EMPRO INSURANCE

Healthcare Entity
Application

PART I - PRODUCER INFORMATION

Agency Name		Address	Telephone
Agency License Number	State	Federal Tax ID	Email Address

PART II - APPLICANT INFORMATION

Name of Facility	Name of Facility D/B/A
Contact Person	Telephone
Fax	Business Address
Mailing Address	Billing Address, if different
Email Address	Website
Risk Management Contact Person	Telephone

PART III - COVERAGE INFORMATION

Coverage Effective Date

From: _____

To: _____

Coverage Type

☐ Occurrence
☐ Claims Made *For claims made, enter retroactive date desired* _____

Most Recent Carrier

The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, please complete and submit **APP 015, Prior Acts Professional Liability Addendum** and **APP 028, Notice to New Applicants**

PART IV - LIMITS OF LIABILITY
(Indicate Limits Desired)

Professional Liability

$ _____ Each Claim $ _____ Annual Aggregate

Deductible/Annual Aggregate (*select one*)

☐ 100K/300K ☐ 250K/750K ☐ no annual aggregate ☐ no deductible

☐ Other _____ (note: 100K/300K is the minimum, except in New Jersey)

Self-Insured Retention

☐ Yes ☐ No

Is there a self-insured retention program?
To what line of coverage will a self-insured apply? _____

$ _____ Each Claim $ _____ Aggregate

What organization handles the claims? _____

What legal firm is responsible for defending claims against the insured? _____

Commercial General Liability

☐ Yes ☐ No

Do you wish to purchase Commercial General Liability coverage?

If yes, please complete and submit **APP 007, Commercial General Liability Application**

PART V - FACILITY INFORMATION

Type of Facility

☐ Hospital-General ☐ Clinic-MD Owned ☐ Laboratory ☐ Other _____
☐ Hospital-Children ☐ Community Health Center ☐ Surgical Center ☐

☐ Hospital-Specialized (*please indicate which below*)
☐ Psychiatric ☐ Teaching ☐ Detox ☐ Geriatric ☐ Rehabilitation ☐ Women's ☐ Other _____

Services

Does the facility own, operate or anticipate acquiring any of the following?

☐ Abortion Clinic ☐ Dietary ☐ Obstetrical ☐ Robotic Surgery
☐ Ambulance ☐ Emergency Center, Freestanding ☐ Open Heart ☐ Self-Care/Wellness
☐ Blood Bank ☐ Gift Shop ☐ Pathology ☐ Shock Trauma
☐ Burn Unit ☐ Heliport # of landings _____ ☐ Pharmacy ☐ Substance Abuse Center, Freestanding
☐ Coronary Rescue ☐ Inhalation Therapy ☐ Physical Fitness Center
☐ Day Care ☐ Morgue ☐ Radiation Therapy ☐ Surgical Center
☐ Dialysis ☐ Nursery ☐ Radiology

Which of the following are performed at your facility?

☐ Experimental surgery ☐ Neurosurgery ☐ Open-heart surgery ☐ Weight reduction surgery ☐ Bariatric Surgery

Will any new services be provided in the next 12 months? ☐ Yes ☐ No

Will any services be discontinued in the next 12 months? ☐ Yes ☐ No

Have any services been discontinued in the last 24 months? ☐ Yes ☐ No

If yes to any of the above, provide details _____

Operations/Ownership

☐ Individually Owned ☐ Partnership ☐ Corporate ☐ Municipal ☐ Non-Profit ☐ For Profit ☐ Other _____

Do you have any revenue affiliations (e.g., Joint ventures, PPSs, HMOs, etc.)?
If yes, please provide details:

Name of Entity	**Relationship** (e.g., Joint Venture, Owner, etc.)

Affiliations/Accreditations

☐ JCAHO Accredited Date _____ ☐ Medicare Approved ☐ Member AHA
☐ AAAHC Accredited Date _____
☐ AAASF Accredited Date _____

Please list any medical school affiliations or allied healthcare school affiliations below: _____

_____

Type of Patients (Indicate % of each)

_____ Medical _____ Substance Abuse _____ Surgical _____ Psychiatric
_____ Obstetrical _____ Rehabilitation _____ Long Term _____ Other

Owned Nursing Homes

Do you own a Nursing Home? ☐ Yes ☐ No

Please indicate distance between main hospital facility and nursing home. _____

If coverage is desired, please complete **APP 013, Long-Term Care Facility Professional Liability Application**, and indicate services provided.

Explain any telemedicine activities in which your entity takes part.

_____

_____

PART V - FACILITY INFORMATION (continued)

Clinical Research

Describe the aims and specific objectives of any human clinical trials to be performed and by whom.

