Renewal 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: ☐ For-Profit Corp. ☐ Not-for-Profit Tax-Exempt Corp. ☐ Not-for-Profit Taxable Corp. ☐ Limited Liability Company ☐ Partnership ☐ Joint Venture ☐ Other (describe):_____

b) ☐ HMO If so, please indicate: ☐ Staff Model ☐ Network or IPA Model ☐ Combined ☐ PPO ☐ PHO ☐IPA ☐MSO ☐Medical Group or Clinic ☐ Third Party Administrator ☐ Peer Review Organization ☐ Utilization Review Organization ☐ 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:_____		
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.

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						
Stop Loss						
lnsolvency						
Fidelity						
Fiduciary						
Other						

9. 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:_____
_____

10. Have there been any changes in the Applicant's board of directors or senior management within the past two (2) years for reasons other than death or retirement? ☐ Yes ☐ No
If "Yes," please explain:_____

11. Number of Applicant's: Full-time employees:_____
Part-time employees:_____

12. 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.)

(a) Merger, acquisition, or consolidation with another entity? ☐ Yes ☐ No
(b) Sale, distribution, or divestiture of any assets or stock, other than in the ordinary course of business? ☐ Yes ☐ No
(c) Any registration for a public offering or private placement of securities? ☐ Yes ☐ No
(d) Any joint ventures? ☐ Yes ☐ No
(e) Any new business activities or services? ☐ Yes ☐ No
(f) Any new Medicare or Medicaid contracts? ☐ Yes ☐ No

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

_____

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

_____

_____

14. **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

15. **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):

Activity or Service	**Yes**	**No**	**Yes, For Others For Fee**
a) Credentialing or peer review of health care providers	☐(Complete Part II)	☐	☐(Complete Part II)
b) Utilization review	☐(Complete Part III)	☐	☐(Complete Part III)
c) Handling and adjusting of claims for enrollee benefits	☐(Complete Part IV)	☐	☐(Complete Part IV)
d) Advertising, marketing, or selling of health care plans/products	☐(Complete Part V)	☐	☐(Complete Part V)
e) Drafting practice guidelines/ critical pathways	☐	☐	☐
f) Case Management	☐	☐	☐
g) Disease Management	☐	☐	☐
h) Enrollment processing for enrollees	☐	☐	☐

of health care plans

i) Billing/other processing of enrollees' claims under health care plans	☐	☐	☐
j) Establishing health care provider networks to provide managed care	☐	☐	☐
k) Actuarial services for health care plans	☐	☐	☐
l) Assisting customers in securing reinsurance	☐	☐	☐
m) Third Party administration (TPA) services for health care plans	☐	☐	☐

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:_____
_____

16. **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

b) Have there been any changes made to the program in the past 12 months? ☐ 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

17. **HIPAA:**

(1) Does the Applicant have a Privacy Officer? ☐ Yes ☐ No
(2) Does the Applicant have a Security Officer? ☐ Yes ☐ No
(3) Has the Applicant established a HIPAA team? ☐ Yes ☐ No
(4) Has the Applicant conducted a HIPAA risk analysis? ☐ Yes ☐ No
(5) Has the Applicant modified its policies and procedures such that they are consistent with the elements of HIPAA? ☐ Yes ☐ No
(6) Has the Applicant conducted HIPAA privacy training? ☐ Yes ☐ No
(7) Is employee and vendor adherence to confidentiality requirements audited? ☐ Yes ☐ No
(8) Does the Applicant have a plan for ongoing HIPAA privacy training? ☐ Yes ☐ No
(9) Does the Applicant have a policy and procedure to address the responsibilities of its "Business Partners" under HIPAA? ☐ Yes ☐ No

18. **COMPLIANCE:**

(1) Does the Applicant have a written Corporate Compliance program? ☐ Yes ☐ No
If "Yes," how long has it been in place?_____

(2) Does the Applicant have an employee hotline as a part of the Compliance program? ☐ Yes ☐ No

If "Yes", what is the average number of calls per month made to the hotline?
_____

APPLICANT: PLEASE COMPLETE THE FOLLOWING SECTIONS WHICH CORRESPOND TO "YES"ANSWERS IN QUESTION 15 ABOVE. IF NO CORRESPONDING SECTIONS ARE INDICATED, PLEASE PROCEED TO PART VI

PART II. CREDENTIALING OR PROVIDER SELECTION OF HEALTH CARE PROVIDERS

14. Total revenue for credentialing/peer review services performed for others for a fee: Last 12 months **$**_____ Next 12 months **$**_____

15. a) Who does the credentialing of contracted health care providers?
Applicant: ☐ Yes ☐ No
Subcontractor: ☐ Yes ☐ No
Other:_____ ☐ Yes ☐ No

b) If credentialing is subcontracted:
(1) Does the Applicant review or audit the process? ☐ Yes ☐ No
(2) Is 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

19. Does the Applicant have written policies and procedures in place for provider selection, credentialing, re-credentialing, and making decisions which adversely affect a provider's credentials? ☐ Yes ☐ No

a) Do the written credentialing procedures follow JCAHO or NCQA standards and comply with all applicable laws? ☐ Yes ☐ No
b) Are the procedures given to health care providers? ☐ Yes ☐ No
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

20. 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

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

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

23. 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:_____

24. 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

25. 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: _____

26. 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 (FEE) 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

27. 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

	Last 12 months	Next 12 months
28. Total revenue for claims handling and adjusting services performed for others for a fee:	_____	_____
29. 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: ☐ Yes ☐ No
Subcontractor: ☐ Yes ☐ No
Other:_____ ☐ Yes ☐ 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

30. 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. REPRESENTATION APPLICABLE TO INCREASED LIMIT REQUEST

1. If the Insured Entity requests limit(s) of liability for the renewal of its expiring policy with the Insurer that are larger than the limit(s) of such expiring policy, the Insured Entity must complete the following statement, which applies to such larger limit(s) of liability.

   Neither the Insured Entity 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 result in a claim that may fall within the scope of the proposed larger limits of liability, except as follows. If the answer is none, so state:

   _____

   _____

   NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE INSURER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN QUESTION 1 OF THIS SECTION IS EXCLUDED FROM THE PROPOSED LARGE LIMITS OF LIABILITY.

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;
    And, if any changes since the date of last application:
    c) Current list of Board of Directors;
    e) Applicant's by-laws;
    d) Applicant's organization chart;

e) Written utilization review procedures, including procedures for denials of benefits and appeals;
f) Written credentialing and peer review procedures;
g) Sample contract(s) with health care providers (physicians, hospitals, and others);
h) Sample contract(s) with enrollee(s) or membership handbook;
i) Sample contracts with vendors;
j) Sample TPA or ASO contract(s);
k) Sample sales literature, brochures, advertisements, and other marketing materials (including enrollee packet);
l) Privacy policies and procedures; and
m) 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:_____