SPG SPECIALTY PROGRAM GROUP

Healthcare Organization Liability Insurance Application

Broker Name:

Broker Street Address:

Broker City, State, Zip Code:

All applicants must submit the following information in addition to the application:

1. Minimum of current and prior 5 years of currently valued insurance carrier and/or third-party administrator loss runs with values of paid and outstanding reserve amounts for indemnity and expenses for all coverages requested for all named insureds. For losses valued at $50,000 or higher, attach a detailed description of each incident or loss.
2. Audited financial statements or pro forma financial statements (if applicant is a newly formed organization).
3. Organizational chart and schedule of named insureds.
4. Copy of current policy including declarations, policy forms, and any pertinent endorsements.
5. Specimen copies of third party contracts.
6. Facility licenses, if applicable.
7. Most recent inspection reports, if applicable.
8. Most recent state or federal or any mandated regulatory or accreditation reports, if applicable.

If space provided is insufficient to fully respond to a question, please provide additional information in a separate attachment.

GENERAL INFORMATION

1. Please fill out applicant information below:

Full legal name of applicant:		Date:	
Risk management contact:		Phone:	
Address:		City:	
State:		Zip code:	
Company website:		D&B No.:	
Email address:		NAICS:	

Company is a/an:

☐ Individual	☐ Partnership	☐ Corporation	☐ Joint Venture*	☐ Other (please describe):

*If company is a joint venture, please list joint owner organization(s): _____

2. Tax Status:

☐ Not for profit	☐ For profit-private	☐ For profit-publicly traded	☐ Governmental

3. Year established: _____ If less than 3 years in business, attach a copy of any resume for any principal(s).

4. Please list all states in which the applicant operates or provides services, indicating the percentage of services provided in each state (total must equal 100%):

State	% of Services	State	% of Services	State	% of Services	State	% of Services	State	% of Services
	%		%		%		%		%

5. Does the applicant conduct any operations outside of the United States? ☐ Yes ☐ No

If yes, please list applicable countries: _____

6. Does the applicant currently participate in, or plan to participate in, a state patient compensation fund, health care stabilization fund, or other governmentally established liability funding mechanism? ☐ Yes ☐ No

   If yes, please list the applicable states: _____

7. Please list all subsidiaries or affiliate organizations for which the applicant is seeking coverage:

Name	Relationship	Description of operations	Date acquired	Ownership %	Retroactive date
				%	
				%	
				%	

8. Is the applicant owned or controlled by another organization including, but not limited to, any private equity firm? ☐ Yes ☐ No

   If yes, please provide details: _____

9. Within the past 12 months has the applicant sold, merged with, or acquired another entity, or does the applicant plan to sell, merge with, or acquire another entity within the next 12 months? ☐ Yes ☐ No

   If yes, please provide details: _____

10. Has the applicant discontinued any programs or services in the last 5 years? ☐ Yes ☐ No

    If yes, please provide details: _____

PROFESSIONAL SERVICES AND EXPOSURES

1. Detailed description of operations and medical services provided by the applicant: _____
2. Revenue:

Year Prior	Current Year (last 12 months)	Projected (next 12 months)
$	$	$

3. Does the applicant expect any significant changes to their operations or services in the next year, aside from any divestitures, mergers, or acquisitions addressed in question 9. under General Information? ☐ Yes ☐ No

   If yes, please provide details: _____

4. Location of services: Indicate all locations where the applicant's services are provided, and the percentage of the applicant's total services provided at each location (total must equal 100%):

Location	Percentage %	Location	Percentage %
Applicant's owned/leased locations	%	Correctional facilities	%
Patients' homes	%	Outpatient facilities	%
Hospitals	%	Schools	%
Long term care facilities	%	Mobile facilities	%
Remote/virtual/telehealth*	%	Other (describe):	%

   *Provide a detailed description of the applicant's telehealth activities including the type(s) of and the technology(ies) used for patient interactions. _____

5. Patient profile: Indicate the percentage of the applicant's total patients annually for the following age groups (total must equal 100%):

Age Group	Percentage %	Age Group	Percentage %
Child (up to 12 years old)	%	Adult (18-64 years old)	%
Teenage (13-17 year old)	%	Senior (65+ years old)	%

6. Please complete all applicable fields in the table below and provide exposures projected for the next 12 months. A supplemental application must be completed for exposures marked with an asterisk (*):

