



- ACE American Insurance Company
- Illinois Union Insurance Company
- Westchester Surplus Lines Insurance Company

# Long Term Care Professional and General Liability Policy Application

Along with this completed and signed application, prospective insureds must also submit the following information:

1. Past five (5) year loss run currently valued within the last three (3) months. Please provide detailed information on all claims with a \$25k incurred loss or greater.
2. Copy of the most current audited financial statement
3. Copy of current State License
4. Copies of most recent State Inspection Reports including any complaint investigations. Include all statements of deficiencies and plans of correction.
5. Updated Form CMA 671 Facility Staffing and 672 Resident Census (SNF/ICF only) for each facility
6. Resumes and Job Descriptions of the Administrator and Director of Nursing
7. Current Quality Indicator Profile for the past 3 months
8. Skin Care Policy and Procedure
9. Resident Admission Agreement
10. Elopement Policy and Procedure
11. Description of Fall Prevention Program
12. Restraint Protocols
13. Abuse & Prevention Policy and Procedure
14. Medication Administration Policy
15. Names and locations of all entities to be covered under this policy (Attachment #1)
16. Diagram/Map of the facility
17. Marketing brochures and advertising materials

The requested information is necessary before a quotation can be obtained.



13. Is your organization planning to acquire or open any new locations in the next year?  Yes  No  
 If yes, please provide details (location and # of licensed beds):

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**B. Prior Insurance History**

**Primary Coverage**

Policy Period	Carrier	PL/GL Limits	Deductible/SIR	CM/OCC	Retro Date	Premium

**Excess/Umbrella Coverage**

Policy Period	Carrier	PL/GL Limits	Deductible/SIR	CM/OCC	Retro Date	Premium

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you?  Yes  No

If yes, please provide detailed descriptions on all claims with a \$25k incurred loss or greater on a separate sheet of paper.

2. In the last three (5) years, has any malpractice insurance carrier denied, restricted, limited or terminated coverage?  Yes  No

If yes, please explain:

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3. Has the applicant facility, or any other person for whom insurance is being requested, aware of any fact(s), incidents(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you?  Yes  No

If yes, please provide detail:

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4. Has the applicant facility experienced any allegations or substantiated incidents of physical or sexual abuse (resident upon resident, staff upon resident, visitor upon resident) in the past three (3) years?  Yes  No

If yes, please provide detail:

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**C. Licensing/Certification**

1. Has your state license for any locations been revoked, suspended or limited within the last three (3) years?  Yes  No

If yes, please explain:

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2. Has your Medicare or Medicaid certification for any location been limited, suspended or revoked, for any reason, within the last three (3) years?  Yes  No

If yes, please explain:

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3. Has your facility been placed under Immediate Jeopardy during the past three (3) years?  Yes  No

If yes, please explain:

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4. Date of last State Inspection/Survey: \_\_\_\_\_

Total Number of Deficiencies:	
Number of D, E & F Deficiencies:	
Number of G, H & I Deficiencies:	
Number of J, K, L Deficiencies:	

Corrective action plan accepted by the State?

Yes  No Date Accepted: \_\_\_\_\_  
 Not Applicable, no deficiencies

5. Number of complaints investigated by State in the past three (3) years: \_\_\_\_\_

Number of substantiated complaints in the past three (3) years: \_\_\_\_\_

**D. Classification**

**Percent of residents**

1. By age range: < 30 \_\_\_\_ 30-64 \_\_\_\_ 65-74 \_\_\_\_ 75-84 \_\_\_\_ 85-94 \_\_\_\_ >95 \_\_\_\_

If there are residents below age 64, please explain:

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2. Please state percentage of payment/reimbursement in each category:

