SENIOR LIVING FACILITY PROFESSIONAL, GENERAL AND EMPLOYEE BENEFITS LIABILITY INSURANCE APPLICATION
(Nursing Homes, Assisted Living, Residential Facilities)

Portions of the policy for which this application is made provide claims made and reported coverage, which applies only to claims first made against the insured during the policy period or an applicable extended reporting period and reported in accordance with the policy's reporting provisions. Read the policy and this application carefully and contact your producer with any questions.

INSTRUCTIONS:

- Carefully review and fully answer each of the following questions completely.
- Complete the application in its entirety. Do not leave any question unanswered. If any question does not apply to you, state N/A.
- If additional space is needed to answer any questions fully, attach a separate page.
- This application must be completed, dated and signed by a principal or officer of the business.

Please attach the following:

The items requested below are to be submitted with this application before a quotation can be developed and released.

1. Completed separate supplemental applications for each location that you are requesting coverage.
2 Copy of facility license for each location
3. Current CMS Forms 671 *Facility Staffing* and 672 *Resident Census* (SNF only) for each location
4. Minimum five (5) years recently valued (3 months) loss history, including the current year for each coverage being requested.
5. Copy of most recent inspection survey for ALFs for each location
6. Copy of CMS form 2567 Long Form for SNF surveys completed during the past 12 months (includes complaints surveys)
7. Most recent accrediting agency report (TJC, CARF, etc.).
8. Most recent CPA prepared and audited financial statement.
9. Copy of marketing materials/brochures.
10. List of all entities, subsidiaries, joint ventures, etc. requested to be included for coverage under the proposed insurance. Include name & address, description of operations, relationship, date acquired, ownership percentage and retroactive date.

SECTION I. GENERAL INFORMATION

☐ New Applicant ☐ Renewal If Renewal, POLICY NUMBER:____

1. Employers Federal Tax ID #(FEIN): _____
2. Corporate/Parent Name (d/b/a): _____

   Corporate Address: _____

   City: _____ State: _____ Zip Code: _____
3. Website: _____
4. Contact Person: _____ Title: _____

   E-mail: _____ Phone #: _____ Fax #: _____
5. Number of years the organization is in operation: _____ Number of years under current ownership: _____

6. Number of years under current management company (if applicable): _____

   Name of Management Company: _____

7. Does the Applicant provide management services to other entities for a fee? ..... ☐ Yes ☐ No

8. Applicant is (check all that applies):

   ☐ Profit ☐ Individual ☐ Accredited by TJC
   ☐ Non-Profit ☐ Partnership ☐ Accredited by CARF
   ☐ Governmental ☐ Corporation ☐ **Other Accreditation - List:**
   ☐ Joint Venture _____

9. If the Named Insured owns or manages multiple facilities:

   a. Are all facilities governed by the same corporate policies and procedures? ..... ☐ Yes ☐ No

   b. Is there a Corporate Risk Manager who is responsible for all facilities? ..... ☐ Yes ☐ No

   If "Yes" to a. and b., please complete questions 13, 14, 15, 21 and 28 for each location using the Supplemental Application. All other questions should be answered on a corporate level.

