Application Form

Beazley | Miscellaneous Medical

beazley

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112022 ed.

Beazley MiscMed Application

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CAN BE WRITTEN ON A CLAIMS MADE AND REPORTED BASIS OR ON A CLAIMS MADE/OCCURRENCE COMBINED BASIS, WHICH MEANS THAT SOME COVERAGES UNDER THE POLICY APPLY ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE INSURANCE COMPANY DURING THE POLICY PERIOD OR THE EXTENDED REPORTING PERIOD, IF APPLICABLE, OR OCCURRENCE TAKING PLACE DURING THE POLICY PERIOD. AMOUNTS INCURRED AS DEFENSE COSTS SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE RETENTION. PLEASE READ THIS APPLICATION CAREFULLY.

BACKGROUND INFORMATION – PLEASE READ:

1) Please type or print clearly.
2) Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3) If additional space is needed to answer any questions fully, please attach a separate page.
4) This Application must be completed, dated, and signed by either a Principal, C-suite Executive, Risk Manager or General Counsel of the Applicant.

Requested Attachments:

1) Currently valued loss runs for minimum of prior FIVE years.

General Information

1. Applicant (first named insured):

2. Additional named insureds (please include subsidiaries for which coverage is sought under this policy):

3. Physical address:

4. Mailing address (if different from above):

5. List all states in which applicant is operating or providing services:

6. Website: Year Established:

7. Legal Structure:

Corporation Joint Venture LLC Sole Proprietorship

8. Tax Status:

Non-profit For-Profit Governmental

9. Accreditation(s):

CARF CHAP COA JCAHO

10. Gross Revenue:

	Projected Next 12 Months	Past 12 Months	First Year Prior
U.S. Revenue			
Outside U.S.			
Total			

If outside U.S. please list applicable countries:

Professional Services

11. Please provide detailed description of business operations and professional services provided by the applicant:

12. Please complete all applicable fields in the grid below providing **projected** exposure details for the next 12 months. If multiple services are provided, complete exposure information for each.

Beds – occupied count and licensed count

Doses – number of times drug is administered

Hours – weekly hours worked by each specialty

Occupancy – average daily attendance of clients at facility

Procedures – number of surgeries performed

Receipts/Budget – gross receipts received from all sources without the deduction of any costs or expenses

Placements – number of instances child is placed with a foster or adoptive family