Ambulance	**Transfers**	**Receipts**	**Home Healthcare***	**Billable Hours**	**Receipts**
Air		$	Advanced skilled care		$
Ground – emergency		$	General nursing		$
Ground – non-emergency		$	Personal and companion care		$
Ground – paratransit/wheelchair		$	Other (describe)		$
Other (describe)		$	**Hospice**		**Receipts**
Behavioral Health – Inpatient*	**Beds**	**Receipts**	Inpatient	Beds:	$
Mental Health Treatment		$	Outpatient	Visits:	$
Substance Abuse Treatment		$	**Imaging Services**	**Scans**	**Receipts**
Other (describe)		$	Bone density		$
Other (describe)		$	CT		$
Behavioral Health – Outpatient*	**Visits**	**Receipts**	Mammogram		$
Mental Health Counseling		$	MRI		$
Substance abuse counseling		$	PET		$
Other (describe)		$	Ultrasound		$
Blood, Organ, or Tissue Services	**Donations**	**Receipts**	X-ray		$
Blood banking		$	Other (describe)		$
Bone/tissue procurement		$	**Laboratory**	**Tests**	**Receipts**
Egg/sperm banking		$	Dental		$
Organ procurement		$	DNA/ancestry		$
Other (describe)		$	Drug/alcohol		$
Case Management/ Utilization Review	**Cases**	**Receipts**	Fertility		$
			Genetic testing		$
(describe):		$	Other (describe)		$
Clinic Services	**Visits**	**Receipts**	**Medical Equipment Services**		**Receipts**
Abortion		$	Durable medical equipment		$
Alternative therapies		$	Manufacturer's rep in operating room		$
Cardiac rehabilitation		$	Prosthetic fitter/manufacturers		$
Chiropractic		$	Other (describe)		$
Dental		$	**Medical Spa**	**Visits/Procedures**	**Receipts**
Dialysis		$	Other (describe)		$
Employee health center		$	Other (describe)		$
Eye care		$	Other (describe)		$
Federally qualified health center		$	**Medical Training School**	**Students**	**Faculty**
Fertility		$	Allied medical professionals		
Pain Management		$	CPR/first aid		
Physical therapy		$	Other (describe)		
Physical/wellness exams		$	**Pharmacy**	**Scripts**	**Receipts**
Primary care		$	Compounding (describe)		$
Radiation/oncology		$	Infusion therapy		$
School/student health center		$	Mail-order		$
Sleep		$	Retail		$
Speech/hearing		$	Specialty		$
Urgent care		$	Wholesale		$
Veterinarian		$	Other (describe):		$
Weight loss (non-surgical)		$	**Surgery Center**	**Procedures**	**Receipts**
Clinical Trials	**Subjects**	**Receipts**	(describe):		$
(describe):		$	(describe):		$
(describe):		$	(describe):		$
(describe):		$	(describe):		$
Day Care	**Clients/Patients**	**Receipts**	(describe):		$
Pediatric – medical		$	**Telemedicine**	**Visits**	**Receipts**
Pediatric – non-medical		$	Crisis hotline		$
Adult/Geriatric – medical		$	General telehealth		$
Adult/Geriatric – non-medical		$	Remote patient monitoring		$
Other (describe):		$	Specialty (describe)		$
Healthcare staffing*	**Billable Hours**	**Receipts**	Teleradiology		$
Hospitals		$	**Any other medical services**	Exposure (describe)	**Receipts**
Outpatient facilities		$	Description:		$
Senior care facilities		$	Description:		$
Other (describe):		$	Description:		$

7. Does the applicant prescribe medication to any patients? ☐ Yes ☐ No
   If yes, please provide details: _____
8. Does the applicant provide any medications or perform any procedures that are non-FDA approved? ☐ Yes ☐ No
   If yes, please provide details: _____
9. Does the applicant conduct clinical research? ☐ Yes ☐ No
   If yes, please provide details: _____
10. Does the applicant administer anesthesia (other than topical)? ☐ Yes ☐ No
    If yes, please provide details: _____
11. Does the applicant perform surgical procedures? ☐ Yes ☐ No
    If yes, please provide details: _____
12. Does the applicant conduct biomedical device research and development? ☐ Yes ☐ No
    If yes, please provide details: _____
13. Does the applicant sell, rent, or lease medical supplies or equipment to others? ☐ Yes ☐ No
    If **yes,** with respect to that equipment:
    a. Does the applicant provide maintenance services to others? ☐ Yes ☐ No
    b. Does the applicant check equipment prior to release? ☐ Yes ☐ No
    c. Does the applicant perform preventative maintenance? ☐ Yes ☐ No
    d. Describe any medical products or equipment sold (if no products or equipment are sold, enter N/A):