10. Is the facility approved for Medicare? ..... ☐ Yes ☐ No

    If "Yes," # of beds: _____

11. Is the facility approved for Medicaid? ..... ☐ Yes ☐ No

    If "Yes," # of beds: _____

12. Has the facility license been suspended, revoked or placed on probation in the past seven years? ..... ☐ Yes ☐ No

13. Has Medicare or Medicaid Certification been suspended or revoked in the last seven years? ..... ☐ Yes ☐ No

14. Has the facility been classified by CMS as a Special Focus Facility in the past seven years? ..... ☐ Yes ☐ No

15. Has a state or federal agency fined this facility within the past seven years? ..... ☐ Yes ☐ No

16. Date of last inspection/survey: _____

    a. Total number of deficiencies: _____

       D, E, F deficiencies: _____

       G, H, I, J, K, L deficiencies: _____

    b. Was a Corrective Action Plan accepted by the state? ..... ☐ Yes ☐ No

    c. How many complaints were investigated in the past three (3) years? _____

    d. How many complaints were substantiated? _____

17. Within the past 5 years or within the next 12 months, has the Applicant or does the Applicant expect to:

    a. Merge, acquire or consolidate with another entity? ..... ☐ Yes ☐ No

    b. Sell or divest another entity or facility? ..... ☐ Yes ☐ No

    c. Discontinue any operations or services? ..... ☐ Yes ☐ No

    d. Offer any new business activities or services (including an increase in licensed beds or new facilities)? ..... ☐ Yes ☐ No

    If "Yes" to any of the above, please attach a description for each transaction.

18. Corporation Officers:

Name	Title	Status
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive

SECTION II. COVERAGE INFORMATION

19. Current Coverage: (expand the table with additional rows as needed, or attach separate page)

PRIMARY	Effective Date	Retroactive Date	Limits Per Occ/Agg	Deductible or SIR
Professional Liability				
General Liability				
Employee Benefits Liability				
Other (describe):				
EXCESS	**Effective Date**	**Retroactive Date**	**Limits Per Occ/Agg**	**Deductible or SIR**
Professional Liability				
General Liability				
Employee Benefits				
Auto Liability				
Employers' Liability				
Other (describe):				

20. Coverage Requested: (expand the table with additional rows as needed, or attach separate page)

PRIMARY	Carrier	Effective Date	Occ. or Claims Made	Retro Date	Limits Per Occ/Agg	Deductible or SIR	Premium
Professional Liability							
General Liability							
Employee Benefits Liability							
Other (describe):							
EXCESS	**Carrier**	**Effective Date**	**Occ. or Claims Made**	**Retro Date**	**Limits Per Occ/Agg**	**Deductible or SIR**	**Premium**
Professional Liability							
General Liability							
Employee Benefits Liability							
Auto Liability							
Employers' Liability							
Other (describe):							

Has any insurer canceled or declined to renew professional liability coverage
(**Missouri Residents Do Not Answer**)? ..... ☐ Yes ☐ No

If yes, please explain: _____

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 result in a claim that may fall within the scope of the proposed insurance, except as follows: (If none, state so):

_____

It is agreed that with respect to the immediately preceding question, if any such fact, circumstance, situation, transaction, event, act, error, or omission exists, then such fact, circumstance, situation, transaction, event, act, error, or omission and any claim, proceeding or action arising therefrom is excluded from the proposed coverage.

SECTION III. FACILITY EXPOSURE INFORMATION

(Please complete the Supplemental Application for each location).

21. Applicant is (check all that apply):

☐ Sub-Acute	Ventilator care, wound management, postoperative/trauma recovery, intravenous antibiotic &/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ Skilled Nursing	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 care and services. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ Intermediate Care	Administration of oral medications, assistance with Activities of Daily Living (ADLs), preventive turning/positioning, restorative rehabilitation. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ Assisted Living	Combination of housing, personalized support services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ Independent Living	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. **# Units:** _____ **# Residents:** _____ **Average Occupancy:** _____
☐ Home & Community-Based Services	Repair person services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic, skilled nursing care. **Home Health Care:** **# Annual Skilled Nursing Visits:** _____ **# Annual Companion Care Visits:** _____ **Hospice Care:** # **Annual Visits:** _____
☐ Personal Care	Assistance provided at home or care facilities to help clients with common tasks, such as bathing, grooming and using toilet facilities, as well as dressing, cooking and house cleaning. **# Annual visits:** _____
☐ Adult Day Care – Social	Social – Services include but not limited to recreational activities (crafts, music, games, shopping, trips), intergenerational programs, promotion of wellness and socialization programs, educational programs. **Projected # Annual Participants:** _____
☐ Adult Day Care – Enhanced (Mentally Challenged)	Enhanced – Services include but not limited to/for the same as social, yet will also include additional services such as medication supervision; medical, nursing nutritional and therapy services, disabled and rehabilitation services, counseling services, physical therapy (PT), speech and occupational therapy (OT); the mentally challenged, cognitively impaired, developmentally disabled, chronically ill. **Projected # Annual Participants:** _____

