

Application for Managed Care Errors and Omissions Liability

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES.

PART I. GENERAL INFORMATION, OPERATIONS, AND STRUCTURE

1.
 - a) Name of Applicant: _____
(Note: Wherever used, 'Applicant' means this entity and any other entities listed in question 3.)
 - b) Address: _____
City: _____ State: _____ ZIP: _____
Website: _____ Telephone Number (____) _____
 - c) Contact person and title: _____
Email address: _____ Telephone Number (____) _____
 - d) Name of risk manager (if different than contact person): _____
Email address: _____

2. a) Applicant is:

| | |
|---|--|
| <input type="checkbox"/> For-Profit Corp. | <input type="checkbox"/> Not-for-Profit Tax-Exempt Corp. |
| <input type="checkbox"/> Not-for-Profit Taxable Corp. | <input type="checkbox"/> Limited Liability Company |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Joint Venture |
| <input type="checkbox"/> Other (describe): _____ | |

 b)

| | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> HMO | If so, please indicate: | <input type="checkbox"/> Staff Model | <input type="checkbox"/> Network or IPA Model | <input type="checkbox"/> Combined |
| <input type="checkbox"/> PPO | <input type="checkbox"/> PHO | <input type="checkbox"/> IPA | <input type="checkbox"/> MSO | <input type="checkbox"/> Medical Group or Clinic |
| <input type="checkbox"/> Third Party Administrator | <input type="checkbox"/> Peer Review Organization | <input type="checkbox"/> Utilization Review | | |
| Organization | | | | |
| <input type="checkbox"/> Other (describe): _____ | | | | |

 c) Does the Applicant have any exclusive agreements with providers? Yes No
 d) Date of incorporation: _____ Date operations began: _____
 e) State(s) where Applicant operates: _____

3. If coverage is desired for any other entities (e.g., subsidiaries, joint ventures, or partnerships), please list each such entity below. If required, list additional entities on a separate attachment. Please note that coverage for such entities is not automatically available; the terms and conditions of the policy, if issued, will determine actual coverage.

| Name and Address | Relationship to Applicant | Description of Operations | Tax Status | Percent Owned |
|------------------|---------------------------|---------------------------|------------|---------------|
| | | | | |
| | | | | |

4. a) Is the Applicant licensed by federal, state, or local government? Yes No
 If "Yes," identify the licensing government: _____

b) Is the Applicant accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? Yes No
 If "Yes," identify the accrediting or certifying organization(s): _____

c) Has the Applicant's license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? Yes No
 If "Yes," please explain: _____

5. **REVENUES:** Last 12 Months Next 12 months (est.)

a) Total Gross Revenues: _____
 If this revenue number does not match that in the attached audited financials, please explain why.

b) Percent of Gross Revenues from "at risk" agreements: _____
 (Note: Wherever used, "at risk" means capitation, withhold or bonus.)

6. **ENROLLMENT:**

Total number of enrollees: _____

(Note: Wherever used, "enrollees" means covered lives, not just covered employees and not member months.) If enrollees are in more than one state, provide breakdown by state on a separate attachment.

a) Number of enrollees in managed care plan(s): _____
 b) Number of enrollees in non-managed care plan(s): _____

7. **HEALTH CARE PROVIDER:**

a) Total number of physicians under contract: _____
 (1) Number of employed physicians: _____
 (2) Number of independent contractor physicians: _____

- b) Total number of non-physician health care professionals under contract: _____
- c) Total number of hospitals under contract: _____
- d) Total number of other facilities under contract (e.g., clinics, nursing homes, laboratories, pharmacies): _____
- e) Does Applicant require and verify that all contracted health care providers (physicians, hospitals, and others) maintain medical malpractice insurance? Yes No
If No, what are the minimum limits required? _____
- f) Provide details of the Applicant's compensation or participation arrangements with contracted health care providers or attach copies of sample contracts. _____
- g) Does Applicant have any provider agreements in which the Applicant assumes responsibility for overseeing the quality of the services provided by the health care providers? Yes No

8. Please provide details of insurance/self-insurance/reinsurance currently in force (if none, so state):

| Type of Coverage | Insurance Carrier(s) | Limits | Deductible/Retention | Premium | Policy Period | If Claims Made, Retroactive Date |
|---------------------|----------------------|--------|----------------------|---------|---------------|----------------------------------|
| Medical Malpractice | | | | | | |
| D&O | | | | | | |
| E&O | | | | | | |
| Stop Loss | | | | | | |
| Insolvency | | | | | | |
| Fidelity | | | | | | |
| Fiduciary | | | | | | |
| Other | | | | | | |

