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

Health Care Organizations and Providers 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. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

ACCOUNT INFORMATION

1.	Applicant Name	
2.	Mailing Address	Street: City: State: Zip: County: Website Address:
3.	Risk Management Contact	Name/Title: Email Address: Telephone Number:
4.	Applicant's Legal Structure	☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC ☐ Other: _____
5.	Tax Status	☐ For Profit – Private ☐ For Profit – Publicly Traded ☐ Not for Profit ☐ Governmental
6.	Type of Risk (check all that apply)	☐ Acute care hospital ☐ Critical access hospital ☐ Behavioral health hospital ☐ Long term acute care hospital (LTAC) ☐ Rehabilitation hospital ☐ Children's hospital ☐ Chemical dependency/substance abuse facility ☐ Research hospital ☐ Specialty hospital: _____ ☐ Senior living / LTC facility ☐ Other: _____ ☐ Accountable care organization

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

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

9. Does the Applicant have any operations outside of the United States of America? ☐Yes ☐No

If "Yes," please provide details:

10. Is the Applicant owned, controlled or managed by another entity? ☐Yes ☐No

If "Yes," please provide details:

11. 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 transation.

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

Name & Address	Decription of Operations	Relationship	Ownership %	Retroactive Date

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

13. 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.

CURRENT AND REQUESTED COVERAGE

14. Requested policy period: _____

15. Retroactive date: _____

16. Coverage requested: ☐ Primary ☐ Excess ☐ Both

Primary limits of liability requested:	Each claim:	_____	Aggregate:	_____
Excess limits of liability requested:	Each claim:	_____	Aggregate:	_____
Deducitible/SIR requested:	Each claim:	_____	Aggregate:	_____

☐ Deductible ☐ SIR

17. Please provide current insurance information:

	Carrier	Policy Period MM/DD/YY-MM/DD/YY	Limits	Ded/SIR	CM or Occ	Retroactive Date	Premium
Professional Liaiblity							
General Liability							
Excess Liability							
Auto Liability							
Employers Liablility							
Helipad Liability							
Other (describe): _____							

18. Please describe any additional insureds to be included, a description of their operations, their interest and requested coverage:

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

19. 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

20. Please provide the following information:

Total number of licensed beds: _____

Inpatient Services (Number of Occupied Beds)	Projected Next 12 Months	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year
Acute Care Beds					
Bassinets/Cribs					
Pediatric Beds					
ICU					
CCU Beds					
NICU					
Long Term Acute Care Beds (LTAC)					
Behavioral Health Beds					
Rehabilitation Beds					
Hospice Beds					
Substance Abuse Beds					
Swing Beds					
Skilled Nursing Care Beds					
Independent Care Beds					
Residential/Assistant Living Beds					

Total Number of Deliveries					
Total Number of Inpatient Surgeries					

Outpatient Services (Do not include Lab, X-Ray, and Radiology Units)	Projected Next 12 Months	Current Year	1st Prior Year	2nd Prior Year	3rd Prior Year
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): _____					

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

If "Yes," please attach a schedule which includes physician name, specialty and retroactive date.

Allied Health Care Providers:

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

_____ Certified Nurse Midwives
_____ Lay Midwives
_____ Certified Registered Nurse Anesthetists
_____ Emergency Medical Technicians
_____ Therapists: Occupational, Physical, Speech and Respiratory
_____ Paramedics
_____ Pharmacists
_____ Physician Assistants
_____ Surgical Assistants
_____ Advanced Practice Registered Nurses
_____ Other (describe): _____
_____ Podiatrists
_____ Psychologists
_____ Social Workers

Hiring/Credentialing:

23. Total number of medical staff: _____ Board Certified: _____% Board Eligible: _____%

24. 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

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

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

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

28. 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:

29. Do the Applicant's bylaws require physicians to carry health care professional liability insurance? ☐Yes ☐No

If "Yes," what limit is required? _____

30. 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 actions by other facilities ☐Yes ☐No

e. Criminal background check: ☐County ☐State ☐Federal ☐None

f. Require information on any professional liability or work related claims that have previously been made against any individual ☐Yes ☐No

g. Require information on any allegations of sexual abuse or molestation previously made against any individual ☐Yes ☐No

h. Drug/alcohol testing ☐Yes ☐No

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

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

Obstetrics:

33. a. Indicate the minimum health care professional liability insurance limits required for providers: _____

Are such limits required on a separate or shared basis? ☐Separate per provider ☐Shared among all providers

b. In the last 12 months, what percentage of the Applicant's deliveries were:

Elective C-sections: _____% Emergency C-sections: _____% VBACs: _____%

c. Who has privileges to perform vaginal deliveries?

