



Application for Benefit Plan Purchasers Liability Insurance

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY, WHICH SHALL BE ISSUED ON EITHER AN INDEMNITY OR DUTY-TO-DEFEND BASIS. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES.

I. GENERAL INFORMATION ABOUT APPLICANT

- (1) Name of Applicant: _____
(Note: Wherever used in this Application, 'Applicant' shall mean the entity named above, which shall be designated as the Named Insured on any subsequently issued Policy)
- (2) Address: _____
City: _____ State: _____ ZIP: _____
Website: _____ Telephone Number (____) _____
- (3) Contact Person and Title (Human Resources Contact or Plan Fiduciary):

Email address: _____ Telephone Number (____) _____
- (4) Date of Incorporation or Formation of Applicant: _____
- (5) Date Applicant's operations first began: _____
- (6) State(s) in which the Applicant operates: _____

- (7) Number of Applicant's Employees: Full-time: _____
Part-time: _____
- (8) Type of Entity:
 For-Profit Corporation – Publically Traded
 For-Profit Corporation – Private
 Not-for-Profit Corporation – Subject to Taxation
 Not-for-Profit Corporation – Tax Exempt
 Limited Liability Company
 Partnership
 Joint Venture
 MEWA or MET
 Taft-Hartley Plan
 Union Plan (Collective Bargaining Plan)
 Trust
 Other (describe): _____

(9) Description of Primary Operations of Applicant: _____

(10) Is the Applicant currently insured for Healthcare Purchasers Professional Liability? Yes No

If "Yes," please provide the following current insurance information:

Insurance Carrier	Limits of Liability	Deductible/Retention	Annual Premium	Policy Period	If Claims Made, Retroactive Date

II. APPLICANT'S EMPLOYEE BENEFIT PLANS

(1) Applicant purchases or obtains healthcare services and other benefits:

- Exclusively for its own employees;
- On behalf of multiple employers, for their respective employees; or
- Other: _____

(2) With respect to its Employee Benefits Program, the Applicant is:

- Fully Self-Insured for all Benefits Offered
- Fully Insured for all Benefits Offered (see below)
- Some Benefits are Self Insured, Some Benefits are Insured

(a) If Applicant is "Fully Self-Insured for all Benefits Offered" please indicate the length of time that Applicant has been self-insured: _____

II. APPLICANT'S EMPLOYEE BENEFIT PLANS (Cont.)

(3) Please complete the grid below. If the Applicant does not offer a specific Benefit, please indicated "N/A"

<u>Type of Benefit</u>	<u>Number of Enrollees, Current Year</u>	<u>Number of Enrollees, Previous Year</u>	<u>Self-Insured</u>	<u>Insured</u>	<u>If Insured, Name of Insurer or Vender</u>	<u>Type of Plan (HMO, PPO, TPA, POS, Indemnity, Consumer Driven Plan, or Other)</u>	<u>Self Administered by Applicant</u>	<u>Third Party Administered</u>	<u>Reinsured by Applicant, in whole or in part?</u>
<u>Health</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Vision</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Dental</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Disability</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Worker's Compensation</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Prescription Benefit Management</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Behavioral/Mental Health</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Flexible Spending Plan</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Healthcare Reimbursement Plan</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Other*:</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Other*:</u>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Please list under "Other" any additional employee benefit programs not shown above, such as life, case management, disease management, employee assistance program, health and wellness fairs, nurse call lines, employee health clinic, etc.

(4) Describe the Applicant's process for selection of Plan Insurers/Vendors: _____

(5) Please indicate the name and title of the person who makes the final decision on selection of an Insurer/Vendor: _____

III. OTHER ENTITIES PROPOSED FOR COVERAGE

If coverage is being requested for any other entities other than the Applicant identified in Question (1) above (e.g., subsidiaries, joint ventures, or partnerships), please list each such entity below.

Note that coverage for such other entities is not automatically available. The terms and conditions of the Policy and any Endorsements thereto, if issued, will determine actual coverage.

PLEASE PROVIDE INFORMATION IN A SEPARATE ATTACHMENT, IF NECESSARY.