Medicare: \_\_\_\_ Medicaid: \_\_\_\_ Private Pay: \_\_\_\_

<b>Sub-Acute:</b> Ventilator care, post-operative/trauma recovery, wound management, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total prenaternal nutrition (TPN), blood plasma transfusion, central line care, tracheostomy, dialysis.			
<input type="checkbox"/> For-Profit	<input type="checkbox"/> Non-Profit	Total Licensed Beds: ____	Average Occupied Beds: ____
<b>Skilled Nursing:</b> Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's patients.			
<input type="checkbox"/> For-Profit	<input type="checkbox"/> Non-Profit	Total Licensed Beds: ____	Average Occupied Beds: ____
<b>Intermediate Care:</b> Administration of oral medications, assistance with activities of daily living, preventive turning/positioning, restorative rehabilitation.			
<input type="checkbox"/> For-Profit	<input type="checkbox"/> Non-Profit	Total Licensed Beds: ____	Average Occupied Beds: ____
<b>Assisted Living:</b> Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to take care of themselves. Provides protective environment, meals, assistance with medications, group socials, spiritual activities, etc.			
<input type="checkbox"/> For-Profit	<input type="checkbox"/> Non-Profit	Total Licensed Beds: ____	Average Occupied Beds: ____
<b>Personal Care:</b> Security, transportation, nutritional meals, recreation, self administration/assistance with medications, guidance with activities of daily living (bathing, dressing, eating, walking). Residents normally not safe to stay by themselves.			
<input type="checkbox"/> For-Profit	<input type="checkbox"/> Non-Profit	Total Licensed Beds: ____	Average Occupied Beds: ____
<b>Independent Care:</b> Residents of retirement age, total self care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full-time caretaker on premises.			
<input type="checkbox"/> For-Profit	<input type="checkbox"/> Non-Profit	Total Units: ____	Total Residents at Full Occupancy: ____
Are there Common Dining Facilities?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do individual units have cooking appliances (excluding microwaves)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Please check type:		<input type="checkbox"/> Gas	<input type="checkbox"/> Electric
Are residents checked every day?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain procedure: _____			
_____			
Are Residents allowed to have Home Health Care Aides?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, do you require them to maintain separate professional liability insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are the Aides contracted independently?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Through Facility?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

**E. Administrator**

- 1. Name: \_\_\_\_\_ License Number: \_\_\_\_\_ State: \_\_\_\_\_
- 2. Length of time at this facility: \_\_\_\_\_ Number of years as a NHA: \_\_\_\_\_

**F. Nurse Staffing**

- 1. Name of Director of Nursing: \_\_\_\_\_ Professional Credentials:  RN  LPN
- 2. Length of time at this facility: \_\_\_\_\_ Length of time as DON: \_\_\_\_\_
- 3. Total # of Nurse Employees: \_\_\_\_\_

	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>d</sup> Shift	Turnover %
RN				
LPN/LVN				
CNA/Personal Caregiver				
Agency Staff				

- 4. Does the facility utilize agency staff?  Yes  No  
If yes, what percentage is agency staff: \_\_\_\_\_
- 5. Do you verify nursing license upon hire and annually thereafter?  Yes  No
- 6. Do you obtain and review nurses' certificates of malpractice insurance?  Yes  No
- 7. Do you verify nursing assistant certification upon hire and annually thereafter?  Yes  No

**G. Medical Director**

- 1. Name of Medical Director: \_\_\_\_\_ License Number/State: \_\_\_\_\_
- 2. Length of time at this facility: \_\_\_\_\_ Medical Specialty: \_\_\_\_\_
- 3. Is the Medical Director:
  - Full Time at this facility  Part Time at this facility
  - Employed  Contracted (If contracted, please provide a copy of the contract)
- 4. How many hours does the Medical Director spend onsite per month? \_\_\_\_\_
- 5. How many residents utilize the Medical Director as their attending physician? \_\_\_\_\_
- 6. Do you require the Medical Director to maintain separate medical malpractice liability for their non-administrative duties?  Yes  No
- 7. Is there an evaluation of the Medical Director's performance?  Yes  No  
If yes, by whom? \_\_\_\_\_
- 8. Is a Physician on site or on call on a 24 hour basis?  Yes  No

**H. Medical Staff**

- 1. Number Physicians Employed On Staff: \_\_\_\_\_ Affiliated: \_\_\_\_\_ Contracted: \_\_\_\_\_
- 2. Do you obtain and review physicians' certificates of malpractice insurance?  Yes  No
- 3. What limits do you require physicians to maintain? \_\_\_\_\_
- 4. Do you have a formal Medical Staff Credentialing Program?  Yes  No

5. Do credentialing activities include:
- Criminal background checks
  - Verification of current professional license
  - DEA Certificate
  - Past malpractice history