_____

_____

_____

Is this research clinical or academic in nature? ☐ Clinical ☐ Academic

What are the risks and potential benefits of the research to the subjects?

_____

_____

_____

What primary coverage is in place for clinical research exposure?

_____

Please provide a copy of the following:

☐ Study protocols ☐ Conflict of interest policy ☐ Patient selection criteria

☐ Informed consent policy ☐ Institutional Review Board Rules and Regulations as they relate to your entity

PART VI - HISTORICAL FACILITY INFORMATION

Beds

For each category below please indicate the **number of available beds** and **number of patient days.**

Facility		**Current Facility Year** Year	**Prior Facility Year** Year	**2 Years Ago** Year	**3 Years Ago** Year	**4 Years Ago** Year	**5 Years Ago** Year
Acute Care	Beds						
	Days						
Bassinets/Cribs	Beds						
	Days						
Clinic	Beds						
	Days						
Extended Care	Beds						
	Days						
ICU/CCU	Beds						
	Days						
Maternity	Beds						
	Days						
Neonatal	Beds						
	Days						
Psychiatric	Beds						
	Days						
Rehabilitation	Beds						
	Days						
Substance Abuse	Beds						
	Days						
TCU	Beds						
	Days						

PART VI - HISTORICAL FACILITY INFORMATION (continued)

Utilization

	Current Facility Year	Prior Facility Year	2 Years Ago	3 Years Ago	4 Years Ago	5 Years Ago
	Year	Year	Year	Year	Year	Year
Outpatient Threshold Visits						
Acute Care						
Clinic						
Community Health Center						
Emergency Room						
Home Health Care						
Psychiatric						
Rehabilitation						
Substance Abuse						
Physician Visits						
Other						
TOTAL						

For utilization purposes, please include procedures such as endoscopies and colonoscopies under the appropriate outpatient visits classification, not under surgery.

Inpatient Surgery						
Via Local Anesthesia						
Via IV Sedation						
Via Regional Sedation						
Via General Anesthesia						
TOTAL						
Outpatient Surgery						
Via Local Anesthesia						
Via IV Sedation						
Via Regional Sedation						
Via General Anesthesia						
TOTAL						
Deliveries						
Via Cesarean Section						
Via VBAC						
Vaginal (excluding VBACs)						
TOTAL						
Total Operating Rooms						
Total 3rd Party Lab Receipts						

Third party lab receipts are lab receipts provided on behalf of unaffiliated individuals/entities.

PART VI - HISTORICAL FACILITY INFORMATION (continued)

Utilization

	Current Facility Year	Prior Facility Year	2 Years Ago	3 Years Ago	4 Years Ago	5 Years Ago
	Year	Year	Year	Year	Year	Year
Per 100 Home Visits						
Home Hospice Care						
Home Health Aid						
Medical Social Work						
Nutrition						
Occupational Therapy						
Speech Therapy						
Maternal and Child Health						
Mental Health Services						
Nursing (LPN, RN, LVN)						
Pediatric Care						
Physical Therapy						
Nurse Practitioner						
Skilled Therapy NOC						
Intravenous Therapy						
Respiratory Therapy						
Homemaker-No Direct Care						
TOTAL						
Per 100 Prescriptions						
Pharmacy						

PART VII - STAFF

Employees: Non-Physician, Non-Dentist (Indicate the number of the following types of employees in your facility)

_____ Lab Technicians _____ Perfusionists _____ Registered Nurses _____ Pharmacists _____ CRNAs

_____ Paramedics/EMTs _____ X-ray Technicians _____ Volunteer Workers _____ Heart-Lung Technicians _____ LPNs

_____ Nurse Practitioners _____ Physician Assistants _____ Students _____ Traveling Nurses

Do you wish to include the individuals listed above as additional insureds sharing in the facility's limit? ☐ Yes ☐ No

Contracted Physicians/Services

Are your physicians/dentists or any other services contracted? ☐ Yes ☐ No

If contracted, name of group/physician(s) _____

How often does the staff work at the entity? _____

Is the staff obligated to follow entity rules and procedures? ☐ Yes ☐ No

Does the staff have the right to refuse patients? ☐ Yes ☐ No

Employed Physicians/Dentists

Indicate the number of employed physicians/dentists in your facility:

Surgeons _____ Physicians _____ Dentists _____ Interns/Externs _____ Residents/Fellows_____

Is coverage to be provided to the individuals listed? ☐ Yes ☐ No

If yes, please complete and submit **APP 001, Physicians and Surgeons Professional Liability Application.**

Do the individuals share the limits? ☐ Yes ☐ No

Do excess limits apply? ☐ Yes ☐ No

PART VII - STAFF (continued)