22. Specific services provided (check all that apply):

- ☐ IV Infusion Therapy
- ☐ Ventilation Therapy
- ☐ Physical Therapy
- ☐ Psychiatric
- ☐ Developmentally Disabled
- ☐ Alzheimer's/Dementia/Memory Care – Number of beds designated to accommodate these specific resident needs _____
- ☐ Chemical Dependency Treatment
- ☐ AIDS
- ☐ **Other: Specify** _____

23. Please indicate the number of residents by age group:

< 18 yrs. of age: _____ 18 – 54 yrs. of age: _____ 55 yrs. of age and >: _____

SECTION IV. STAFFING INFORMATION

(Please complete the Supplemental Application for each location).

24. Provide the # of employed and/or contracted staff:

Type	Total FTEs	Employed FTEs	Contracted FTEs	Limits of Insurance
Physicians				
Dentists				
Podiatrists				
Chiropractors				
Psychologists/Psychiatrists				
Registered Nurses				
Licensed Practical Nurses				
Respiratory Therapists				
CNAs				
Personal Caregiver				
Physical Therapists				
Occupational Therapists				
Speech Therapists				
Dietician				
Laboratory				
Pharmacists				
Medical Records				
Social Services				
Recreational Services				
Transportation				
Beautician/Barber				
Laundry				
Food				
Other:				
Total Number				

25. Are Certificates of Insurance obtained and updated annually for all professional services that are contracted? ..... ☐ Yes ☐ No

26. Does the organization conduct a background check for criminal history, sex offender, and abuse or neglect, at a minimum, on all staff? ..... ☐ Yes ☐ No

27. Does the organization obtain driving records/MVRs on employees assigned to driving residents? ..... ☐ Yes ☐ No

28. Nurse Employees:

	1st Shift (FTE)	2nd Shift (FTE)	3rd Shift (FTE)	% Turnover (prior 12 months)
R.N.				
LPN/LVN				
CNA/Personal Caregiver				
Agency				
Pool				

Are there any changes on weekends and holidays? ..... ☐ Yes ☐ No

If "Yes," please explain: _____

Director of Nursing: _____ ☐ RN ☐ LPN

Length of time at the facility: _____ Length of time as DON: _____

☐ Employed ☐ Contracted

SECTION V. PROGRAMS/POLICIES/PROCEDURES

29. **ELOPEMENT**

a. Are nursing assessment protocols in place to identify residents at risk for elopement? ..... ☐ Yes ☐ No

b. Do you conduct elopement drills? ..... ☐ Yes ☐ No

c. Is the elopement management program drilled at least twice a year? ..... ☐ Yes ☐ No

If "No," explain: _____

d. Are Wander Guards or similar devices used as part of the elopement mitigation practices? ..... ☐ Yes ☐ No

If "Yes," provide type: _____

e. Are Wander Guard devices maintained and inspected according to manufacturer's specification? .. ☐ Yes ☐ No

If "Yes," at what intervals are they inspected? _____

f. Number of elopements in the past three years: _____

30. **FALLS**

a. Are nursing assessment protocols in place to identify residents at risk for falling? ..... ☐ Yes ☐ No

b. Is there a formal fall mitigation program? ..... ☐ Yes ☐ No

c. What devices are used to manage falls: _____

d. Number of falls in the past quarter: _____ Falls with injury in past quarter: _____

31. **SKIN INTEGRITY**

a. Are nursing assessment protocols in place to identify residents at risk for skin breakdown? ..... ☐ Yes ☐ No

b. Is nutrition and hydration management incorporated into skin breakdown prevention programs? ... ☐ Yes ☐ No

c. Number of current pressure ulcers: Stage I: _____ Stage II: _____ Stage III _____ Stage IV: _____