☐Family Practioner ☐Certified Nurse Midwife ☐Obstetrician ☐Lay Midwife ☐Other: _____

d. Who has privileges to perform C-sections?

☐Family Practioner ☐Obstetrician ☐General Surgeon ☐Other: _____

e. Do certified nurse midwives practice at the Applicant's facility? ☐Yes ☐No

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

If employed, do they deliver babies in a home setting? ☐Yes ☐No

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

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

If employed, do they deliver babies in a home setting? ☐Yes ☐No

g. What is the service level of the nursery: ☐Level I ☐Level II ☐Level III

h. Are obstetricians, family practitioners, physicians, lay midwives and certified nurse 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 processes? ☐Yes ☐No

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

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

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

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

m. 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:

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

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

Surgery:

34. Indicate the minimum health care professional liability insurance limits required for providers: _____

Are such limits required on a separate or shared basis? ☐Separate per provider ☐Shared among all providers

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

a. Experimental Surgery ☐Yes ☐No

b. Neurosurgery (brain) ☐Yes ☐No

c. Weight Loss/Bariatric Surgery ☐Yes ☐No

d. Spinal Surgery ☐Yes ☐No

e. Cardiothoracic Surgery ☐Yes ☐No

f. Organ Transplantation ☐Yes ☐No

g. Gender Reassignment Surgery ☐Yes ☐No

36. Does the Applicant have a quality improvement/risk management process in place for monitoring and review of policies, procedures, practices and outcomes for:

a. Surgical Mortality ☐Yes ☐No
b. Surgical Complications ☐Yes ☐No
c. Surgical Site Infection Rate ☐Yes ☐No
d. Pre and Post-Operative Tissue Diagnosis ☐Yes ☐No
e. Readmission within 30 days of surgery ☐Yes ☐No
f. OR/PAR Cardiac Arrest/Mortality ☐Yes ☐No
g. Occurrences/near misses of wrong site/wrong patient/wrong procedure surgery ☐Yes ☐No
h. Occurrences of unintentionally retained foreign body (e.g.instrument/sharps/sponges) ☐Yes ☐No
i. Equipment (patient) related errors, malfunctions and injuries ☐Yes ☐No
j. Unscheduled return to the OR ☐Yes ☐No
k. Unscheduled admissions following ambulatory surgery ☐Yes ☐No
l. Mortality within 30 days of surgery ☐Yes ☐No

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

Bariatric / Weight Loss Surgery:

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

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

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

c. Does the Applicant perform bariatric/weight loss surgery on adolescents (under age 18 yrs)? ☐Yes ☐No

If "Yes," how many in the last 12 months? _____

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

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

f. Is the Applicant designed as a Bariatric/Weight Loss Surgery Center of Excellence? ☐Yes ☐No

Anesthesia:

39. a. Indicate the minimum health care professional liability insurance limits required for providers: _____

Are such limits required on a separate or shared basis? ☐Separate per provider ☐Shared among all providers

b. Staffing of the anesthesia department is by : (check all that apply)

☐Contracted Anesthesiologists
☐Certified Registered Nurse Anesthetists
☐Anesthesia Assistants
☐Physician Assistants
☐Employed Anesthesiologists/Certified Registered Nurse Anesthetists
☐Residents

If contracted, name of contracted group: _____

c. Are non-physician providers supervised by an anesthesiologist? ☐Yes ☐No

If "No," please explain: _____

d. Is an anesthesiologist/certified registered nurse anesthetist on the premises 24 hours a day? ☐Yes ☐No
If "No," what is the maximum time for arrival at the hospital? _____

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

Emergency Department:

40. a. Indicate the minimum health care professional liability insurance limits required for providers: _____

Are such limits required on a separate or shared basis? ☐ Separate per provider ☐ Shared among all providers

b. Staffing of 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. What level of care does the emergency department provide?

☐ Level I ☐ Level II ☐ Level III

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

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

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

41. Does the Applicant have a quality improvement/risk management process in place for monitoring and review of policies, procedures, practices and outcomes for:

a. Mortality ☐Yes ☐No

b. Unexpected deaths within 72 hours of an emergency department visit ☐Yes ☐No

c. Patients leaving without being seen/against medical advice/elopement ☐Yes ☐No

d. Discrepancies in X-Ray interpretations ☐Yes ☐No

e. Discrepancies in EKG interpretations ☐Yes ☐No

f. Unanticipated return to the emergency department within 72 hours ☐Yes ☐No

g. Compliance with clinical practice guidelines (if used) ☐Yes ☐No

h. Transfers to another facility ☐Yes ☐No

42. Does the Applicant utilize evidence based on clinical practice guidelines to manage the following:

a. Chest pain/myocardial infarction ☐Yes ☐No

b. Stroke ☐Yes ☐No

c. Trauma ☐Yes ☐No

d. Headache ☐Yes ☐No

e. Intoxication/substance abuse ☐Yes ☐No

f. Altered mental status ☐Yes ☐No

g. Abdominal pain ☐Yes ☐No

Radiology Department

43. a. Indicate the minimum health care professional liability insurance limits required for providers: _____