**I. Human Resources/Employee Screening**

1. Does the employee screening/hiring process include verification of the following:
- Educational Background
  - Work History with at least two previous employers  In Writing  By Telephone
  - Personal references  In Writing  By Telephone
  - Criminal Background
  - Drug Testing
  - Abuse Registry
  - Driving Record (MVR, when appropriate)
  - Any pending license suspensions, revocations, or pending disciplinary actions
2. Are background checks conducted on Agency staff?  Yes  No
3. Are employee competencies assessed and documented?  Yes  No
4. Do you conduct an orientation and regularly scheduled in-servicing for all staff/employees including agency staff?  Yes  No
5. Are volunteers utilized?  Yes  No

If yes, please describe selection process and training process: \_\_\_\_\_  
 \_\_\_\_\_

**J. Risk Management**

1. Who is the individual responsible for risk management (Name/Title)? \_\_\_\_\_  
 Contact Number: \_\_\_\_\_ Contact Email: \_\_\_\_\_  
 Length of time at this facility: \_\_\_\_\_
2. What other responsibilities do they have?  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Does the risk management program include the following:
- Incident Reporting Process
  - Claims Management
  - Resident Complaints and Grievances Process and Procedures
  - Contract Review and Evaluation
4. Are incidents trended and presented to the Executive Committee and Board of Directors?  Yes  No
5. How many formal complaints have been reported by families, residents or advocates in the last 6 months? \_\_\_\_\_
6. Is there a formal safety program?  Yes  No

## K. Policy and Procedures

### Elopement

1. How and when are residents assessed for the potential to wander or elope? \_\_\_\_\_  
\_\_\_\_\_
2. What is the number of elopements in the past 12 months? \_\_\_\_\_
3. What is the number of elopements in the past 12 months that resulted in injury to resident? \_\_\_\_\_
4. What is the number of elopements in the past 12 months that resulted in death of resident? \_\_\_\_\_
5. Are Wander Guards or similar devices used as part of elopement prevention practices?  Yes  No  
If yes, provide type: \_\_\_\_\_
6. Are Wander devices for residents inspected according to manufacturer's specifications?  Yes  No
7. Are buildings inspected and maintained under life safety codes?  Yes  No
8. What security measures are used to control unauthorized entrance/exits from facility? \_\_\_\_\_  
\_\_\_\_\_

### Fall Prevention

1. Do you have a Fall Prevention Program?  Yes  No
2. Are Nursing Assessment Protocols in place to identify residents at risk for falls?  Yes  No
3. Are falls monitored and tracked to identify patterns or problems?  Yes  No
4. Are handrails provided in halls and bathrooms?  Yes  No
5. Are call buttons operational in each room and bathroom?  Yes  No
6. Are residents accounted for at least once every 24 hours?  Yes  No
7. What is the current number of residents with the following:  
Lap Buddies/Seat Belts or Waist Belts: \_\_\_\_\_  
Geri Chairs: \_\_\_\_\_  
Chest/Vest Restraints: \_\_\_\_\_  
Bed Rails (any): \_\_\_\_\_

### Abuse

1. Are policies in place for the immediate suspension/termination of staff suspected or involved in Resident Abuse?  Yes  No
2. Does facility have a written procedure for reporting Resident Abuse?  Yes  No  
Who is responsible for the investigation? \_\_\_\_\_
3. Do you provide abuse training beyond the mandatory requirements?  Yes  No
4. Number of alleged abuse incidents investigated and/or reported in the 12 months year: \_\_\_\_\_

### Skin Care and Pressure Ulcer Prevention

1. Are there written policy and procedures for the prevention and treatment of skin breakdown?  Yes  No
2. Are all residents evaluated for skin breakdown and risk of breakdown at the time of admission?  Yes  No
3. How often does the nursing staff perform total body skin care assessments? \_\_\_\_\_
4. Do you have a wound care team or designated individual responsible for this program?  Yes  No



5. What is your current resident population with facility acquired Stage III or IV Pressure Ulcers?

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**Additional Services**

1. Do you have a specialized Alzheimer's Unit within the facility?  Yes  No  
If yes, is this a locked unit?  Yes  No  
If yes, please provide number of residents and capacity: \_\_\_\_\_
2. Do you have an in-house pharmacy?  Yes  No  
Who dispenses medications? \_\_\_\_\_
3. Are monthly reviews of drug regimens performed?  Yes  No  
By Whom? \_\_\_\_\_
4. Is there a system in place to identify, track and trend medication errors?  Yes  No

**L. Independent Contractors and Services**

Below please address:

1. Which of the following medical services are performed at your facility?
2. Indicate Yes or No if the services provided are on a contractual basis?
3. If yes, indicate the required limits of liability contractors are mandated to cover:

Services Provided		Contracted or Non Contracted Service	Limits of Liability
Physicians	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pharmaceutical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychologists	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Podiatrists	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chiropractors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dietary	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recreational Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Barber/Beautician	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Day Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Have Certificates of Insurance been obtained from Independent Contractors?  Yes  No  
 Are these reviewed annually?  Yes  No

**M. Non-Resident Services**

Please indicate the annual number of visits or clients for the following.