9. a) Stock ownership of the Applicant, if applicable:
Total number of authorized common shares: _____
Total number of outstanding common shares: _____
Does any person or entity own more than 5% of the Applicant's stock? Yes No
If yes, please provide the names and ownership percentage: _____
- b) Have there been any changes in the Applicant's board of directors or senior management within the past 5 years for reasons other than death or retirement? Yes No
If "Yes," please explain: _____
- c) Number of Applicant's: Full-time employees: _____
Part-time employees: _____

d) Has the Applicant been involved in within the past 36 months, or does the Applicant contemplate being involved in within the next 12 months, any of the following, whether or not such transactions were or will be completed? Yes No
(If "Yes," please describe the essential terms of each such transaction as an attachment to this Application.)

(1) Merger, acquisition, or consolidation with another entity? Yes No

(2) Sale, distribution, or divestiture of any assets or stock, other than in the ordinary course of business? Yes No

(3) Any registration for a public offering or private placement of securities? Yes No

(4) Any joint ventures? Yes No

(5) Any new business activities or services? Yes No

(6) Any new Medicare or Medicaid contracts? Yes No

If "Yes" to any of the above, please explain: _____

10. List the primary professional groups or associations to which the Applicant belongs: _____

11. ANTITRUST MARKET POSITION:

a) Does the Applicant contract with more than 25% of the physicians in any given field of practice (including without limitation primary care, family practice, or any specialty) within its geographical service area? Yes No
If "Yes," please explain: _____

b) Do the Applicant's members control more than 25% of the hospital beds or specialty services within its geographic service area? Yes No
If "Yes," please explain: _____

c) Does Applicant have exclusive contracts with any hospitals? Yes No

d) Has the Applicant obtained advice from antitrust legal counsel (particularly related to mergers, acquisitions and network development)? Yes No
If "Yes" please specify firm name _____

e) Has the Applicant received an opinion from the Federal Trade Commission (FTC) confirming that their activities (such as developing joint ventures or new plans) will not violate antitrust laws? Yes No

f) Does the Applicant have any provider agreements that contain "Most Favored" pricing clauses? Yes No

g) Does the Applicant have any provider agreements that contain non-compete clauses? Yes No

12. ACTIVITIES OR SERVICES:

Please indicate those managed care activities or services which the Applicant performs or subcontracts now or intends to begin performing or subcontracting within the next 12 months (Note: not all checked services may be covered):

| <u>Activity or Service</u> | <u>Yes</u> | <u>No</u> | <u>Yes, For Others For Fee</u> |
|---|--|--------------------------|--|
| a) Credentialing or peer review of health care providers | <input type="checkbox"/> (Complete Part II) | <input type="checkbox"/> | <input type="checkbox"/> (Complete Part II) |
| b) Utilization review | <input type="checkbox"/> (Complete Part III) | <input type="checkbox"/> | <input type="checkbox"/> (Complete Part III) |
| c) Handling and adjusting of claims for enrollee benefits | <input type="checkbox"/> (Complete Part IV) | <input type="checkbox"/> | <input type="checkbox"/> (Complete Part IV) |
| d) Advertising, marketing, or selling of health care plans/products | <input type="checkbox"/> (Complete Part V) | <input type="checkbox"/> | <input type="checkbox"/> (Complete Part V) |
| e) Drafting practice guidelines/ critical pathways | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Case Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Disease Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Enrollment processing for enrollees of health care plans | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Billing/other processing of enrollees' claims under health care plans | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Establishing health care provider networks to provide managed care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Actuarial services for health care plans | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Assisting customers in securing reinsurance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Third Party administration (TPA) services for health care plans | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please describe the services provided: _____ | | | |
| n) Services for automobile liability or disability plans (please describe): _____ | | | |
| o) Employee Assistance Program (EAP) services (please describe): _____ | | | |
| p) Nurse call line (please describe): _____ | | | |
| q) Any additional services provided: _____ | | | |

13. RISK MANAGEMENT:

- a) Does the Applicant have a formal risk management program (i.e, a formal overall approach to avoiding situations that might give rise to a claim)? Yes No
If "Yes," please explain: _____
- b) Does the Applicant have someone designated as a "legislative or executive" inquiry ombudsman (i.e., someone who investigates all problems or complaints once they rise to a certain level)? Yes No
- c) Does the Applicant have contracts with any employers or other member groups in which the Applicant assumes any of the employer's liability, fiduciary obligations or decision-making?

