



**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):

- |   |   |
|---|---|
| <input type="checkbox"/> General Hospital             | <input type="checkbox"/> Operated For-Profit    |
| <input type="checkbox"/> Children's Hospital          | <input type="checkbox"/> Not-for-Profit         |
| <input type="checkbox"/> Teaching Hospital            | <input type="checkbox"/> Medicare Approved      |
| <input type="checkbox"/> Psychiatric Hospital         | <input type="checkbox"/> Partnership            |
| <input type="checkbox"/> Research Hospital            | <input type="checkbox"/> Corporation            |
| <input type="checkbox"/> Convalescent or Nursing Home | <input type="checkbox"/> Licensed by the State  |
| <input type="checkbox"/> Clinic                       | <input type="checkbox"/> Charitable             |
| <input type="checkbox"/> Community Health Center      | <input type="checkbox"/> Surgicenter            |
| <input type="checkbox"/> Governmental                 | <input type="checkbox"/> 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	Prior Years				
	Estimated Average Annual Occupancy/Visits	1	2	3	4	5
<b>a. Beds</b>						
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>b. Outpatient Services</b>						
Emergency Room Visits	_____	_____	_____	_____	_____	_____
Outpatient Surgery	_____	_____	_____	_____	_____	_____
Other Outpatient Visits (per Patient per Registration Day)	_____	_____	_____	_____	_____	_____
Home Health Care Visits	_____	_____	_____	_____	_____	_____
Clinic Visits	_____	_____	_____	_____	_____	_____
Reference Laboratory Tests	_____	_____	_____	_____	_____	_____
<b>c. Inpatient Surgeries</b>						
_____	_____	_____	_____	_____	_____	_____
<b>d. Deliveries</b>						
(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	_____ Day Care	_____ Lifeline
_____ Ambulance Service	_____ Dental Services	_____ Mobile Unit (blood-mobiles, mammography, CAT scan units, etc.)
_____ Base Hospital	_____ Emergency Room	_____ Nursery
_____ Blood Bank	_____ Managed Care Services	_____ Neonatal
_____ Burn Units	_____ Home Health Care	_____ Off-Premises Food Services
_____ Cardiac Catheterization Centers	_____ Hospice	_____ Off-Premises Labs
_____ Coronary Care Unit	_____ Hospital Foundation	_____ Pharmacy
_____ Dialysis	_____ Inhalation or Respiratory Therapy	_____ Transportation Services (other than ambulance)
_____ Ob/Gyn	_____ Intensive Care Unit	
_____ Oncology	_____ Organ Bank	
_____ Cardiovascular Surgery	_____ Organ Transplants	
_____ Off-Premises Clinics	_____ Outpatient	
	_____ Surgicenters	

\_\_\_\_\_ 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.





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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Claims-Made <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-paid Claims-Made <input type="checkbox"/> Yes <input type="checkbox"/> No	Includes General Liability <input type="checkbox"/> Yes <input type="checkbox"/> 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
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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.



**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 <i>(Chairman and/or President)</i>	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 <i>(Insurance Agent)</i> Please print and sign name  _____		
INSURANCE AGENCY		
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.	
ADDRESS <i>(No., Street, City, State, and ZIP)</i>		
EMAIL ADDRESS		
SUBMITTED BY <i>(Insurance Agency)</i>	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS <i>(No., Street, City, State, and ZIP)</i>		