Scans – number of imaging scans

Scripts – total annual number of prescriptions filled

Tests – number of laboratory tests analyzed

Students – number of persons enrolled for all terms annually

Transfers – number of transports of each patient

Units –number of blood, tissue, organs stored and/or procured

Visits – each encounter between patient and facility

Alternative/Holistic Medicine	**Visits**	**Receipts**	**Laboratory**	**Tests**	**Receipts**
Acupuncture, Physical Medicine			Chemistry		
Naturopathy			DNA (Ancestry/Lifestyle)		
Ambulance	**Transfers**	**Receipts**	Drug		
Air			Fertility		
Ground Emergency			Genetic		
Ground Non-emergency			Pathology		
Ground Paratransit, Wheelchair			Other (describe) ________________		
Standby EMS			**Medical/Day Spa**	**Visits**	**Receipts**
Clinic	**Visits**	**Receipts**	Botox. Fillers, Injectables		
Abortion			Cryotherapy		
Chiropractic			Hormone Therapies		
Dental			Laser, Liposuction		
Dialysis			Massage, Facial		
Eye Care			**Medication Assisted Treatment**	**Doses**	**Receipts**
FTCA/FQHC			Detox Maintenance Medication		
Mental Health			**Occupational Healthcare**	**Visits**	**Receipts**
Pain Management			Primary Care, Therapies		
Primary Care			Wellness Screenings, IME		
Radiation/Oncology			**Organ/Tissue/Blood**	**Units**	**Receipts**
Reproductive Medicine			Bones, Tissue Procurement		
Therapy - PT/OT/ST/ABA			Organs Procurement		
Urgent Care			Blood Banking		
Veterinary			Egg, Sperm Banking		
Weight Loss			**Pharmacy**	**Scripts**	**Receipts**
Other (describe) ________________			Retail, Specialty		
Day Care	**Occupancy**	**Receipts**	Compounding		
Developmentally Disabled (DD/ID)			**Residential**	**Beds Lic/Occ**	**Receipts**
Elderly			Behavioral, Mental Health		
Pediatric Medical/PPEC			Group Homes		
Governmental/Non-Profits	**Visits**	**Budget**	Halfway House/Shelter		
Humanitarian Relief			Hospice		
Military Medical			Senior Care (ALF, SNF)		
Healthcare Staffing	**Hours**	**Receipts**	Substance Abuse Rehab		
Allied Health, Nurses			**School**	**Students**	**Receipts**
Correctional			Allied Health		
CRNA			Graduate, Doctorate Medical		
Locum Tenens			Non-Medical (describe)		
Mid-Level PA, NP			**Social Services**	**Placements**	**Budget**
Home Healthcare	**Visits**	**Receipts**	Adoption		
Companion/Personal Care			Foster		
Hospice Care			**Surgery Center**	**Procedures**	**Receipts**
Skilled Medical			Bariatric, Plastic, Spine/Neurology		
Hospital	**Beds Lic/Occ**	**Receipts**	Cosmetics, Orthopedic, Reproductive		
Critical Access, Rural			ENT, Gynecology, Urology		
LTAC, Rehabilitation			General, Pain Management, Podiatry		
Psychiatric			GI, Ophthalmology, Oral		
Imaging	**Scans**	**Receipts**	**Telemedicine**	**Visits**	**Receipts**
Xray CT, PET, MRI			Remote Patient Monitoring		
Mammogram			Telehealth		
Ultrasound			Teleradiology		

13. Does the applicant anticipate any significant changes to their services/products in the next year? Yes No
Please describe:

14. Please provide details on any prior and/or anticipated merger/acquisition activity:

15. Please list all Patient Compensation (PCF) and similar state medical malpractice funds the applicant participates in:

16. Does the applicant provide any non-FDA approved medications or procedures? Yes No
Please describe:

17. Please specify percentage of patient population: (Does not have to equal 100%)

% Critical Care/ICU % Correctional % DD/ID % Elderly

% Non-Ambulatory % Obstetrics % Pediatric % Prenatal Care

% Psychiatric % Trach/Vent/Technologically Dependent % Wound Care

18. Where does the applicant provide services for the client/patient? (Must equal 100%)

% Applicant's Location % Hospital % LTC Facility % Mobile Clinic

% Patient's Home % Physician's Office/Clinic % Remote/Virtual* % ______________

**If more than 50% of services are remote/virtual please instead complete a Virtual Care application*

19. Who are the applicant's three largest clients?

Client	Scope of Services	Size of Contract
		$
		$
		$

Healthcare Staff

20. Does the applicant have a Medical Director? Yes No
   a. Is coverage for Medical Director services requested on this policy? Yes No
   b. Is the Medical Director providing direct patient care services? Yes No
   Please provide details:

Name and Title	Specialty	Board Certified	Hours (Weekly)	Employed/Contracted

21. Schedule of providers: (please attach schedule for additional providers)

Physicians, Surgeons, Osteopaths, Podiatrists, Orthodontists, Psychiatrists, Psychologists, Chiropractors or Dentists						
Name	Specialty	Hours (Weekly)	Employed/ Contracted	Insurance Limits Maintained	Coverage Requested?	Direct Patient Care?