- c) Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials becomes final? Yes No
- d) Are all providers offered a hearing or appeal prior to termination? Yes No
If "No," please explain: _____
- e) What group has the final authority for credentialing or provider selection?
 Board of Directors or Trustees: Yes No
 Committees: Yes No
 Other: _____ Yes No

17. Does the Applicant query the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank or the Federal or State Medical Boards as part of the credentialing process? Yes No

18. How often does the Applicant re-credential contracted health care providers? _____

19. Does the Applicant perform on-site visits of contracted health care providers? Yes No
If "Yes," how often? _____

20. Does the Applicant restrict the practice of any health care provider who has a mental, physical disorder, or substance abuse problem which may impair his/her ability to practice? Yes No
If "Yes," please explain: _____

21. Have any providers been removed or disqualified from the Applicant's panel in the last 12 months? Yes No
If "Yes," a) How many for credentialing or professional conduct reasons? _____
 b) How many for reasons other than professional competence? _____
 c) Is complete documentation maintained on all terminations? Yes No

PART III. UTILIZATION REVIEW

22. a) Please specify number or percentage (%) of enrollees by type of payor (Note: Wherever used, "enrollees" means covered lives, not just covered employees and not member months). If utilization review services are performed for others for a fee, indicate amount or percentage (%) of revenue generated by type of payor.

| Type of Payor | % of Enrollees Last 12 Months | % of Enrollees Next 12 Months | % of Revenue Last 12 Months | % of Revenue Next 12 Months |
|---|-------------------------------|-------------------------------|-----------------------------|-----------------------------|
| Private (non-government) employer plans or trusts | | | | |
| Government employer plans | | | | |
| Union plans | | | | |
| Medicare or Medicaid plans | | | | |
| Other | | | | |

b) Total revenue for utilization review services performed for others for a fee:
 (1) Last 12 months: _____ (2) Next 12 months: _____

23. a) Who does utilization review?
 Applicant: Yes No
 Subcontractor: Yes No
 Other: _____ Yes No

b) Percentage of benefits denied/avoided in the utilization review process (e.g. denial rate): _____ %

- c) Number of full-time equivalent (FTE) reviewers: _____
 Number of part-time equivalent (PTE) reviewers: _____
- d) If utilization review is subcontracted:
- (1) Does the Applicant review or audit the process? Yes No
 - (2) Is the subcontractor required to maintain errors and omissions insurance? Yes No
 - (3) What minimum limits are required? _____
 - (4) Does the Applicant indemnify the subcontractor? Yes No
 - (5) Does the subcontractor indemnify the Applicant? Yes No
- e) Does the Applicant have written policies and procedures for utilization review, including for denials and appeals? Yes No
 If "Yes," do such policies and procedures follow NCQA or URAC standards and comply with all applicable laws? Yes No
- f) Does the Applicant use practice guidelines as part of its utilization review procedures? Yes No
 If "Yes," do guidelines state in writing that physician's judgment may override a guideline? Yes No
- g) Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals? Yes No
- h) Does a physician review all proposed denials of benefits prior to issuance of the denial? Yes No
- i) Are external reviewers involved in the final level of review before appeal? Yes No
- j) What percentage of decisions which go through the external review process are ultimately decided in favor of the enrollee? _____%
- k) Does the Applicant have a "fast track" appeal system regarding denial of benefits or postponement of benefit procedures for organ transplants or any other procedure which may severely impair the quality of life for an enrollee if not performed? Yes No
- l) Does the Applicant utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers? Yes No
- m) Does the Applicant adhere to government mandated external review requirements in the states where it operates? Yes No
- n) Does the Applicant have an external review process in those states where external review is not mandated? Yes No

24. Attach a sample copy of a utilization review denial letter (with the identity of the enrollee removed).

PART IV. HANDLING AND ADJUSTING OF ENROLLEES' HEALTH CARE BENEFIT CLAIMS

| | <u>Last 12 months</u> | <u>Next 12 months</u> |
|--|-----------------------|-----------------------|
| 25. Total revenue for claims handling and adjusting services performed for others for a fee: | _____ | _____ |
| 26. a) Number of claims processed: | _____ | _____ |
| b) Number of FTE claim adjusters: | _____ | _____ |
| c) Number or percentage of PTE claim adjusters: | _____ | _____ |
| d) Percentage of claims denied: _____% | | |