14. Does the applicant provide social services including, but not limited to, foster care and adoption services, public housing, food banks, emergency relief, legal/financial counseling, youth support, immigration support, etc.? ☐ Yes ☐ No
    If yes, please provide details: _____

PROFESSIONAL STAFF

1. Please provide the following information for any medical directors:

Name	License Number and Specialty	Status	Hours/ Month	Maintains Own Insurance	Insurance Limits Maintained	Coverage Requested
	License No. Specialty	☐ Employed ☐ Contracted		☐ Yes ☐ No	$ $	☐ Yes ☐ No
	License No. Specialty	☐ Employed ☐ Contracted		☐ Yes ☐ No	$ $	☐ Yes ☐ No

2. Please provide the following information for any physicians:

Name	License Number and Specialty	Status	Hours/ Month	Maintains Own Insurance	Insurance Limits Maintained	Coverage Requested
	License No. Specialty	☐ Employed ☐ Contracted		☐ Yes ☐ No	$ $	☐ Yes ☐ No
	License No. Specialty	☐ Employed ☐ Contracted		☐ Yes ☐ No	$ $	☐ Yes ☐ No
	License No. Specialty	☐ Employed ☐ Contracted		☐ Yes ☐ No	$ $	☐ Yes ☐ No

3. Are physicians required to be board certified in their specialty? ☐ Yes ☐ No

Note: Coverage for physicians is not automatically included. If coverage is required, a separate application must be completed.

4. Please provide the following information for any healthcare professional staff:

Professional Type	Employees		Contractors		Volunteers	
	Number of Employees	Hours (annual)	Number of Contractors	Hours (annual)	Number of Volunteers	Hours (annual)
Acupuncturists						
Addiction or Mental Health Counselors						
Anesthesia assistants						
Athletic trainers						
Case managers						
Certified nursing assistants						
Chiropractors						
Companions						
Dentists						
Dietician/Nutritionists						
Home health aides						
Naturopaths						
Nurses (RN, LPN)						
Nurse practitioner/ advanced practice nurse						
Optometrists						
Paramedic/EMTs						
Pharmacists						
Physician Assistants						
Psychologists						
Social Workers						
Therapist – Massage						
Therapist – Occupational						
Therapist - Physical						
Therapist – Respiratory						
Therapist – Speech						
Technicians (specify)						
Veterinarians						
Other (specify)						
Other (specify)						

5. Are all staff members included in the table above licensed in accordance with the applicable state and federal regulations? ☐ Yes ☐ No

   If no, please explain: _____

6. Are independent contractors required to carry separate insurance? ☐ Yes ☐ No

   If yes:

   a. Amount of limits required: $_____

   b. Are certificates of insurance requested and stored on file? ☐ Yes ☐ No

7. Is the applicant requesting coverage for any independent contractors? ☐ Yes ☐ No

8. What is the applicant's annual turnover rate for the professional staff listed above? _____

RISK MANAGEMENT

1. Does the applicant have an individual on staff responsible for risk management? ☐ Yes ☐ No
2. Does the applicant have a formal written risk management and patient safety program? ☐ Yes ☐ No
3. Are written policies and procedures in place regarding the following:
   a. Admission criteria including assessment and acceptance of patients ☐ Yes ☐ No ☐ N/A
   b. Voluntary and involuntary discharging of patients and transitions of care ☐ Yes ☐ No ☐ N/A
   c. Treatment plans or orders prescribed by physicians ☐ Yes ☐ No ☐ N/A
   d. Medical emergency response ☐ Yes ☐ No ☐ N/A
   e. Medical record documentation/management, including HIPAA compliance ☐ Yes ☐ No ☐ N/A
   f. Medical administration, medical director oversight ☐ Yes ☐ No ☐ N/A
   g. Patient and family grievances ☐ Yes ☐ No ☐ N/A
   h. Physical/sexual abuse awareness and prevention ☐ Yes ☐ No ☐ N/A
   i. Incident reporting, follow up, tracking, and monitoring ☐ Yes ☐ No ☐ N/A
   j. Informed consent and refusal ☐ Yes ☐ No ☐ N/A
   k. Reporting alleged or suspected abuse ☐ Yes ☐ No ☐ N/A
   l. Disaster preparedness, workplace violence ☐ Yes ☐ No ☐ N/A
4. Is training provided on the above policies and procedures? ☐ Yes ☐ No ☐ N/A
5. Is compliance with the above policies and procedures monitored and enforced? ☐ Yes ☐ No ☐ N/A
6. Are complete records maintained on all patients? ☐ Yes ☐ No ☐ N/A
7. Does applicant use electronic medical records? ☐ Yes ☐ No ☐ N/A
8. Do third-party contracts contain the following provisions:
   a. Clauses requiring that the applicant be held harmless and indemnified? ☐ Yes ☐ No
   b. A requirement that the party with whom the applicant is contracting maintain insurance? ☐ Yes ☐ No