32. **ABUSE**

a. Are nursing assessment protocols in place to identify residents at risk for abuse and at risk for being abusive? ..... ☐ Yes ☐ No

b. Is there a formal abuse prevention program? ..... ☐ Yes ☐ No

c. How are sexually aggressive residents managed? _____

d. Number of abuse incidents in the past quarter: _____ Abuse incidents in past year: _____

33. **VOLUNTEER SERVICES**

a. What is the total number of volunteers? _____

b. What are the primary sources for volunteers? _____

c. Is there a formal screening and orientation process for volunteers? ..... ☐ Yes ☐ No

If "No," please explain: _____

d. Does the organization conduct a sex offender background check? ……..... ☐ Yes ☐ No

e. Are roles and responsibilities of volunteers clearly communicated to staff and volunteers? ..... ☐ Yes ☐ No

f. Do volunteers assist with resident feeding? ..... ☐ Yes ☐ No

34. **DAY CARE SERVICES FOR CHILDREN**

a. Is there a day care center that is owned, operated or provided by the organization? ..... ☐ Yes ☐ No

If "Yes," is it on the premises? ..... ☐ Yes ☐ No

b. Is the day care center open to the public? ..... ☐ Yes ☐ No

c. Number of children enrolled in the past 12 months? _____

d. Does the organization complete a background check for criminal history, sex offender, abuse / neglect and credentialing of licensure for all staff? ..... ☐ Yes ☐ No

35. **POOL**

a. Is there a swimming pool? ..... ☐ Yes ☐ No

b. Is it open to the public? ..... ☐ Yes ☐ No

c. Is a waiver in place for public use of the pool? ……... ☐ Yes ☐ No

d. Is the pool locked when not in use? ..... ☐ Yes ☐ No

e. Is a full-time lifeguard on duty? ..... ☐ Yes ☐ No

f. Are there depth markings? ..... ☐ Yes ☐ No

36. **MEDICATION STORAGE AND DISPENSING**

a. Who is responsible for administering medications? ☐ RN/LPN/LVN ☐ Medication Aides

b. How are medications stored? _____

c. How often does pharmacy review the medical records? _____

37. **PHYSICIANS**

a. Does the credentialing process include verification of current professional license? ..... ☐ Yes ☐ No

b. Does the credentialing process include verification of current DEA license? ..... ☐ Yes ☐ No

Name of Medical Director: _____ Specialty: _____

License No.: _____ State: _____

Length of time as Medical Director: _____ ☐ Full Time ☐ Part-Time

☐ Employed ☐ Contracted

Does the Medical Director act as attending physician to residents? ..... ☐ Yes ☐ No

If answered "Yes" to the above, how many residents? _____

Limits of Insurance: $_____ Each Professional Incident / $_____ Annual Aggregate

38. **RESEARCH SERVICES**

a. Does the organization sponsor clinical trials? ..... ☐ Yes ☐ No

If "Yes," does the applicant draft protocols for these trials? ..... ☐ Yes ☐ No

b. Does the applicant act as an investigator in the clinical trial process for the product of another party? ..... ☐ Yes ☐ No

c. Are clinical trials being conducted at the applicant's facility? ..... ☐ Yes ☐ No

If "Yes," are these clinical trials approved by the applicant's Institutional Review Board? ..... ☐ Yes ☐ No

d. For each clinical trial where the applicant is acting as a sponsor, attach a list providing the following information:

Name of Clinical Trial	Protocol Number	# of Residents Involved in the Clinical Trial

39. **ASSISTED LIVING ADMISSION and ASSESSMENT**

a. Do you require evidence of acceptable health of all residents admitted to your facility? ..... ☐ Yes ☐ No

b. Are sex offender background checks completed on residents prior to admission? …….. ☐ Yes ☐ No

c. What conditions would preclude acceptance of an individual? _____

d. Is a health assessment conducted for new residents? ..... ☐ Yes ☐ No

If "yes," does the assessment include key risk drivers such as Fall Mitigation, Elopement Prevention and Skin Integrity? ..... ☐ Yes ☐ No

e. Who completes the nursing assessment? _____

f. How frequently is it repeated? _____

Please attach a copy of your assessment form.

g. What specific criteria determines if a resident should be in a different level of care? _____

h. How often are residents re-assessed for appropriate level of health and health care needs? _____

SECTION VI. RISK & CLAIMS MANAGEMENT INFORMATION

40. **RISK MANAGEMENT**

a. Please indicate who is responsible for the facility's risk management program.