- e) Who does the handling and adjusting of claims for health care benefits?
- | | | |
|----------------|------------------------------|-----------------------------|
| Applicant: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Subcontractor: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- f) If claim handling and adjusting are subcontracted:
- (1) Does the Applicant review or audit the process? Yes No
- (2) Is the subcontractor required to maintain errors and omissions insurance? Yes No
- (3) What minimum limits are required? _____
- (4) Does the Applicant indemnify the subcontractor? Yes No
- (5) Does the subcontractor indemnify the Applicant? Yes No
- g) Does the Applicant utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with claim handlers or adjusters? Yes No

PART V. ADVERTISING/MARKETING/SALES

27. a) Do all contracts, sales literature, and brochures expressly identify covered and non-covered procedures? Yes No
- b) Do any contracts, sales literature, or brochures use the term(s) “investigative” or “experimental” procedures? Yes No
- If “Yes”:
- (1) Do all such materials define what is considered “investigative” or “experimental”? Yes No
- (2) Do all such materials clearly state that the Applicant has discretionary authority in the interpretation and administration of the plan’s provisions? Yes No
- c) Do contracts, sales literature, and brochures expressly refer to all contracted health care providers as independent contractors? Yes No
- d) Do any contracts, sales literature, or brochures make statements or warranties as to the quality of health care, breadth of plan, providing all the needed care or being the “best” plan, etc.? Yes No
- e) Does the Applicant’s legal counsel review and approve all contracts, sales literature, brochures, advertisements, and other marketing materials prior to their use? Yes No
- f) Are enrollee satisfaction surveys conducted? Yes No
- If “Yes,” how often? _____ (Please attach or describe results from the most recent enrollee survey).

PART VI. CLAIMS INFORMATION

28. During the past five (5) years, no claims of a type which might fall within the scope of the proposed insurance have been made against the Applicant or any individual or entity proposed for coverage, except as follows (include loss payments and defense costs). If answer is none, so state:
- _____
- _____

NOTE:WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 28 OR CLAIM RELATED THERETO IS EXCLUDED FROM THE PROPOSED INSURANCE.

29. During the past five (5) years, neither the Applicant nor any individual or entity proposed for coverage, has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument, except as follows. If answer is none, so state:

NOTE:WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 29 OR CLAIM RELATED THERETO IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 29 IS EXCLUDED FROM THE PROPOSED INSURANCE.

30. Neither the Applicant nor any individual or entity proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance, except as follows. If answer is none, so state:

NOTE:WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 30 OR CLAIM RELATED THERETO IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VII. ATTACHMENTS

31. Please attach copies of the following documents to this Application. These documents shall be a part of this Application:

- a) Applicant's last 2 audited or accountant-prepared financial statements with notes;
- b) Most recent actuarial report, if applicable;
- c) If the Applicant is newly formed, Pro Forma financial statements;
- d) If the Applicant is newly formed, Business Plan;
- e) Applicant's by-laws;
- f) List of the Board of Directors
- g) Applicant's organization chart;
- h) Written utilization review procedures, including procedures for denials of benefits and appeals;
- i) Written credentialing and peer review procedures;
- j) Sample contract(s) with health care providers (physicians, hospitals, and others);
- k) Sample contract(s) with enrollee(s) or membership handbook;
- l) Sample contracts with vendors;
- m) Sample TPA or ASO contract(s);
- n) Sample sales literature, brochures, advertisements, and other marketing materials (including enrollee packet);
- o) Privacy policies and procedures; and
- p) Sample consent forms.

PART VIII. SIGNATURES

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Underwriter in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance by the Underwriter upon the Application, and the Application will be the basis of the contract. The Application is on file with the Underwriter, and will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.

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

The undersigned declares that all individuals and entities proposed for this insurance understand:

- a) the policy, if issued, shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Underwriter in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period, if applicable and reported to the Underwriter in writing during the Extended Reporting Period or within the time period set forth in the policy; and
- b) the limit of liability available under the policy, if issued, to pay damages, settlements, or judgments shall be reduced, and may be exhausted, by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

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 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 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.

A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.

Signature of Applicant: _____
(MUST be signed by an Owner, Partner, Director, or Officer of the Named Insured.
It is agreed the signer has authority to act on behalf of all insureds.)

Printed Name of Applicant: _____ Title _____

Date: _____