Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

HEALTH CARE ORGANIZATION AND PROVIDER PROFESSIONAL LIABILITY APPLICATION

BY COMPLETING THIS APPLICATION, THE APPLICANT IS APPLYING FOR INSURANCE WITH EXECUTIVE RISK INDEMNITY INC.

NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR WITHIN SIXTY (60) DAYS AFTER THE END OF THE "POLICY PERIOD". IF AN EXTENDED REPORTING PERIOD IS APPLICABLE, SUCH COVERAGE WILL APPLY ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE EXTENDED REPORTING PERIOD AND REPORTED TO THE UNDERWRITER DURING THE EXTENDED REPORTING PERIOD. THE COVERAGE AFFORDED UNDER THIS POLICY DIFFERS IN SOME RESPECTS FROM THAT AFFORDED UNDER OTHER POLICIES. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

A. APPLICANT

1. Legal name of facility or hospital ("**Applicant**"): _____
2. Address: _____

   City: _____ State: _____ ZIP: _____
3. Telephone number:_____ Website (if applicable):_____
4. Name of Risk Manager: _____ Email address: _____

   Telephone number:_____
5. How many years has the **Applicant** been in operation? _____
6. How many years has the **Applicant** been under present ownership? _____
7. Please list all affiliates and subsidiaries to which this insurance is to apply. Please include a complete description of the operations of each affiliate/subsidiary and the relationship to the **Applicant**. (Please attach a separate sheet if necessary.) (*Note that coverage for such entities is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage.)

   _____

   _____

   _____

B. GENERAL INFORMATION

Applicant is (please check all appropriate categories):

___ General Hospital	___ Operated For-Profit
___ Children's Hospital	___ Not-for-Profit
___ Teaching Hospital	___ Medicare Approved
___ Psychiatric Hospital	___ Partnership
___ Research Hospital	___ Corporation
___ Convalescent or Nursing Home	___ Licensed by the State
___ Clinic	___ Charitable
___ Community Health Center	___ Surgicenter
___ Governmental	___ Other (explain):_____

1. Is the **Applicant** accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)? ☐ Yes ☐ No
   Date of last accreditation: _____
   Accreditation period: _____
   (Please attach a copy of the most recent survey.)

Is the **Applicant** licensed by the State? ☐ Yes ☐ No
(Please attach a copy of the most recent State license survey.)

2. Has the **Applicant** or other associated entity ever had its license revoked, suspended or been placed on probation by any governmental licensing agency? ☐ Yes ☐ No
If "Yes," please explain: _____

3. Has the **Applicant** ever been investigated by any third party for alleged fraud, erroneous billing or entered into a Compliance Integrity Agreement? ☐ Yes ☐ No
If "Yes," please explain: _____

4. Has the **Applicant** entered into any joint ventures or limited partnerships? ☐ Yes ☐ No
If "Yes," please explain: _____

5. Is any part of the **Applicant** operated/leased by a management corporation? ☐ Yes ☐ No
If "Yes," please give the name of the corporation and details of structure: _____
Attach a copy of the management or services agreement.

6. Does the **Applicant** participate in any teaching programs? ☐ Yes ☐ No
If "Yes," please describe the type of programs: _____
Is the program hospital-sponsored? ☐ Yes ☐ No
If "Yes," please provide the name of the sponsoring institution: _____

7. Does the **Applicant** participate in any clinical research or clinical trials? ☐ Yes ☐ No
If "Yes," please explain and discuss whether the **Applicant** has an IRRB in place: _____

8. Does the **Applicant** anticipate any facility or service expansions (for example, an increase in licensed beds) within the next year? ☐ Yes ☐ No
If "Yes," please explain: _____

9. Does the **Applicant** anticipate any sale of assets, mergers, acquisitions, consolidation or change in operations or services within the next twelve (12) months? ☐ Yes ☐ No
If "Yes," please explain: _____

C. PERSONNEL

1. Indicate the number of persons employed by or working under the control of the **Applicant** in each of the following classifications:

___	Certified Registered Nurse Anesthetists**	___	Nurse Practitioners*
___	Dentists*	___	Paramedics
___	Emergency Medical Technicians	___	Registered Nurses
___	Interns	___	Respiratory Therapists
___	Laboratory or X-ray Technicians	___	Pharmacists
___	Licensed Vocational/Practical Nurses	___	Physician Assistants*
___	Nurse's Aides	___	Physicians and Surgeons**
___	Nurse Midwives*	___	Residents
___	Other (explain): _____		

* Please provide separate listings of names and specialties (and contract, if applicable) for each.
** A separate application will be required for each to evaluate coverage for such professionals.