Name: _____ Title: _____

How long in this role? _____

b. Who does this individual report to? _____

c. Does this individual have responsibilities other than risk management? ..... ☐ Yes ☐ No

If "Yes," please describe: _____

d. Are all incident reports reviewed by this individual and the medical director? ..... ☐ Yes ☐ No

e. Do all contracts for clinical services include mutual hold harmless and indemnification agreements? ..... ☐ Yes ☐ No

If "No," describe the contracted services where these provisions do not exist: _____

f. Do all contracts for clinical services contain minimum Professional Liability insurance requirements for the other party? ..... ☐ Yes ☐ No

If "Yes," what is the minimum amount required? $_____ Each Professional Incident / $_____ Annual Aggregate

If "No," describe the contracted services where this provision does not exist: _____

g. Is an electronic medical records system (EMR) fully integrated at all sites? ..... ☐ Yes ☐ No

If "No," what is the plan for full integration? _____

h. Does the organization have a formal Just Culture Program? ..... ☐ Yes ☐ No

i. Does the organization require an arbitration agreement be signed prior to admission? ……. ☐ Yes ☐ No

41. **CLAIMS MANAGEMENT**

a. Who, within the organization, is responsible for claims management activities?

Name: _____ Title: _____

b. Is there a written claims management policy/procedure? ..... ☐ Yes ☐ No

If "Yes," please attach.

c. Does a Third Party Administrator manage claims within the SIR (if applicable)? ☐ Yes ☐ No

If "Yes," please provide name of TPA Firm and Contact: _____

d. Please provide names of defense firms who currently represent you in professional liability matters.

_____

SECTION VII. LIFE SAFETY INFORMATION

42. How many resident care buildings does the organization own, lease, or operate? _____

43. Please provide the # of bed bound residents residing above the 1st floor of any one location: _____

If any, please provide a copy of your evacuation plan.

44. How many other, non-resident care buildings does the organization own, lease, or operate? _____

45. Are all of the resident buildings fully sprinklered? ..... ☐ Yes ☐ No

If "No," please explain: _____

Do all the resident buildings have:

Smoke detectors? ..... ☐ Yes ☐ No

Heat detectors? ..... ☐ Yes ☐ No

Automatic alarms? ..... ☐ Yes ☐ No

46. Does the organization conduct periodic evacuation drills? ..... ☐ Yes ☐ No

If "Yes," which departments and how often? _____

47. Does the organization conduct periodic fire drills? ..... ☐ Yes ☐ No

If "Yes," how often? _____

48. Does the organization have a written Emergency Management Preparedness Plan? ..... ☐ Yes ☐ No

If "Yes," please provide a copy.

49. Is new construction and/or abatement ☐ contemplated or ☐ pending? ..... ☐ Yes ☐ No

If "Yes," please explain:

50. Has the organization identified and developed back-up systems for the loss of essential utilities, supplies, equipment, and dietary needs? ..... ☐ Yes ☐ No

If "No," please explain: _____

SECTION VIII. AUTOMOBILE LIABILITY INFORMATION (Applicable only for UMBRELLA – N/A for primary coverage)

