

**Beazley** | Miscellaneous Medical

# 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):  
[Redacted]
- 2. Additional named insureds (please include subsidiaries for which coverage is sought under this policy):  
[Redacted]
- 3. Physical address:  
[Redacted]
- 4. Mailing address (if different from above):  
[Redacted]
- 5. List all states in which applicant is operating or providing services:  
[Redacted]
- 6. Website: \_\_\_\_\_ Year Established: [Redacted]
- 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

Scans – number of imaging scans

Doses – number of times drug is administered

Scripts – total annual number of prescriptions filled

Hours – weekly hours worked by each specialty

Tests – number of laboratory tests analyzed

Occupancy – average daily attendance of clients at facility

Students – number of persons enrolled for all terms annually

Procedures – number of surgeries performed

Transfers – number of transports of each patient

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

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

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

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%)

<input type="text"/> % Critical Care/ICU	<input type="text"/> % Correctional	<input type="text"/> % DD/ID	<input type="text"/> % Elderly
<input type="text"/> % Non-Ambulatory	<input type="text"/> % Obstetrics	<input type="text"/> % Pediatric	<input type="text"/> % Prenatal Care
<input type="text"/> % Psychiatric	<input type="text"/> % Trach/Vent/Technologically Dependent	<input type="text"/> % Wound Care	

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

<input type="text"/> % Applicant's Location	<input type="text"/> % Hospital	<input type="text"/> % LTC Facility	<input type="text"/> % Mobile Clinic
<input type="text"/> % Patient's Home	<input type="text"/> % Physician's Office/Clinic	<input type="text"/> % Remote/Virtual*	<input type="text"/> % _____

*\*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	<input type="checkbox"/>	<input type="checkbox"/>
Complications/Emergencies	<input type="checkbox"/>	<input type="checkbox"/>
Medical Record Documentation/HIPAA	<input type="checkbox"/>	<input type="checkbox"/>
Medical Record Documentation/HIPAA	<input type="checkbox"/>	<input type="checkbox"/>
Patient Rights & Refusal of Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Patient Scheduling/Afterhours Care	<input type="checkbox"/>	<input type="checkbox"/>
Test Result Management	<input type="checkbox"/>	<input type="checkbox"/>

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