Name and Address of Entity	Relationship to Applicant	Description of Operations	Type of Entity (See Part I, Q.H.)	Tax Status	Percent Owned by Applicant

IV. OPERATIONS

(1) Does the Applicant fund or subsidize premiums, in whole or in part, for any Employee Benefit? Yes No

If "Yes," please answer the following:

(a) List which Employee Benefits the Applicant funds or subsidizes premiums on, and the percentage funded:

(b) Is the amount or percent funded or subsidized the same regardless of the option selected by an employee? Yes No

(2) Does the Applicant ensure that the Employee Benefit Plans are funded at adequate levels at all times to ensure the payment of claims? Yes No

(a) Is funding audited on a regular basis by an outside auditing firm? Yes No
If "Yes," how often do such audits take place? _____

- (3) Does the Applicant require that all vendors, TPAs or others providing services on their behalf under an employee benefit plan carry Professional Liability Insurance? Yes No
- (a) Minimum Limits Required: _____
- (b) Is the Applicant an “Additional Insured” on each vendor’s or TPA’s Errors and Omissions Liability Insurance policy? Yes No
- (4) With respect to the Applicant’s standard contracts with its vendors, TPAs and others providing services on the Applicant behalf:
- (a) Do they require the Applicant to hold harmless the third party? Yes No
- (b) Do they require the Applicant to indemnify the third party? Yes No
- (c) Do they include a provision providing reciprocal indemnification between the Applicant and the third party? Yes No
- (5) Please describe any programs or policies the Applicant or its vendors have for facilitating or encouraging the use of non-U.S. based medical providers by participants in the Applicant’s Benefit Plans, and attach any advertising materials pertaining thereto which are provided to participants:
- _____
- _____

V. CLAIMS HANDLING

- (1) If Applicant is Self-Insured:
- (a) Claims are handled:
- by internal staff/employees of Applicant; or
- by an outside Third Party Administrator (TPA) on behalf of the Applicant
- (b) If Claims are handled by internal staff/employees of Applicant:
- | | Last 12 Months | Next 12 Months |
|----------------------------|----------------|----------------|
| # of Claims Examiners | | |
| Number of Claims Handled | | |
| \$ Value of Claims Handled | | |
- (c) If Claims are handled by an outside TPA for the Applicant, please indicate the name and address of the TPA:
- _____

VI. MEDICAL SERVICES PROVIDED BY APPLICANT

- (1) Does the Applicant own, operate, or supervise a hospital, inpatient or outpatient clinic, pharmacy, dispensary, or any other medical facility? Yes No
- If “Yes,” please provide details in a separate attachment.**

- (2) Does the Applicant employ physicians, surgeons, dentists or other healthcare professionals, in any medical capacity except to perform administrative duties, peer review or utilization review functions? Yes No
If “Yes,” please provide details in a separate attachment.

VII. ADVERTISING

- (1) Who prepares benefit plan documents, advertising materials and communications to participants?
Applicant
Vendor
- (2) Does the Applicant modify plan booklets or plan documents provided by a Vendor? Yes No
- (3) Do all plan documents, or advertising materials clearly indicate which procedures are covered and which are not covered by the plan? Yes No
Please enclose specimens.
- (4) Do plan documents or advertising materials ever use the term(s) "investigational," "experimental" or "medically necessary"? Yes No
- (5) If “Yes” to (4), do plan documents or advertising materials and certificates of coverage define what is considered “investigational,” “experimental” or “medically necessary”? Yes No
- (6) Are all contracted healthcare providers always referred to as independent contractors or participating providers? Yes No
- (7) Does the Applicant conduct satisfaction surveys of its Participants? Yes No
If “Yes,” how often? _____
Please provide details on latest survey results in a separate attachment.
- (8) Do all plan documents and certificates of coverage provide details or instructions for the Applicant’s internal appeal process or state mandated external review process? Yes No
Please provide details in a separate attachment.
- (9) Does the Applicant’s legal representatives review and approve all plan documents, contracts and advertising materials prior to their use, including any amendments or revisions thereto? Yes No
If “No,” are your advertising materials subject to state approval? Yes No
- (10) Do all plan documents clearly state that the Applicant has discretionary authority in the interpretation and administration of the plan’s provisions? Yes No

VIII. HIPAA COMPLIANCE

- (1) Does Applicant take appropriate measures to assure that plans comply with HIPAA? Yes No
If “Yes,” please explain in detail in an attachment or provide a copy of the Applicant’s written procedures.