51. Please check and complete for all that apply:

Vehicle Type	Service Radius (in miles per vehicle)	Number of Urban Use Vehicles	Number of Non-Urban Use Vehicles	Used for Patient Transport?
Private Passenger - Delivery				☐ Yes ☐ No
Private Passenger – Resident Service				☐ Yes ☐ No
Private Passenger - Other				☐ Yes ☐ No
Van (< 8 passengers)				☐ Yes ☐ No
Van (8-15 passengers)				☐ Yes ☐ No
Light Truck - Delivery				☐ Yes ☐ No
Light Truck – Resident Service				☐ Yes ☐ No
Light Truck - Other				☐ Yes ☐ No
Medium Truck				☐ Yes ☐ No
Bus (15-30 passengers)				☐ Yes ☐ No
Bus (> 30 passengers)				☐ Yes ☐ No
Hired & Non-Owned Autos				☐ Yes ☐ No
Other:				☐ Yes ☐ No

SECTION IX. EMPLOYER'S LIABILITY & EMPLOYEE BENEFITS LIABILITY INFORMATION

52. Number of employees: _____

53. Are employee benefits self-administered? ..... ☐ Yes ☐ No

If "No," are they administered by an outside vendor? ..... ☐ Yes ☐ No

If "Yes," what is the name of the vendor? _____

ADDITIONAL DOCUMENTS AND INFORMATION INCORPORATED BY REFERENCE

ALL WRITTEN STATEMENTS, MATERIALS OR DOCUMENTS FURNISHED TO THE **INSURER** IN CONJUNCTION WITH THIS **APPLICATION**, REGARDLESS OF WHETHER SUCH DOCUMENTS ARE ATTACHED TO THE POLICY, ARE HEREBY INCORPORATED BY REFERENCE INTO THIS **APPLICATION** AND MADE A PART HEREOF, INCLUDING WITHOUT LIMITATION ANY SUPPLEMENTAL APPLICATIONS OR QUESTIONNAIRES.

LEGAL NOTICE

BEFORE YOU SIGN THIS APPLICATION, READ THESE NOTICES CAREFULLY AND DISCUSS WITH YOUR BROKER IF YOU HAVE ANY QUESTIONS.

FOR THE PURPOSES OF THIS **APPLICATION**, THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE OF ALL PERSON(S) OR ENTITIES PROPOSED FOR THIS INSURANCE DECLARES THAT THE STATEMENTS IN THIS **APPLICATION**, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE.

THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE AGREES THAT IF THE STATEMENTS AND INFORMATION SUPPLIED ON THIS **APPLICATION** OR INCORPORATED BY REFERENCE CHANGES BETWEEN THE DATE OF THIS **APPLICATION** AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE **INSURER** OF SUCH CHANGES, AND THE **INSURER** MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

SIGNING OF THIS **APPLICATION** DOES NOT BIND THE **APPLICANT** OR THE **INSURER** TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS **APPLICATION** AND ANY INFORMATION INCORPORATED BY REFERENCE HERETO, SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IS INCORPORATED INTO AND IS PART OF THE POLICY.

SHOULD **INSURER** ISSUE A POLICY, **APPLICANT** AGREES THAT SUCH POLICY IS ISSUED IN RELIANCE UPON THE TRUTH OF THE STATEMENTS AND REPRESENTATIONS IN THIS **APPLICATION** OR INCORPORATED BY REFERENCE HEREIN. ANY MISREPRESENTATION, OMISSION, CONCEALMENT OR INCORRECT STATEMENT OF A MATERIAL FACT, IN THIS **APPLICATION**, INCORPORATED BY REFERENCE OR OTHERWISE, SHALL BE GROUNDS FOR THE RESCISSION OF ANY POLICY ISSUED.

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

STATE FRAUD NOTICES

NOTICE TO ARKANSAS, NEW MEXICO 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 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 AUTHORITIES.

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, 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 MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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 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 (365:15-1-10, 36 §3613.1).

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

FOR THE PURPOSES OF THIS **APPLICATION**, THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE OF ALL PERSON(S) OR ENTITIES PROPOSED FOR THIS INSURANCE DECLARES THAT THE STATEMENTS IN THIS **APPLICATION**, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE.

SIGNATURES

Signed: _____

Date: _____

Title: _____ Organization: _____

(Must be signed by an authorized officer) (Organization's seal)

Producer: _____

License Number: _____

Address: _____

_____