D. OPERATIONS

1. EXPOSURES (Please complete for the current year and five (5) previous years.)

	Current Year Estimated Average Annual Occupancy/Visits	Prior Years 1	2	3	4	5
a. **Beds**						
Total Hospital Beds	____	____	____	____	____	____
Total Average Annual Occupancy Breakdown Capacity:	____	____	____	____	____	____
_____ Acute Care Beds	____	____	____	____	____	____
_____ Cribs	____	____	____	____	____	____
_____ Bassinets	____	____	____	____	____	____
_____ Extended Care	____	____	____	____	____	____
_____ Skilled Nursing Beds	____	____	____	____	____	____
_____ Psychiatric	____	____	____	____	____	____
_____ Rehabilitation	____	____	____	____	____	____
_____ Chemical Dependency	____	____	____	____	____	____
_____ Hospice	____	____	____	____	____	____
_____ Other	____	____	____	____	____	____
b. **Outpatient Services**						
Emergency Room Visits	____	____	____	____	____	____
Outpatient Surgery	____	____	____	____	____	____
Other Outpatient Visits (per Patient per Registration Day)	____	____	____	____	____	____
Home Health Care Visits	____	____	____	____	____	____
Clinic Visits	____	____	____	____	____	____
Reference Laboratory Tests	____	____	____	____	____	____
c. **Inpatient Surgeries**	____	____	____	____	____	____
d. **Deliveries** (excluding cesarean sections)	____	____	____	____	____	____
(i) Cesarean Sections	____	____	____	____	____	____
(ii) VBAC's	____	____	____	____	____	____

2. Other:
Is coverage requested for the following? If "Yes," please indicate name and profession:
Nurse Anesthetist: ☐ Yes ☐ No
Physician Assistants: ☐ Yes ☐ No
Employed or contract physicians (see question "3" below for Emergency Room Physicians*).*

3. If the **Applicant** provides professional liability coverage for Emergency Room Physicians, what is the total estimated number of patients examined or treated for the current year and the actual number for the five (5) previous years?

Current Year	Previous Five (5) Years				
_____	_____	_____	_____	_____	_____

4. SERVICES (Please indicate if the **Applicant** presently provides, plans to provide, or presently operates any of the following):

_____ Abortion Clinic
_____ Ambulance Service
_____ Base Hospital
_____ Blood Bank
_____ Burn Units
_____ Cardiac Catheterization Centers
_____ Coronary Care Unit
_____ Dialysis
_____ Ob/Gyn
_____ Oncology
_____ Cardiovascular Surgery
_____ Off-Premises Clinics
_____ Day Care
_____ Dental Services
_____ Emergency Room
_____ Managed Care Services
_____ Home Health Care
_____ Hospice
_____ Hospital Foundation
_____ Inhalation or Respiratory Therapy
_____ Intensive Care Unit
_____ Organ Bank
_____ Organ Transplants
_____ Outpatient Surgicenters
_____ Lifeline
_____ Mobile Unit (blood-mobiles, mammography, CAT scan units, etc.)
_____ Nursery
_____ Neonatal
_____ Off-Premises Food Services
_____ Off-Premises Labs
_____ Pharmacy
_____ Transportation Services (other than ambulance)

_____ Other (explain): _____

5. ANESTHESIA SERVICES

a. Staffing is by: ____ Contracted Physicians ____Employed Physicians ____ Residents
____ Contracted Certified Registered Nurse Anesthetists (CRNAs)
____ Employed CRNAs ____ Staff Physicians

b. Are all physicians board certified or eligible? ☐ Yes ☐ No
If "No," please explain: _____

c. If services are provided via contract, to whom is staffing contracted? Please explain and attach a copy of the contract: _____

d. Are contract physicians required to carry professional liability insurance? ☐ Yes ☐ No
If "Yes," what limits are required? _____

Does the **Applicant** obtain a Certificate of Insurance? ☐ Yes ☐ No

e. Describe the minimum qualifications required for administration of general anesthesia: _____

_____

f. CRNAs

(i) Do CRNAs provide anesthesia service? ☐ Yes ☐ No
If "Yes," please describe the relationship between the **Applicant** and the CRNAs below:
Are they: Employed by the **Applicant**? ☐ Yes ☐ No
Employed by the Anesthesiologist? ☐ Yes ☐ No

Employed by the Surgeon? ☐ Yes ☐ No
Independent? ☐ Yes ☐ No

(ii) Do CRNAs work under the direct supervision of an anesthesiologist? ☐ Yes ☐ No
If "No," please submit written guidelines developed with the collaborative physician or qualified physician designee of the primary physician or the dentist responsible for the patient's immediate care.