- (2) Is the Applicant in compliance with the Electronic Transactions Standards? Yes No
If “No,” have the Applicant filed and been approved for an extension? Yes No
Extension date: _____

- (3) Has the Applicant established privacy policies and procedures to comply with the Health Insurance Portability and Accountability Act (HIPAA)? Yes No
Please describe: _____

- (4) Has the Applicant’s legal counsel reviewed all materials related to the rule? Yes No

- (5) Do marketing materials and enrollee plan documents explain the HIPAA rule and the impact on enrollees, including consent procedures and protected health information? Yes No
Please describe: _____

- (6) Have “firewalls” been established in claim handling for employees to ensure proper privacy? Yes No
Please describe: _____

- (7) Has a HIPAA compliance officer and training staff been established? Yes No
Please describe: _____

- (8) Have amendments to employee handbooks been drafted to explain HIPAA and outlined violations and sanctions? Yes No
Please describe: _____

IX. INFORMATION SECURITY

- (1) Please quantify (number of individual records) the Personally Identifiable Information (“PII”) the Applicant currently stores in its Network?
(If unable to provide an exact number, please provide a best estimate, and describe the methodology for arriving at this estimate.)

_____#

Methodology:

“Personally Identifiable Information” is information from which an individual may be uniquely and reliably identified, including, but not limited to an individual’s name, address, telephone number, in combination with their social security number, account relationships, account numbers, passwords, PIN numbers, credit or debit card numbers, biometric information, Nonpublic Personal Information as defined by the Gramm-Leach Bliley Act of 1999, Protected Health Information (“PHI”) as defined by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), or personal information as defined by an applicable state privacy protection law.

(2) Does the Applicant transmit, receive, store, handle or have access to any of the following information:

- Credit Card numbers (If checked, please answer question (c) below.)
- Medical Records
- Social Security Numbers
- Drivers License Numbers
- Other: (describe) _____

(3) If Credit Card information is transmitted, received, stored, handled or accessed by the Applicant, indicate the Applicant's Payment Card Industry (PCI) Compliance Level.

- Level 1 Level 2 Level 3 Level 4 Level 5

(4) Please indicate where PII may be stored by the Applicant?

- Desktop drive Laptop Offsite facility
- PDA Network drive Software Application
- Other (describe): _____

(5) Is the Applicant's PII encrypted during transmission, receipt and storage?

- Yes No

(6) Please indicate which encryption method is used by the Applicant (check all that apply):

- File based encryption Secure email
- Encrypted VPN Tunnel Secure Wide Area Network
- Other (describe): _____

(7) Is anyone permitted to connect to the Applicant's Network through a wireless network?

- Yes No

(8) Complete the following table with respect to encryption of technology assets within the Applicant's Network:

Technology Assets	Encrypted?
Laptops	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mobile Devices	Yes <input type="checkbox"/> No <input type="checkbox"/>
Backups	Yes <input type="checkbox"/> No <input type="checkbox"/>
Wireless Network	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>

(9) Are any persons or entities permitted to connect to the Applicant's network from an off-site location?

- Yes No

If "Yes," please complete the chart below.

Name of Person or Entity	Services provided to You	Type of remote connection that is permitted

- (10) Does Applicant have any data leakage controls and/or information security software packages in place? Yes No

Please check all that apply.

- Firewall
- Intrusion Detection System or Intrusion Prevention System
- Network Admission Control
- Secure Tokens
- Biometrics Devices
- Other (describe): _____

- (11) Does Applicant have an Incident Response Plan in place for dealing with a data breach? Yes No

X. RISK MANAGEMENT

- (1) Does the Applicant have a formal Risk Management Program (i.e., a formal approach to avoiding situations that might give rise to a claim)? Yes No
If “Yes,” please explain: _____

- (2) 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

- (3) 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? Yes No
If “Yes,” please explain and attach a copy of the contract: _____

XI. CREDENTIALING OF PROVIDERS

- (1) Does the Applicant contract **directly with** Healthcare Providers (e.g. physicians, surgeons, hospitals, etc.)? Yes No
If “Yes,” please complete the following section (2).

- (2) Please provide the following information:

	# For Last 12 Months	# For Next 12 Months
Physicians contracting directly with Applicant		
Hospitals contracting directly with Applicant		
Physicians available through a Network Vendor		
Hospitals available through a Network Vendor		

- (3) Who provides credentialing services for the Applicant?
 The Applicant; or
 A third party, on behalf of the Applicant.

If a third party conducts credentialing on behalf of the Applicant:

- (a) Please indicate the name and address of the individual or entity below:

- (b) Does the Applicant review or audit the third party's credentialing process?
Yes No
- (c) Does the Applicant require the third party conducting to carry Professional Liability Insurance? Yes No
If "Yes," what minimum Limits of Liability are required? _____

Complete Questions (4)-(12) below only if the Applicant performs the Credentialing function.