      If yes:

      (1) Does the applicant require certificates of insurance? ☐ Yes ☐ No

      (2) Please indicate the type of insurance and limits required below:

Type of Insurance	Limits Required
	$
	$

      (3) Are third parties required to name the applicant as additional insureds? ☐ Yes ☐ No

      If yes, please provide details of the third party(ies) and their relationship(s) to the applicant: _____

   c. Confidentiality clauses? ☐ Yes ☐ No

LICENSURE/ACCREDITATIONS

1. Please list all licenses, accreditations, and certifications held by the applicant:
   a. Licences: _____
   b. Certifications: _____
   c. Accreditations: _____

   Have any of the above been suspended, revoked, or cancelled? ☐ Yes ☐ No

   If yes, please explain: _____
2. Is the applicant a member of any professional associations? ☐ Yes ☐ No

   If yes, please list the professional associations: _____

3. Has applicant ever been investigated by any health departments or governmental agencies? ☐ Yes ☐ No
   If yes, please explain: _____

HIRING AND STAFF MANAGEMENT

1. Are job descriptions provided for all employees? ☐ Yes ☐ No
2. Are all professional staff credentialed prior to hiring? ☐ Yes ☐ No
   If no, please explain: _____
3. Does the applicant use the following procedures in hiring and screening staff members:
   a. Verification of employment history ☐ Yes ☐ No
   b. Verification of education ☐ Yes ☐ No
   c. Verification of certifications/licensure ☐ Yes ☐ No
   d. Professional reference checks ☐ Yes ☐ No
   e. Verification of driver's license ☐ Yes ☐ No
   f. Verification of denial or cancellation of prior insurance ☐ Yes ☐ No
   g. Verification of prior professional liability claims/litigation ☐ Yes ☐ No
   h. State and federal criminal background checks ☐ Yes ☐ No
   i. Drug/alcohol testing ☐ Yes ☐ No
   j. Screening for prior allegations involving sexual abuse ☐ Yes ☐ No
      If yes:
      (1) Sources used in screening:
      [ ] National Sex Offender Public Website
      [ ] Other (please describe): _____
      (2) Are employees rescreened on a regular basis? ☐ Yes ☐ No
      If yes, at what intervals: _____

GENERAL LIABILITY (complete only if this insurance is requested)

1. Please provide the following information for any owned, occupied, or leased location:

Location description and address	Square footage	Year built	Type of construction	Number of stories	Type of fire protection

2. Does the applicant:
   a. Have any planned renovations or new construction? ☐ Yes ☐ No
   b. Have a written emergency evacuation plan? ☐ Yes ☐ No
   c. Have emergency backup systems at each location in the event of loss of utilities? ☐ Yes ☐ No
   d. Are the following security measures in place at each location:
      (1) Locked exits ☐ Yes ☐ No
      (2) Alarms ☐ Yes ☐ No
      (3) Security guards ☐ Yes ☐ No
      (4) Check-in/sign-out procedures ☐ Yes ☐ No
      (5) Video surveillance ☐ Yes ☐ No
      (6) Other (please describe): _____

e. Sponsor any sporting or social events? ☐ Yes ☐ No
If yes, please describe: _____

f. Own, operate, or provide access to or services involving any: animal or equine therapy, camps, pools, ponds, lakes, playgrounds, gyms, fitness centers, ropes courses, climbing walls, or any other recreational facilities or activities? ☐ Yes ☐ No
If yes, please describe: _____

g. Sell, rent, or lease medical supplies or equipment? ☐ Yes ☐ No
If yes, please describe: _____

h. Repair or perform maintenance on medical supplies or equipment? ☐ Yes ☐ No
If yes, please describe: _____

i. Manufacture any products? ☐ Yes ☐ No
If yes, please describe: _____

j. Modify products in any way from their original form or intended use? ☐ Yes ☐ No
If yes, please describe: _____

Complete the following for all products sold or leased:

Product Category	**Sales Receipts**	**Rental/Lease Receipts**
Category I Expendable Items: Intended for one-time usage and disposed of (e.g., adhesive tape, bandages, hypodermic needles, etc.)	$	$
Category II Non Expendable Items: Durable medical equipment, excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids, walkers, strollers, canes, crutches, wheelchairs, prosthetic devices, and IV stands.	$	$
Category III Diagnostic or Treatment Devices: Treatment devices or equipment not used to sustain life or perform critical life monitoring functions, including items such as blood pressure gauges, IV pumps, portable EKG machines, or sensing devices.	$	$
Category IV Life Sustaining or Critical Life Monitoring Equipment or Devices: Includes oxygen and other medical gases used in conjunction with respiratory therapy, dialysis, or heart/lung machines, apnea monitors, any other life dependent monitors, or any other equipment or devices that could result in the death or serious deterioration of the patients' health condition in the event of malfunction or failure.	$	$

3. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? ☐ Yes ☐ No
If yes, provide details for each: _____

4. Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, circumstance, situation, or incident that may result in a General Liability claim, such as would fall under the proposed insurance? ☐ Yes ☐ No
If yes, provide details for each: _____

CURRENT COVERAGE

Coverage Type	**Insurer**	**Policy Period**	**Limits of Insurance**	**Deductible**	**Retroactive Date**	**Premium**
Professional Liability		to	$ /$	$		$
General Liability ☐ Occurrence ☐ Claims made		to	$ /$	$		$
Excess Liability		to	$ /$	$		$

Has any insurance company cancelled, declined, refused to renew, or accept only on special terms the applicant's medical professional liability insurance? ☐ Yes ☐ No

COVERAGE REQUESTED

Please select the coverage(s) requested:

Coverage	Coverage Requested?	Effective Date	Retroactive Date (Claims Made Only)	Limits of Insurance	Deductible (each claim)
Professional liability (Claims made only)	☐ Yes			$ Each claim $ Aggregate	☐ None ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: $
Sexual acts liability (Claims made only)	☐ Yes ☐ No			$ Each claimant $ All claims	☐ None ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: $
General liability [ ] Occurrence [ ] Claims made	☐ Yes ☐ No			$ Each occurrence $ Aggregate	☐ None ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: $
Employee benefits liability* (Claims made only) No. of employees:	☐ Yes ☐ No			$ Each claim $ Aggregate	☐ None ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: $
Hired and non-owned automobile liability*	☐ Yes (**If yes,** please complete supplemental application) ☐ No				
Excess liability	☐ Yes ☐ No			☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000 ☐ Other (specify): $	☐ None ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: $

*May only be purchased if purchasing General Liability coverage.

CLAIM HISTORY

1. Has the applicant or any principal, partner, owner, officer, director, employee, manager, or managing member of the applicant or any person(s) or organizations(s) proposed for this insurance or any predecessor, subsidiary, or affiliated organization ever:
   a. Been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
   b. Been the subject of formal allegations of sexual abuse? ☐ Yes ☐ No
   c. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
   d. Had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, denied renewal or accepted for renewal only on special terms, or have they ever voluntarily surrendered the same? ☐ Yes ☐ No

   If yes to any of the above, please provide full details: _____
2. Has any claim or suit for malpractice ever been made against the applicant or any principal, partner, owner, officer, director, employee, volunteer worker, manager, or managing member of the applicant, or is any person(s) or organization(s) proposed for this insurance aware of any act, error, omission, fact, circumstance, situation, incident, or allegation of negligence or wrongdoing, or records request from any attorney that may result in a malpractice claim or suit? ☐ Yes ☐ No

   If yes, a Supplemental Claim Information Form must be completed for each claim or suit.
3. Have all lawsuits, attorney requests, claims, and legal proceedings been reported to the applicant's current insurer(s)? ☐ Yes ☐ No

FAIR CREDIT REPORT ACT NOTICE

Personal information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You have the right to review your personal information in our files and can request correction of any inaccuracies. A more detailed description of your rights and our practices regarding such information is available upon request. Contact your agent or broker for instructions on how to submit a request to us.

FRAUD WARNINGS

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: 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. *Applies in MD only.

Applicable in CA: For your protection, California law requires the following to appear on your application for insurance. 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.

Applicable in CO: 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.

Applicable in FL and OK: 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)*. *Applies in FL only.

Applicable in KS: 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 commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: 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 material fact may be violating state law.

Applicable in VT: 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.

Applicable in all other states: 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.

Representation Statement

The undersigned authorized officer of the applicant declares that the statements set forth herein are true to the best of his or her knowledge. The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing of this application does not bind the applicant to the insurer to complete the insurance.

Name of applicant	Title
Signature of applicant	Date

(Florida only) Agent license number: _____