6. RADIOLOGY SERVICES

a. Staffing is by: ____ Residents ____ Employed Physicians ____ Contracted Physicians
Are all physicians board certified or eligible? ☐ Yes ☐ No
If "No," please explain: _____

_____

b. If under contract, to whom is staffing contracted? _____

_____

Are contract physicians required to carry professional liability insurance? ☐ Yes ☐ No
If "Yes," what limits are required? _____
Does the **Applicant** obtain a Certificate of Insurance? ☐ Yes ☐ No

c. Please state the number of X-ray machines owned or operated, and whether they are used for diagnosis or treatment or both. Please state by whom the treatment is given:

_____

_____

_____

7. OBSTETRICS

a. Is the **Applicant** a regional referral center for either high-risk OB or newborns requiring intensive care? ☐ Yes ☐ No

b. Number of labor rooms: _____

c. Number of delivery rooms: _____

d. Does the **Applicant** have a separate birthing center? ☐ Yes ☐ No

e. Is the delivery room suite separate from the surgical suite? ☐ Yes ☐ No

f. Can cesarean sections be performed within thirty (30) minutes at all times? ☐ Yes ☐ No

g. Is an anesthesiologist or CRNA available in-house twenty-four (24) hours per day for the obstetrical suite? ☐ Yes ☐ No
If "No," what is the maximum time for arrival at hospital? _____

h. Is an obstetrician available in-house twenty-four (24) hours per day for the obstetrical suite? ☐ Yes ☐ No
If "No," what is the maximum time for arrival at hospital? _____

i. Do Family Physicians or Nurse Midwives perform obstetrical services? ☐ Yes ☐ No
If "Yes," please describe delivery protocols or attach applicable policy:
_____

j. Do Family Physicians or Nurse Midwives perform VBACs or C-Sections? ☐ Yes ☐ No
If "Yes," please describe delivery protocols or attach applicable policy: _____

k. If the **Applicant** has a neonatal intensive care unit (NICU), state:

(i) total number of neonates admitted to NICU in the past twelve (12) months: _____

(ii) total number of neonates admitted to NICU who were transferred from other facilities: _____

(iii) whether full-time attending neonatologist is on-site in NICU twenty-four (24) hours per day? ☐ Yes ☐ No

l. If the **Applicant** does not have NICU, please state the total number of neonates transferred from the institution to other facilities in the past twelve (12) months: _____

8. EMERGENCY ROOM

Does the **Applicant** provide emergency room (ER) service? ☐ Yes ☐ No
If "Yes," please answer the following questions:

a. What level of service does **Applicant** provide (based on the standards of the JCAHO)? (Check all that apply.)
___ I (Tertiary) ___ II (Comprehensive) _____ Trauma Center
___ III (Basic) ___ Stand-by services only

b. Is the **Applicant's** emergency room open and staffed 24 hours a day, 7 days a week, 365 days a year?
If "No," please explain: _____

c. Is the ER service operated by the **Applicant**? ☐ Yes ☐ No

d. If under contract, to whom is staffing contracted? _____
Are contract physicians required to carry professional liability insurance? ☐ Yes ☐ No
If "Yes," what limits are required? _____
Does the **Applicant** obtain a Certificate of Insurance? ☐ Yes ☐ No

e. Staffing is by: ___ Residents
___ Employed Physicians
___ Contracted Physicians
Are physicians board certified or eligible? ☐ Yes ☐ No
If "No," please explain: _____
_____

9. SPECIAL SERVICES

Does the **Applicant** provide the following services**:**

a. Ambulance: ☐ Yes ☐ No If "Yes," Number of vehicles: _____
Number of runs per year: _____

b. Blood Bank: ☐ Yes ☐ No If "Yes," Number of donors (pints): _____
Number of pints purchased from others: _____

c. Organ Tissue Bank: ☐ Yes ☐ No — If "Yes," Number of donors: _____
Number of organ tissue donations per year: _____

d. Day Care: ☐ Yes ☐ No — If "Yes," Number of children per day: _____
Number of days per week: _____
On-hospital premises ☐ Yes ☐ No
Open to the public ☐ Yes ☐ No

e. Dialysis Unit: ☐ Yes ☐ No — If "Yes," Number of procedures per year: _____

E. STAFF PRIVILEGES

1. Please indicate the number of staff physicians in each of the following categories:
   ____ Active ____ Consulting ____ Emeritus
   ____ Associate ____ Courtesy ____ Probationary
2. Are credentials for new staff members checked and approved prior to granting staff privileges? ☐ Yes ☐ No
   If "Yes," by whom?
   How are the potential staff applicants' degree(s) and experience verified?