- (4) Does the Applicant follow NCQA guidelines for credentialing? Yes No
If "No," please provide details in a separate attachment.
If "Yes," what is the Applicant's procedure for quality and disciplinary review between scheduled credential reviews? _____
- (5) How often does Applicant re-credential contracted healthcare providers? _____
- (6) How often does Applicant perform on-site visits of contracted healthcare providers? _____
- (7) Does the Applicant refer to or check on contracted healthcare providers with any available data banks during the credentialing process? Yes No
- (8) Does the Applicant require that all contracted hospitals be JCAHO accredited? Yes No
If "No," please explain: _____
- (9) Does the Applicant require all contracted healthcare providers to have staff privileges at a JCAHO accredited hospital? Yes No
- (10) Are all of the Applicant's contracted healthcare providers required to maintain medical malpractice insurance? Yes No

If "Yes," answer the following questions:

- (a) At what minimum Limits of Liability? _____
- (b) Are all of Applicant's contracted healthcare providers required to warrant that they maintain this insurance in force during their contract period with the Applicant?
Yes No
- (c) Do all contracted healthcare providers provide the Applicant with evidence of insurance?
Yes No
- (11) Does the Applicant provide details on the appeal process to healthcare providers who are not approved or accepted into the Applicant's network as part of the credentialing process?
Yes No
- (12) Does the Applicant send notice of non-acceptance in writing to a healthcare provider as part of the credentialing process?
Yes No

If "Yes," please provide a sample of Applicant's Non-Acceptance Letter.

XII. UTILIZATION REVIEW

- (1) Who performs the Utilization Review function for the Applicant?
 - The Applicant; or
 - A third party, on behalf of the Applicant
- (a) If a third party conducts utilization review on behalf of the Applicant, please indicate the named and address of the individual or entity below:

- (b) If a third party conducts utilization review on behalf of the Applicant, does the Applicant review or audit the credentialing process? Yes No
- (c) Does the Applicant require the third party conducting utilization review on its behalf to carry Professional Liability Insurance? Yes No

If "Yes," what minimum Limits of Liability are required? _____

Complete Questions (2)-(13) below only if the Applicant performs the Utilization Review function.

- (2) Please provide the following information:

	Last 12 Months	Next 12 Months
# of Cases Reviewed		
# of Cases Denied		
% of Cases sent to Independent Review		
% of Cases Upheld		
# of Full Time Reviewers		
# of Part Time Reviewers		

- (3) Does the Applicant have written policies and procedures for Utilization Review, including processes for denials, appeals and independent and external review? Yes No

If "Yes," do the procedures comply with NCQA or URAC standards and comply with all applicable law? Yes No

If "No," please provide details. _____
- (4) Are denial, appeals and grievance procedures explained to enrollees in writing? Yes No
- (5) Does the Applicant abide by independent review decisions? Yes No

If "No," please describe in detail: _____

- (6) Do the denial letters to enrollees identify all applicable internal or external review procedures, including any state mandated review organizations? Yes No

(7) Does a physician or specialist review all proposed denials prior to an issuance of a denial letter? Yes No

(8) What are the procedures for notifying a stop loss carrier of a claim (please provide a copy of Applicant's written procedure, if existing)? _____

(9) Does the Applicant use practice guidelines as a part of the Utilization Review process? Yes No

If "Yes," do the guidelines state that the physician's judgment may override a guideline? Yes No

(10) Does the Applicant have profit sharing or other financial incentives in its compensation arrangements with Utilization Reviewers? Yes No

If "Yes," please describe: _____

(11) Does the Applicant use same specialty reviewers for high risk or life-threatening benefit denials? Yes No

(12) How often does the Applicant perform internal audits? _____

(13) What problems or inconsistencies, etc., are the audit guidelines designed to reveal? _____

XIII. EMPLOYEE ASSISTANCE PROGRAM

(1) Does the Applicant provide an Employee Assistance Program ("EAP"), or offer mental health or chemical dependency counseling services to its employees? Yes No

If "Yes," does the Applicant provide such services to any third party for a fee? Yes No

(2) Does the Applicant employ any counselors for such programs? Yes No
(a) If "Yes," please indicate the number of employed counselors: _____

(b) If "Yes," do these employed counselors provide the following services?