Are such limits required on a separate or shared basis? ☐ 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: _____

c. Does the Applicant perform interventional radiology procedures? ☐ Yes ☐ No

d. Does the Applicant or the contracted group use teleradiology services? ☐ Yes ☐ No

If "Yes," please provide details:

e. Is there a radiologist on the premises 24 hours a day? ☐ Yes ☐ No

44. Does the Applicant have a process in place to review and measure radiology related practices, policies, quality of care and outcomes for:

a. Discrepancies in x-ray interpretations ☐ Yes ☐ No

b. Mortality ☐ Yes ☐ No

c. Communication of critical test results ☐ Yes ☐ No

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.

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

46. Does the Applicant have any new construction or renovation projects planned for the next 12 months? ☐ Yes ☐ No

If "Yes," briefly describe:

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

48. 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?

If "Yes," is it open to the public? ☐ Yes ☐ No

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

50. Does the Applicant have a heliport/helipad? ☐Yes ☐No

If "Yes,"

a. Where is the pad located (e.g. parking lot, top of building, etc.)? _____

b. Estimated number of landings per year? _____

c. Is the helicopter: ☐Owned ☐Leased

Auto Liability Exposure:

51. 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): _____

OPERATIONS AND ADMINISTRATION

52. 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 Norsk e Veritas Health Care (DNV)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
☐ Clinical Laboratory Improvement Amendment (CLIA)
☐ Other: _____

53. Does the Applicant provide or participate in any student programs? ☐Yes ☐No

54. Does the Applicant provide or participate in any resident physician programs/rotations? ☐Yes ☐No

If "Yes," in what clinical specialties? _____

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

56. 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

57. Does the Applicant have any technology upgrades planned in the next 12 months? ☐Yes ☐No

If "Yes," please provide details:

58. Does the Applicant use E-prescribing? ☐Yes ☐No

59. Does the Applicant utilize Computer Physician Order Entry (CPOE) that includes prescribing error detection and override alerts? ☐Yes ☐No

60. Does the Applicant utilize telehealth (eICU, teleradiology, etc)? ☐Yes ☐No

61. Are clinical research studies performed? ☐Yes ☐No

a. If "Yes," is IRB approval obtained? ☐Yes ☐No

b. Who obtains consent from study participant(s)? _____

62. Does the Applicant participate in a patient safety organization? ☐Yes ☐No

63. Please indicate all written policies and procedures that the Applicant has in place:

☐HIPAA privacy and security
☐Data breach/Red Flag (identity theft)
☐Social media/text messaging/cellular phone use
☐RAC audits
☐Release of records
☐Medical record retention/destruction
☐Disclosure of unanticipated outcomes of care
☐Service recovery/billing adjustments
☐Patient/family/visitor complaints
☐Incident reporting
☐Mandated reporting of adverse events to regulatory agencies
☐Product recalls
☐Medical device failure
☐Medication safety
☐Informed consent/refusal of treatment
☐Emergency preparedness
☐Patient emergencies
☐Visitor emergencies
☐Safety/security
☐Patient abduction
☐AMA/elopements
☐EMTALA
☐Chain of command
☐Peer review

64. Does the Applicant lease or rent any equipment from others? ☐Yes ☐No

If "Yes," please provide a description of the equipment:

65. Does the Applicant sell, rent or donate equipment to others? ☐Yes ☐No

If "Yes," please provide details:

66. Does the Applicant have any contractual agreements with independent contractors who provide services at its facility? ☐Yes ☐No

If "Yes,"

a. Indicate which services are contracted:

☐Housekeeping ☐Laboratory ☐Pharmacy
☐Laundry ☐Pathology ☐Other (describe): _____

b. Are certificates of insurance obtained from all contracted providers? ☐Yes ☐No

If "Yes," indicate the minimum insurance limits required: _____

Please submit a copy of each contract.

67. Does the Applicant agree to hold others harmless (indemnify) or assume any liability in any contractual agreement? ☐Yes ☐No

CLAIMS HISTORY

68. During the past five (5) 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 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 OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 68 IS EXCLUDED FROM THE PROPOSED INSURANCE.

69. 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 provide details:

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 69 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.

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.