Professional Liability Requirements for Physicians/Dentists

Do the medical staff by-laws require each employed or contracted physician or dentist to maintain Professional Liability insurance? ☐ Yes ☐ No

If yes, what are the minimum limits of liability required? _____

How many physicians are credentialed and on staff?_____

How is coverage verified (e.g., Certificate of Insurance required?) _____

Please describe the monitoring system to ensure malpractice policies of physicians are kept current. _____

Has the license of any physician been restricted or suspended in the last two years? ☐ Yes ☐ No

If yes, was the employee employed or contracted? ☐ employed ☐ contracted Name: _____

Have the privileges of any physician been restricted or suspended in the last year? ☐ Yes ☐ No

If yes, was the employee employed or contracted? ☐ employed ☐ contracted Name: _____

Risk Management

Is there a designated Risk Manager? ☐ Yes ☐ No

If yes, please provide a copy of the Risk Manager's C.V. and answer the following:

Does the Risk Manager have support from the board of directors? ☐ Yes ☐ No

Does the Risk Manager have the authority to implement change? ☐ Yes ☐ No

Does the entity have a written Risk Management Program? ☐ Yes ☐ No

If yes, please provide.

PART VIII - SPECIFIC DEPARTMENTS

Anesthesia ☐ Contracted ☐ Employed

If contracted, name of group/physician(s) _____

Are CRNAs always supervised by an anesthesiologist? ☐ Yes ☐ No _____ Number of Anesthesiologists

Are Family Practitioners administering anesthesia? ☐ Yes ☐ No _____ Number of CRNAs

If yes, indicate the number administering anesthesia _____

Emergency ☐ Contracted ☐ Employed

If contracted, name of group/physician(s) _____

If your facility does not operate an Emergency Room, check here: ☐

If there is no Emergency Department, how does the facility arrange for treatment of trauma patients? _____

_____

If there is a JCAHO accredited Emergency Department, select the level of service provided:

- ☐ Level I (Tertiary)
- ☐ Level II (Comprehensive)
- ☐ Level III (Basic)
- ☐ N/A
- ☐ Other _____

If the Emergency Department is not JCAHO accredited, what is the designated level of service provided? _____

_____

Does the ER have a trauma center designation? (If yes, attach protocol) ☐ Yes ☐ No

Does the ER have a fast track service? ☐ Yes ☐ No

(If yes, who provides care? _____)

Does the Emergency Department have 24 hour in-house physician coverage? ☐ Yes ☐ No

PART VIII - SPECIFIC DEPARTMENTS (continued)

Obstetrics ☐ Contracted ☐ Employed

If contracted, name of group/physician(s) _____

Total number of OB on staff? _____

Level of OB Unit:

☐ **Level I** is usually categorized as a basic or well-newborn unit. It provides care for low-risk infants born in the hospital and for stable, growing, or recovering infants who are returned to their birth hospital from a Level II or Level III facility. The service must have a professional staff member skilled in neonatal resuscitation on site, and a pediatrician on call 24 hours a day.

☐ **Level II** is usually categorized as a specialty unit. It provides all Level I services and offers specialized services to moderately ill infants either born in the hospital or transferred from Level I facilities. They must provide certain medical specialty and support services including on site, 24 hour coverage by a pediatrician, and specially trained laboratory and radiology staff.

☐ **Level III** is usually categorized as a Perinatal Center and/or Neonatal Intensive Care Unit. It provides services to newborns of all risk levels, including babies with unusual or severe complications and anomalies, in addition to Level I and II services. They offer a comprehensive range of specialty and subspecialty services to maternal and newborn patients at the center, and to others referred to it from Level I or II facilities.

Do family/general practice physicians have OB privileges? ☐ Yes ☐ No

If yes, how many? _____

What is the number of deliveries per individual practitioner? _____

Do midwives practice in labor and delivery? ☐ Yes ☐ No

If yes, are there written protocols for privileges? ☐ Yes ☐ No

Do you follow ACOG guidelines concerning VBACs? ☐ Yes ☐ No

Who provides anesthesia during labor and delivery? _____

PART IX - PREVIOUS INSURANCE CARRIERS

PROFESSIONAL LIABILITY	YEARS:	YEARS:	YEARS:	YEARS:	YEARS:
CARRIER					
POLICY NUMBER					
POLICY TYPE (select a choice)	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE
LIMITS					
RETRO DATE					
PREMIUM PAID					

Has any insurance company ever:

a) declined ? ☐ Yes ☐ No

b) failed to renew ? ☐ Yes ☐ No

c) conditionally renewed ? ☐ Yes ☐ No

d) cancelled your policy ? ☐ Yes ☐ No

If yes to any of the above, please indicate the name of the company, date and brief explanation below.