22. Healthcare staff:

	Employed			Contracted/1099		
	Full Time	Part Time	Hours (Weekly)	Full Time	Part Time	Hours (Weekly)
Companion/Aide						
Counselor						
Chiropractor						
Dentist						
Massage Therapist						
Medical/Nursing Assistant						
Nurse						
Nurse Practitioner						
Optometrist						
Paramedic/EMT						
Pharmacist						
Therapist – PT/OT/ST						
Physician						
Physician Assistant						
Psychologist						
Social Worker						
Technician						
Other (describe):						

23. Are Independent Contractors required to carry separate insurance coverage? Yes No
    a. What limits are required?
    b. Are Certificates of Insurance obtained and held on file? Yes No
    c. Is coverage for Independent Contractors requested on this policy? Yes No

24. Does the applicant have volunteers? Yes No
    a. Please describe services:

25. Prior to hiring any employee or independent contractor does the applicant verify the following:
    a. Education background/training Yes No
    b. Employment references with at least two previous employers Yes No
    c. Criminal record on Local/State/National Yes No
    d. Driving record Yes No
    e. Drug Test Yes No

26. Are all health professionals credentialed prior to hiring? Yes No
    a. How often are physicians re-credentialed?
    b. Does the applicant utilize a third party to perform credentialing services? Yes No
        i. List the provider:
        ii. Attach a copy of facility's current screening, hiring, or credentialing guidelines.

27. Has the applicant or any staff ever been the subject of disciplinary/investigative proceedings, lost a license, or been reprimanded by a governmental/administrative agency, hospital, or professional association? Yes No
    Please describe:

Risk Management

28. Does the applicant have a written Quality Assurance and Risk Management program? Yes No

29. Does the applicant have an individual responsible for Risk Management on staff? Yes No

    Risk Manager Contact information:

Name	Title	Phone Number	Email

30. Does the applicant have a formal training program requiring mandatory staff attendance? Yes No

31. Does the applicant have formal incident reporting protocols? Yes No

32. Does the applicant have formal written informed consent forms outlining the risks, benefits, unanticipated outcomes for all procedures performed? Yes No

33. Does the applicant enter into written contractual agreements? Yes No

34. Do contractual agreements contain indemnification clauses or hold harmless agreements, which are mutual and/or in favor of the applicant? Yes No

35. Has the applicant ever brought suit against a client? Yes No

36. Are written policies in place regarding the following:

Policy	Yes	No
Admissions/Discharge/Follow-up Care		
Complications/Emergencies		
Medical Record Documentation/HIPAA		
Medical Record Documentation/HIPAA		
Patient Rights & Refusal of Treatment		
Patient Scheduling/Afterhours Care		
Test Result Management		

a. Is compliance to above enforced and monitored? Yes No

Sexual Misconduct & Physical Abuse Liability

Coverage not requested

37. Does the applicant conduct state and national criminal background checks for all employees, contractors, and volunteers:
    a. upon hiring? Yes No
    b. annually? Yes No
38. Does the applicant conduct national sexual offender registry checks for all employees, contractors, and volunteers:
    a. upon hiring? Yes No
    b. annually? Yes No
39. Is the applicant aware of any employees, contractors, or volunteers with a prior history of sexual or physical misconduct or allegations of sexual or physical misconduct? Yes No
40. Does the applicant have a formal training program requiring mandatory staff attendance addressing policies and procedures related to sexual and physical abuse prevention and acceptable code of conduct? Yes No
41. Does the applicant provide a checklist of criteria that may indicate increased risk to abuse? Yes No
42. Does the applicant have a written policy which defines inappropriate and appropriate conduct and displays of affection? Yes No
43. Does the applicant have formal incident reporting protocols to respond to allegations of sexual misconduct or physical abuse? Yes No
    Can incidents be reported anonymously or confidentially? Yes No
44. Does the applicant require staff to complete annual abuse prevention training? Yes No
45. Does the applicant allow one-on-one encounters? Yes No
46. Does the applicant have age and gender separation protocols? Yes No

47. Is more than one person responsible for the welfare of any single client or patient? Yes No

48. Does the applicant have a zero-tolerance policy for any physical and sexual abuse? Yes No

General Liability & Products Liability

Coverage not requested

49. Provide the following information for each area owned, occupied, or leased by the Applicant.

Location	Sq Footage	Year Built	Construction	Number of Floors	Type of Fire Protection

