorhinolaryngology					Intravenous Analgesia				
Peripheral Nerve Surgery					Nitrous Oxide				
Prostatectomy					Obstetrical Anesthesia				
Reconstructive Vascular Surgery, Thromboembolctomy and/or Thrombectomy of the arteries or veins					Pain Blocks				
Repair of laceration not involving nerve or tendon					Pain Management				
Submucous Nasal Resections					If "Yes," please complete a Pain Management Questionnaire				
Surgical treatment of cysts, superficial abscesses, minor traumatic wound & superficial biopsies					Peripheral Nerve Block				
Surgical Weight Reduction					Spinal Anesthesia				
If "Yes," complete a Bariatric Surgery Questionnaire					Other (describe):				
Thyroidectomy					If "Yes" for any Anesthesia type, check locations where performed:				
					<input type="checkbox"/> Hospital <input type="checkbox"/> Surgicenter <input type="checkbox"/> Non-hospital facility				
					Do you perform Anesthesia for any Genital Cosmetic Surgery Procedures?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
					Do you perform Anesthesia for any Bariatric Surgery Procedures?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
					Do you employ any inhalation therapists?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

	# Performed		# Assisted			# Performed	# Assisted
	Past Year	Next Year	Past Year	Next Year			
Tonsillectomy					Have you assumed supervisory duties over: Nurse Anesthetists? <input type="checkbox"/> Yes <input type="checkbox"/> No Inhalation Therapists? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None of the above		
Vein Stripping							
Other (describe): _____							
<input type="checkbox"/> None of the above							
H. Plastic & Cosmetic Procedures:					I. Orthopedic & Neurosurgical Procedures:		
Autologous Fat Injection					Any operative orthopedics		
Blepharoplasty (cosmetic)					Arthroscopy or Arthrography		
Botox Injections					Injection of Bursa		
If "Yes," where are, by whom and what procedures are performed? _____					Joint Implants		
					Neuro Implant Surgery for Pain		
					Open Reduction of Fractures		
					Prolotherapy		
					If "Yes," do you use Phenol? <input type="checkbox"/> Yes <input type="checkbox"/> No		
					Repair of Extensor Tendon		
					Repair of Flexor Tendon		
					Spinal Surgery		
					Anterior Cervical Discectomies		
Breast Reduction					Cervical Laminectomies		
Breast Enhancement – Silicone					Pedicle Screw		
Breast Enhancement – Saline					Scoliosis Surgery		
Breast Enhancement – Trans-Umbilical					Stereotactic Neurosurgery		
Chemical Peels					Other (describe): _____		
Collagen Injections					<input type="checkbox"/> None of the above		
Coronal Lift							
					J. Ophthalmology Procedures:	# Performed	# Assisted
Dermabrasion					Automated Lamellar Keratotomy	Past Year	Next Year
Hair transplants or suturing of hair pieces					Blepharoplasty (Cosmetic)		
Injection Treatment of Varicose Veins Laser Therapy (explain): _____					Blepharoplasty (Functional)		
					Cataract Surgery		
Laser vaginal rejuvenation (includes cosmetic and /or plastic surgery procedures performed on the vagina and associated structures. This includes, but is not limited to vaginoplasty, labiaplasty, laser and non-laser rejuvenation procedures)					Chalazion Excision from Eyelids		
Other Surgical Procedures (explain): _____					Corneal Transplants		
					Enucleation		
					Hexagonal Keratotomy (HK)		
Liposuction – under 3500 cc's					Intraocular Lens Implant		
Liposuction - 3500 cc's or more					Iridectomy		
Phalloplasty – including transecting the suspensory ligament of the penis and/or subcutaneous fat injection					LASIK		
Rhinoplasty					Lid-Repair – Ectropion & Entropion		
Silicone Implants (types and where) _____					Photo-Refractive Keratotomy (PRK)		
					Pterygium Excision		
					Refraction's		
					If "Yes," what type? _____		
					Removal of Eyelid Lesion		
Silicone Injections					Retinal Detachments		
Other (describe): _____					Trabeculectomy		
					Treatment of Eye Infection		
					Other (describe): _____		
<input type="checkbox"/> None of the above					<input type="checkbox"/> None of the above		

CURRENT AND REQUESTED COVERAGE

44. MISSOURI RESIDENTS - DO NOT ANSWER.

Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant? Yes No

If "Yes," please provide details:

45. Requested Effective Date of Coverage: _____ Requested Retroactive Date of Coverage: _____

46. Do you intend to purchase a reporting endorsement (aka Tail Coverage) from your current insurer? Yes No

If "No," do you wish to obtain Prior Acts Coverage from us? Yes No

If applying for Prior Acts Coverage, please attach a copy of your most recent Declarations page and Policy (Prior Acts coverage is subject to Underwriter approval)

47. List malpractice coverage for the past 10 years, beginning with your current or most recent carrier:

Carrier	Limits	Policy Period MM/DD/YYYY – MM/DD/YYYY	Claims Made or Occurrence	Retroactive Date (if applicable)	Premium

CLAIMS HISTORY

48. In the past, has the Applicant or any entity or individual proposed for coverage under this insurance, received or been involved in any claim, suit or medical incident that may fall within the scope of the proposed insurance? Yes No

If "Yes," please complete a **Claims Information Form** for each claim, suit or medical incident.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM, SUIT OR MEDICAL INCIDENT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 48 IS EXCLUDED FROM THE PROPOSED INSURANCE.

49. 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 which they have 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 complete a **Claims Information Form** for each fact, circumstance, situation, transaction, event, act, error or omission.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, 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 49 IS EXCLUDED FROM THE PROPOSED INSURANCE.

CLAIMS INFORMATION FORM

(Please make additional copies if needed)

1. Name of Patient: _____ 2. Age: _____ 3. Gender: M F

4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon): _____

5. Date of Incident: _____ 6. Date Reported to Carrier: _____ 7. Location: _____

8. Insurance Carrier(s): _____

9. Other Defendant(s): _____

10. Plaintiff's Counsel: _____

11. Defendant's Counsel: _____

12. Status: Incident Only Suit Closed Settlement Judgement
Amount Paid: _____ If Closed, Date Closed: _____

13. Allegation(s) (as stated by patient/plaintiff): _____

14. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? Yes No

15. Condition and diagnosis at time of treatment: _____

16. Dates and description of treatment rendered: _____

17. Condition of patient subsequent to treatment (include DATES & FOLLOW UP TREATMENT): _____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: X _____ Date: _____

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.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

ARKANSAS, MINNESOTA AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she 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, which is a crime.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS 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 civil fines and criminal penalties.

MAINE, 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 may include imprisonment, fines or a denial of insurance benefits.

MISSOURI APPLICANTS: Any person commits a "fraudulent insurance act" if such person knowingly 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 oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal 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 if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

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.

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.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) no more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, 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 accounts, the preceding sentence is replaced with the following: 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 us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We 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.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us 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 us 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, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

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.

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

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.