Name _____ Date _____

Explanation _____

_____

_____

If necessary, attach information for additional companies.

PART IX - PREVIOUS INSURANCE CARRIERS (continued)

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION FOR ALL FACILITIES:

- ❑ Financial statements for the last two years
- ❑ Copy of brochures and marketing information
- ❑ Copy of contract for contracted physicians/dentists
- ❑ Written procedures for claims handling and risk management
- ❑ Most recent JCAHO survey and the status of any Requirements for Improvements
- ❑ If not insured with EmPRO, a complete copy of current policy and endorsements
- ❑ Copy of AAASF or AAAHC accreditation report
- ❑ Copies of hold harmless agreements
- ❑ Minimum of 10 years loss history
- ❑ Copy of AHA Annual Survey
- ❑ Medical staff by-laws
- ❑ Organizational chart
- ❑ Copy of license
- ❑ Schedule of Named Insureds with relationship to applicant
- ❑ Most recent Medicare recertification survey, statement of deficiencies and plan of correction

Self-insured Retention (SIR) Programs Only

Please include these additional documents if applicable:

- ❑ Copy of trust agreement
- ❑ Copy of SIR coverage wording
- ❑ Financial statement of trust fund
- ❑ Most recent actuarial review supporting the funding of the self-insured retention

Additional Comments: _____

_____

_____

PART X - OPTIONAL COVERAGES

For New Jersey Applicants Only - Consent to Settle

This endorsement is automatically attached to all healthcare facility policies. It requires the Company to obtain your written consent before settling any claims brought against you. In accordance with New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for a 1% premium credit to your policy.

Would you like to remove this endorsement? ☐ Yes ☐ No

Read Carefully Before Signing

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

Representations as to accuracy of application, the authority of person signing, and applicant's obligation to supplement information

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.*

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.*

No obligation to issue or purchase insurance

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

Authorization to obtain information

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

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

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 WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATED AGENCIES.

DISTRICT OF COLUMBIA 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.

MAINE APPLICANTS: THE COMPANY WILL NOT RESCIND OR VOID ANY POLICY ISSUED IN MAINE DUE TO FRAUD OR A MISREPRESENTATION WITHOUT FIRST OBTAINING A COURT RULING THAT VOIDANCE OR RESCISSION OF THE POLICY IS PERMITTED. HOWEVER, IN THE EVENT OF A MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT IN THIS APPLICATION OR INFORMATION PROVIDED TO US TO OBTAIN INSURANCE, THE COMPANY MAY CANCEL THE POLICY AND/OR DENY COVERAGE FOR ANY CLAIM IF SUCH MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT WAS FRAUDULENT OR MATERIAL.IN ACCORDANCE WITH 24-A M.R.S.A. 2186(3), 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 DENIAL OF INSURANCE BENEFITS.

MARYLAND APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN MARYLAND. HOWEVER, COVERAGE WILL NOT BE PROVIDED IF WE DISCOVER CONCEALMENT, MISREPRESENTATION, OR FRAUD. ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO 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.

NEW HAMPSHIRE APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY OR DENY COVERAGE TO ANY INSURED(S) IN NEW HAMPSHIRE IF THE INSURED(S) HAD NO KNOWLEDGE OF CONCEALMENT, MISREPRESENTATION OR FRAUD. HOWEVER, THE COMPANY WILL NOT COVER ANY CLAIMS AGAINST ONE OR MORE INSUREDS WHO HAS INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS INSURANCE.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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.

OREGON 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 MAY HAVE COMMITED A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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.

VIRGINIA APPLICANTS: IN ACCORDANCE WITH VIRGINIA CODE 52-40, 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 DENIAL OF INSURANCE BENEFITS.

WASHINGTON APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN WASHINGTON UNLESS THE INSURED(S) OR SOMEONE ACTING ON BEHALF OF THE INSURED(S) INTENTIONALLY CONCEALS OR MISREPRESENTS A MATERIAL FACT OR CIRCUMSTANCE RELATING TO THIS INSURANCE. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

ALABAMA, ALASKA, ARIZONA, ARKANSAS, DELAWARE, FLORIDA, IDAHO, INDIANA, KENTUCKY, LOUISIANA, MINNESOTA, NEW MEXICO, NEW YORK, OHIO, RHODE ISLAND, TENNESSEE, TEXAS, WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS MATERIALLY FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

Applicant *(print name of entity)*

Title

By *(signature of duly authorized officer or employee)*

Date

Printed Name of Applicant

Signature of Producer *(signature is required for N.H. producers only)*

Date

Printed Name of Producer