50. Does the applicant have any plans for renovations or new construction? Yes No

51. Does the applicant have a written emergency evacuation plan? Yes No

52. Do the premises have emergency back-up systems for the loss of essential utilities? Yes No

53. Does the applicant have sign in / sign out procedures? Yes No

54. Does the facility have a fitness center, pool and/or playground? Yes No
Does the applicant comply with the Virginia Graeme Baker Pool and Spa Safety Act? Yes No

55. Are secure medication storage facilities provided for controlled substances and narcotics? Yes No

56. Type of security provided for the protection of the Applicant's clients / residents?
Guards Locked Exits Video Other:

57. Does the applicant sponsor any recreational activities. sporting or special events? Yes No
a. Please describe the events:
b. Are alcoholic beverages provided at any of these events? Yes No

58. Does the applicant sell any products under its own label? Yes No
Please describe:

59. Has a product ever been recalled? Yes No

60. Is applicant's medical equipment maintained and/or calibrated in accordance with manufacturer guidelines?
Yes No

Coverage Information

61. Proposed effective dates: From: ____/____/______ To: ____/____/______

62. Prior insurance history: No prior coverage

Year	Coverage	Carrier	Limits	Deductible	Retro Date	Premium

63. Has the applicant ever been declined, cancelled, or non-renewed by an insurer for Professional Liability Insurance or General Liability Insurance? Yes No

Please describe:

Loss History

64. Please provide details of applicant's total aggregate losses, from the 1st dollar, including expenses (and also attach currently valued hard copy loss runs for at least 5 years): If None, check here

Policy Period	Insurer	Number Of Claims	Total Cost Incurred

**Complete a copy of our Supplemental Claim Form for each claim.*

a. Has the applicant ever had any claim(s) or suit(s) brought against them or any employees/staff working on the applicant's behalf for which coverage is requested? Yes No

b. Is the applicant aware of any fact, circumstance, or occurrences (including requests for medical records), which might reasonably result in a potential claim against you or any other person in your organization?

Yes No

Please describe:

c. Has the applicant made any changes to their practice as a result of any claims, suits, or incidents?

Yes No

Please describe:

SIGNATURE SECTION

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT TO SIGN THIS APPLICATION ON THE APPLICANT'S BEHALF AND DECLARES THAT THE STATEMENTS CONTAINED IN THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION AND THE UNDEWRITING OF THIS INSURANCE ARE TRUE, ACCURATE AND NOT MISLEADING. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION AND ANY OTHER INFORMATION AND MATERIALS SUBMITTED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING OF THIS INSURANCE ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY. FOR NORTH CAROLINA APPLICANTS, SUCH APPLICATION MATERIALS ARE PART OF THE POLICY, IF ISSUED, ONLY IF ATTACHED AT ISSUANCE.

THIS APPLICATION AND ALL INFORMATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY AS IT DEEMS NECESSARY REGARDING THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING AND ISSUANCE OF THE POLICY.

THE APPLICANT AGREES THAT IF THE INFORMATION PROVIDED IN THIS APPLICATION OR IN CONNECTION WITH THE UNDERWRITING OF THE POLICY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

I HAVE READ THE FOREGOING APPLICATION FOR INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

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

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

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

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

NOTICE TO 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.

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

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD THE INSURER BY SUBMITTING AN APPLICATION CONTAINING A FALSE STATEMENT AS TO ANY METERIAL FACT MAY BE VIOLATING STATE LAW.

NOTICE TO KENTUCKY, NEW JERSEY, OHIO, AND 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 CLAIMS CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

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 CLAIMS 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. IN NEW YORK,

THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signed*:____ Date:______________________

Print Name: ____ Title: _____________
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa, please provide the Insurance Agent's name and signature only.

Agent's Printed Name:

Florida Agent's License Number:

Agent's Signature:

*If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a keypad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

Electronic Signature and Acceptance – Authorized Representative

Electronic Signature and Acceptance - Producer