TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Podiatry 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.

ACCOUNT INFORMATION

1.	Applicant Name	
	Other Names Used	
	Gender	☐ Male ☐ 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 podiatrists. **(Indicate status of each and provide proof of coverage for each).**

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

8. List all states where the Applicant is licensed:

State: _____ License #: _____

State: _____ License #: _____

State: _____ License #: _____

9.

Medical Specialty: _____ % of practice: _____

Sub –Specialty: _____ % of practice: _____

FINANCIAL AND EXPOSURE DETAILS

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

If "Yes," please explain:

13. **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 Podiatric Medicine, 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 podiatrist, 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

14. **Training**

Podiatric Degree from (school): _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Residency/Preceptorship Type: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Other Residency/Preceptorship Type: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Fellowship Training Type: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Additional Medical Specialty training:

Location	Type	Dates

15. Do you perform surgery:

a. In your office? ☐Yes ☐No

b. In any other non-hospital facility? ☐Yes ☐No

If "Yes," list the names and type of facilities:

List the surgical procedures you perform in your office or other non-hospital facility:

c. Is general anesthesia administered in any of the above non-hospital facilities? ☐Yes ☐No

If "Yes:"

By You? ☐Yes ☐No

By Others? ☐Yes ☐No

16. Do you treat or review the treatment of prison inmates? ☐Yes ☐No

If "Yes:"

a. What percentage of your practice? _____%

b. Please explain and provide facilities names:

c. Is insurance provided by the above facility? ☐Yes ☐No

17. Do you practice as a professional or amateur sports team physician? ☐Yes ☐No

If "Yes,"

a. What percentage of your practice? _____%

b. Describe duties, team names and type of sport:

18. Do you perform medical legal evaluations? ☐Yes ☐No

If 'Yes,"

a. What percentage of your practice? _____%

b. For whom?

NOTE: Our standard policy language provides coverage only for claims arising from "Injury", defined as Bodily Injury, sickness or disease, resulting from Professional Services. Therefore, "medical legal evaluations" may generate claims of some other nature and may not trigger coverage.

19. Do you consult on or treat patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands? ☐Yes☐No

If "Yes:"

a. What percentage of your practice? _____%

b. Where?

20. 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:

21. Are you a podiatrist with teaching responsibilities? ☐Yes☐No

If "Yes:"

a. Please explain:

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

22. 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

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

23. Do you treat patients in any nursing home, skilled nursing facility or assisted living center? ☐Yes☐No

If "Yes:"

What percent of your practice? _____%

Do you treat patients other than your own? ☐Yes☐No

24. Are you a medical director of any facility? ☐Yes ☐No

If "Yes" what facility?

If "Yes" provide evidence of coverage for each facility.

25. 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? ☐Yes ☐No

If "Yes:"

a. What percentage of your practice? _____%

b. Identify all states in which such patients reside:

26. Do you treat patients who reside outside the state of your primary office address? ☐Yes ☐No

If "Yes" what percentage of your practice? _____%

What states?

27. Do you have any other practice outside of what you are applying for coverage? ☐Yes ☐No

If "Yes:"

Name of Practice: _____

Name of Carrier: _____

28. List all locations where you have practiced in the last 10 years (include time period, group name and address).

Group Name	Street/City/State	During Years

29. How many:

a. Days do you work per week? _____

b. Hours do you work per day? _____

c. Surgical procedures do you perform each week? _____

30. What is your average weekly patient load? _____

31. What percent of your patients are:

a. Over age 65? _____%

b. Age 18 or younger? _____%

c. Hospitalized patients? _____%

What percent of your practice involves:

a. Diabetic patients _____%

b. Wound care: _____%

32. 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)					
Technicians					
Psychologists					
Physical Therapists					
Physicians Assistants**					
Nurse Practitioners**					
CRNA's**					
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.

33. Do you advertise your podiatric practice? ☐Yes ☐No

If "Yes:"

a. In what state?

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.

34. 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," are the protocols IRB approved? ☐Yes ☐No

If "Yes" describe:

35. 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

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

If "Yes," please explain.

37. Do you have a certificate to perform ankle surgery? ☐Yes ☐No

38. Do you use implants? ☐Yes ☐No

If "Yes," what type and for what purpose?