   _____

   _____

   _____
3. Are privileges provisional for at least six (6) months for all new staff members? ☐ Yes ☐ No
4. Does the **Applicant** have any staff members who are not licensed or who have restricted licenses or privileges? ☐ Yes ☐ No
   If "Yes," please explain: _____
5. Do department heads evaluate the work of their staff members? ☐ Yes ☐ No
6. Is an ongoing medical audit maintained on all staff members' clinical work? ☐ Yes ☐ No
7. Are all staff privileges reviewed each year? ☐ Yes ☐ No
   If "No," how frequently are staff privileges evaluated? _____
8. Does the **Applicant** require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? ☐ Yes ☐ No
9. Staff members' professional liability insurance:
   a. Are all staff members required to maintain professional liability insurance? ☐ Yes ☐ No
   b. Is this requirement stated in the staff bylaws? ☐ Yes ☐ No
   c. What limits are required? _____
   d. What evidence of compliance is required? _____

   _____

   Please include a copy of the medical staff bylaws stating the insurance requirements for staff members.

F. RISK MANAGEMENT

1. Is there a written, formalized risk management program? ☐ Yes ☐ No
   If "Yes," please provide a synopsis of the program: _____

2. Is the program periodically reviewed for effectiveness and necessary changes implemented? ☐ Yes ☐ No

3. Who is in charge of implementing this program and any changes? _____

4. Does the **Applicant** have a formalized quality assurance program? ☐ Yes ☐ No
   If "Yes," please provide a synopsis of the program: _____

G. CONTRACTUAL AGREEMENTS

1. a. Does the **Applicant** lease or rent any equipment from others? ☐ Yes ☐ No
      If "Yes," please provide a description of the equipment: _____

   b. Does the **Applicant** indemnify (hold harmless) the owner for liability? ☐ Yes ☐ No
      If "Yes," please submit a copy of the agreement.

2. a. Please identify any contract professional services performed for the **Applicant**:
      ___ Housekeeping ___ Pathology
      ___ Laboratory ___ Pharmacy
      ___ Laundry ___ Other (explain): _____

   b. Does the **Applicant** require these contractors to provide evidence of insurance? ☐ Yes ☐ No
      If "Yes," what limits of liability does the **Applicant** require? _____
      Please submit a copy of each contract.

3. a. Are there any other service contracts in effect? ☐ Yes ☐ No
      If "Yes," please describe services: _____

   b. Does the **Applicant** indemnify (hold harmless) the service provider? ☐ Yes ☐ No
      If "Yes," please submit a copy of the contract.

H. PHYSICAL PREMISES

1. Please list below all the buildings the **Applicant** owns, controls, or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. Please attach a separate schedule if more space is needed.

a. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? ☐ Yes ☐ No Smoke detectors? ☐ Yes ☐ No

b. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? ☐ Yes ☐ No Smoke detectors? ☐ Yes ☐ No

c. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? ☐ Yes ☐ No Smoke detectors? ☐ Yes ☐ No

d. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? ☐ Yes ☐ No Smoke detectors? ☐ Yes ☐ No

e. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? ☐ Yes ☐ No Smoke detectors? ☐ Yes ☐ No

f. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? ☐ Yes ☐ No Smoke detectors? ☐ Yes ☐ No

2. Does the **Applicant** have a heliport/helipad? ☐ Yes ☐ No
   If "Yes," where is the pad located (e.g., parking lot, top of building, etc.)?

   _____

   _____

   How far is it from the **Applicant**? _____

   Please list the dimensions of helipad: _____

   Please describe the type of construction: _____

3. Are security measures used to control unauthorized access or entrance to any of **Applicant**'s facilities? ☐ Yes ☐ No
   If "Yes", please describe: _____

   _____

I. PROFESSIONAL LIABILITY INSURANCE

1. **Applicant's** current professional liability coverage:
   a. Carrier: _____
   b. Policy period: _____
   c. Limits of liability (per claim and aggregate): _____
   d. Deductible or retention: _____
   e. Present coverage is:

      Occurrence ☐ Yes ☐ No Claims-Made ☐ Yes ☐ No

      Pre-paid Claims-Made ☐ Yes ☐ No Includes General Liability ☐ Yes ☐ No

   f. Current retro date: _____

MISSOURI APPLICANTS/AGENTS: DO NOT ANSWER QUESTION 2.