**Home Health Care:**  Yes  No # of Home Health Care Calls per year: \_\_\_\_\_

Home Health Care provided by Independent Contractors:  Yes  No

Describe Home Health Care Services Offered: \_\_\_\_\_

\_\_\_\_\_

**Day Care** (total licensed # ): \_\_\_\_\_ # of employees' children: \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

Licensed Day Care Center:  Yes  No Open to the Public:  Yes  No

**Adult Day Care** (total licensed # ): \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

Do you provide transportation to and from your facility(ies):  Yes  No

**Respite Care:**  Yes  No If Yes, # annual visits: \_\_\_\_\_

**Hospice Care:**  Yes  No If Yes, # annual visits: \_\_\_\_\_

**Do you provide the following services:**

			# of Residents			# of Residents
AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Alcohol Abuse Rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Alzheimer's/Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Behavioral Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Developmentally Disabled	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Drug Rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hospice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	IV Infusion Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Ventilation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**N. Other Exposures**

**Recreational Activities:** Please check all that apply:

- Swimming Pool, if checked:
  - Open to the Public  Locked when not in use  Fenced
  - Have a F/T Life Guard on Duty  Have a Diving Board/Sliding Board
  
  - Saunas/Hot Tubs
  - Exercise Weight Room
  - Tennis/Racquetball/Handball Courts
  - Other bodies of water – If yes, please describe:  None
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**Safety and Security**

1. Is the applicant:  Building Owner  Tenant  General Lessee
  - a) Type of Construction: \_\_\_\_\_ Number of Floors: \_\_\_\_\_ Number of Elevators: \_\_\_\_\_
  - b) Was the building designed and constructed for elder care occupancy?  Yes  No  
If No, please explain: \_\_\_\_\_
  
2. Are smoke detectors hard wired to central station?  Yes  No
  
3. Do alarms ring into central security desk or nurses station?  Yes  No

4. Are all alarm signals monitored by a UL approved Central Station or the responding Fire Department:  Yes  No
5. How many exits (other than front doorway) are there? \_\_\_\_\_  
Are these equipped with panic alarms?  Yes  No
6. Total # of fire extinguishers: \_\_\_\_\_
7. Has the fire department pre-planned emergency procedures at this location?  Yes  No  
If Yes, describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Are fire drills conducted regularly?  Yes  No  
How Often? \_\_\_\_\_ Date of Last Drill? \_\_\_\_\_
9. If multi-story building, are non-ambulatory residents on lower floors (1st/2nd)?  Yes  No
10. Is facility protected (100%) throughout by an automatic sprinkler system and are these systems tested by a qualified contractor with results documented?  Yes  No  
If not 100%, please specify which areas are not protected:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
If not tested, please explain why:  
\_\_\_\_\_  
\_\_\_\_\_
11. Is electronic surveillance used?  Yes  No  
If Yes, How long do you maintain the film?  
\_\_\_\_\_  
\_\_\_\_\_
12. When was the last time the written emergency management plan was reviewed? \_\_\_\_\_  
Does it address natural disasters such as fire, earthquakes, hurricanes, tornadoes, and floods?  Yes  No

## FRAUD WARNING STATEMENTS

**NOTICE TO ARKANSAS APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO COLORADO APPLICANTS:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete 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 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.

**NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO MAINE APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO 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 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 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 OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he 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.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**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.

**NOTICE TO RHODE ISLAND APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO TENNESSEE 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 include imprisonment, fines and denial of insurance benefits.

**NOTICE TO 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 include imprisonment, fines and denial of insurance benefits.

**NOTICE TO WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**NOTICE TO WEST VIRGINIA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO ALL OTHER APPLICANTS:**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**DECLARATION AND CERTIFICATION**

**BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE.**

**THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.**

**COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED**

**FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.**

**THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Broker/Agent

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed by Licensed Resident Agent  
(Where Required By Law)