39. Do you perform any plastic or cosmetic surgery? ☐Yes ☐No

If "Yes," list all procedures:

40. Do you perform procedures intended to lengthen or shorten the leg? ☐Yes ☐No

41. Do you perform any lower leg deformity correction procedures? ☐Yes ☐No

If "Yes," list all procedures:

42. Please review each of the following classifications of coverage. After reviewing please check the appropriate class (Class I, Class II or Class III) that describes your practice.

☐ **Class I – No Surgery**

Professional Liability Coverage does **not** apply to injury arising out of the rendering of or failure to render any Professional Service listed below, even if such Professional Services are otherwise within the scope of the Applicant's license to practice podiatry:

1) any procedures performed at or above the level of the ankle joint;
2) the administration of anesthesia other than topical or by means of local infiltration;
3) assisting in the performance of any Podiatric surgical procedure;
4) the reduction of any fracture;
5) the use of lasers;
6) the performance of any procedure involving the cutting or penetration of any tissue, except:
   (a) incision, and/or drainage of sebaceous cysts, abscesses or hematoma;
   (b) curettage of verrucae;
   (c) incision and removal of foreign body from the superficial or subcutaneous tissue;
   (d) debridement of infected skin, abrasions or keratotic lesions;
   (e) debridement, excision or avulsion of nail plate, excluding permanent removal except those procedures which involve the use of electrical or chemical cautery;
   (f) needle penetration of the skin and blood vessels;
   (g) treatment of burns except the local treatment of third degree burns;
   (h) closed manipulative reductions of fractures of metatarsals and phalanges.

☐ **Class II – Intermediate Surgery**

Professional Liability Coverage does **not** apply to injury arising out of the rendering of or failure to render any Professional Service listed below, even if such Professional Services are otherwise within the scope of the Applicant's license to practice podiatry:

1) the treatment or reduction of compound fractures of the calcaneus or talus;
2) triple arthrodesis;
3) surgical procedures at or above the level of the ankle joint, which includes, but is not limited to, those parts of the tibia, fibula, their malleoli and their related structures;
4) surgical procedures at or above the level of the ankle joint involving arthroplasty, osteotomy, grafts, implants and arthrodesis;
5) surgical treatment of the muscles and tendons at or above the level of the ankle joint;
6) the administration of general anesthesia.

Coverage is provided for assisting in the performance of any Podiatric surgical procedure.

☐ **Class III – Major Surgery**

Professional Liability Coverage does **not** apply to injury arising out of the rendering of or failure to render any Professional service listed below, even if such Professional Services are otherwise within the scope of the Applicant's license to practice podiatry:

1) the administration of general anesthesia;
2) surgical procedures above the level of the ankle joint.

43. Do you treat any podiatric conditions which fall outside the areas covered in your state's Podiatric Practice Act or do you assist in surgeries outside your state's Podiatric Practice Act (i.e. knee, hip, legs, etc.)? ☐Yes ☐No

If "Yes," please explain:

44. Do you use lasers? ☐Yes ☐No

If "Yes," please answer the following:

a. For what types of treatment do you use a Laser?

b. How many times per week do you perform Laser surgery? _____

c. Please indicate the type of training you received in Laser surgery. Please check all that apply:

☐ Seminar ☐ Course ☐ Hands on ☐ Preceptorship ☐ Other

d. Please specify the name(s) of training program(s):

45.

Do you administer any of the following types of anesthesia or do you perform any of the following procedures?
If "Yes," check all appropriate locations where performed:

		Locations Where Performed		
(a) Acupuncture	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
If "Yes," for anesthesia?	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(b) Caudal	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(c) Digital Block	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(d) General Anesthesia	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(e) Intravenous Anesthesia	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(f) Intravenous Analgesia	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(g) Local	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(h) Nitrous Oxide	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(i) Pain Blocks	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(j) Pain Management	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
If "Yes," complete a Pain Management Questionnaire				
(k) Peripheral Nerve Block	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(l) Spinal Anesthesia	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
(m) Other Anesthesia	☐Yes ☐No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility

If "Yes," specify types:

46. Have you assumed supervisory duties over any nurse anesthetists? ☐Yes ☐No

CURRENT & REQUESTED COVERAGE

Please attach a copy of your most recent declarations page and policy

47. **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:

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

49. 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)

50. 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

51. 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 51 IS EXCLUDED FROM THE PROPOSED INSURANCE.

52. 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 52 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:

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 If Closed, Date Closed:
Amount Paid: ☐ Settlement ☐ Judgement

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	
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.