2. Past Coverage:
   Has any insurer canceled or declined to issue professional liability insurance for the **Applicant**? ☐ Yes ☐ No
   If "Yes," please explain: _____

   _____

3. Claims history:
   (a) Has any individual or entity proposed for coverage ever submitted to a liability insurer or risk transfer instrument any claim or given notice of any fact, situation, transaction, event, act, error or omission for a malpractice claim, suit or incident, either directly or indirectly? ☐ Yes ☐ No

   If "Yes," please attach information about such losses for the last ten (10) years, including the current year and a breakdown of total incurred losses, paid losses, and outstanding losses, separated by year for professional liability and general liability. Please provide full details of any claim paid or outstanding during this period in excess of $100,000 (paid) or $50,000 (outstanding).

(b) Other than claims or potential claims that have been reported to a previous liability insurer or risk transfer instrument, is any individual or entity proposed for coverage aware of any fact, circumstance, situation, transaction, event, act, error or omission which they know or reasonably should know may result in a claim that may fall within the scope of the proposed insurance? For the purposes of this question, "reasonably should know" includes any act, error, omission or occurrence that alleged sexual, physical or emotional abuse or misconduct; or was the subject of any peer review; professional or specialty association investigation or review; FDA MedWatch report; internal review or investigation; inquiry by any accreditation or licensing entity; local, state or federal investigation; JCAHO "near miss" investigation; sentinel event report or root cause analysis; incident report investigation; written inquiry, notification or demand by legal counsel or matter submitted to legal counsel; mandatory report on professional conduct; or similar investigation or review.
☐ Yes ☐ No

If "Yes," please provide details: _____

_____

_____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM, OR RELATED CLAIM, ARISING OUT OF ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION THAT IS OR SHOULD HAVE BEEN DISCLOSED IN RESPONSE TO QUESTION 3(a) OR 3(b) IS EXCLUDED FROM THE PROPOSED INSURANCE.

4. Requested insurance (*Note that requested coverage is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage):

Requested Limit of Liability: _____ _____
Per claim Annual aggregate

Requested Retention: _____ _____
Per claim Annual aggregate

Desired effective date of coverage: _____

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THE RISK WHICH HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. (PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY).

Please include copies of the following:
1. The **Applicant's** most recent annual report
2. A copy of the **Applicant's** most recent JCAHO report and response to any contingencies
3. The **Applicant's** most current audited financial statement
4. A copy of the **Applicant's** current balance of the self-insured trust fund*
5. A copy of the **Applicant's** Trust agreement*
6. Recent actuarial study supporting the funding of the **Applicant's** self-insured trust*
7. A copy of the **Applicant's** Medical Staff Bylaws
8. Carrier claim report(s) for the **Applicant** for the past ten (10) years, including amounts paid and reserved.

* These items apply if **Applicant** has set up a self-insured trust fund.

Notice to Applicant - Please read carefully.

For the purposes of this Application, the undersigned authorized agent of the person(s) and the entity(ies) 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. The Underwriter considers the Application, which is on file with the Underwriter, physically attached to any policy issued. The Underwriter will have relied upon this Application in issuing the policy.

The **Applicant** authorizes the Underwriter to make any inquiry in connection with this Application. Accepting this Application does not bind the Underwriter to complete, or the **Applicant** to purchase, the insurance.

If the information in this Application materially changes between the date of this Application and the policy effective date, the **Applicant** will notify the Underwriter which may modify or withdraw any quotation or agreement to bind insurance.

Notice to 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.

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 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.

Notice to District of Columbia, Maine, Tennessee and Virginia 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 Florida Applicants: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim or an application containing any false or misleading information is guilty of a felony of the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any 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.

Notice to Louisiana and New Mexico 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.

Notice to Maryland 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 may be guilty of insurance fraud.

Notice to 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.

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

HEALTH CARE ORGANIZATION AND PROVIDER PROFESSIONAL LIABILITY APPLICATION

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.

Notice to Oklahoma Applicants: 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 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.

Notice to 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.

I hereby declare that the above statements and particulars are true and that I have not omitted or misstated any material facts and I agree that this Application shall be the basis for any insurance policy that is issued.

APPLICANT		
BY *(Chairman and/or President)*	TITLE	DATE

NOTE: This Application must be signed by the Chairman and/or President of the **Applicant** acting as the authorized agent of all individuals and entities proposed for this insurance.

REQUIRED INFORMATION

PRODUCED BY *(Insurance Agent)* Please print and sign name _____ _____	
INSURANCE AGENCY	
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS *(No., Street, City, State, and ZIP)*	
EMAIL ADDRESS	

SUBMITTED BY *(Insurance Agency)*	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS *(No., Street, City, State, and ZIP)*		