(i) assessment and referral Yes No

(ii) short-term counseling (10 visits or less) Yes No

(iii) longer-term counseling (more than 10 visits) Yes No

(iv) M.D./Psychiatrist clinical services (as employees of Applicant), including prescriptions for drugs. Yes No

(3) Does the Applicant apply its internal Utilization Review procedures to this service? Yes No

XIV. CLAIMS INFORMATION

- (1) In the past 5 (five) years, has any claim, suit or other legal proceeding been brought against any proposed insured, individual or entity? Yes No

If "Yes," please provide details on a separate sheet of paper.

- (2) Does any proposed insured know of any incident, act, error or omission that is reasonably likely to result in a claim or suit against any proposed insured? Yes No

If "Yes," please provide details on a separate sheet of paper.

- (3) Have all matters disclosed in response to Questions (1) and (2) been reported to the Applicant's former or current insurance carrier(s)? Yes No

If "No," please explain in detail in a separate attachment.

- (4) Is the Applicant currently, or ever been under any supervision order, or undergone a receivership, bankruptcy or similar proceeding? Yes No

If "Yes," please explain in detail in a separate attachment.

- (5) Has any proposed insured, individual or entity, currently or ever been the subject of any administrative, regulatory or other governmental proceeding, or the subject of any fines, penalties, sanctions or similar remedies? Yes No

If "Yes," please explain in detail in a separate attachment

WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE INSURER, IT IS AGREED THAT ANY MATTER REQUIRED TO BE DISCLOSED IN RESPONSE TO THE ABOVE QUESTIONS, AND ANY CLAIM ARISING FROM OR RELATED TO SUCH MATTER, IS EXCLUDED FROM ALL PROPOSED INSURANCE.

XV. ATTACHMENTS

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

1. Loss History for the last five years. The loss run should be updated within the last 30 days and include claim descriptions, breakdown of total incurred losses (paid and reserves for indemnity and expense), respective deductibles or retentions and full details on all losses paid or outstanding in excess of \$25,000.

Any loss runs must include open claim reserve amounts. If reserves are not disclosed, the Applicant must provide full details on the claim. Details should include an evaluation from outside counsel with potential claim estimates and estimated defense costs.

2. Most recent Audited Financials.
3. Most recent actuarial report.
4. Copy of plan documents and summary plan descriptions.
5. Specimen provider and vendor contracts.
6. Written credentialing and peer review procedures, if applicable
7. Written utilization review procedures, including procedures for denials of benefits and appeals.
8. Sample Claim Denial letter.

XVI. REPRESENTATIONS OF APPLICANT

The undersigned authorized representative declares, on behalf of all individuals and entities proposed for this insurance, that it is understood and agreed that:

- A. the policy, if issued, shall apply only to “Claims” that are first made against the “Insured” during the “Policy Period” and reported to the Insurer 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 Insurer 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.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, PARTNER, DIRECTOR OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE APPLICANT WILL IMMEDIATELY NOTIFY THE INSURER IN WRITING OF SUCH CHANGES. THE INSURER RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, REPRESENTS AND WARRANTS ON BEHALF OF THE APPLICANT AND ALL PERSONS OR ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF AND AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ARE TRUE AND ACCURATE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE INSURER, ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE INSURER. IF A POLICY IS ISSUED IT WILL BE IN RELIANCE BY THE INSURER UPON THE APPLICATION, AND THE APPLICATION WILL BE THE BASIS OF THE CONTRACT. THE APPLICATION IS ON FILE WITH THE INSURER, AND WILL BE CONSIDERED PHYSICALLY ATTACHED TO, PART OF, AND INCORPORATED INTO THE POLICY, IF ISSUED.

XVII. FRAUD WARNINGS

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, PARTNER, DIRECTOR OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY THE INSURER IN WRITING OF SUCH CHANGES. THE INSURER RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS OR ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF AND AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ARE TRUE AND ACCURATE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE INSURER, ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE INSURER.

NOTICE TO APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, 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,

COMMITTS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, DISTRICT OF COLUMBIA AND 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 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 CLAIMING 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 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, COMMITTS 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 MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON 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 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 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 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 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.

XVIII. SIGNATURE

Signing this form and tendering premium does not bind the Insurer to complete the insurance or issue the Policy.

Signature of Authorized Representative of Applicant:

Print or type Name and Title of Authorized Representative:

Date: _____ (mo/day/year)