



HUMAN SERVICE – BASIC APPLICATION

(INTENDED FOR HUMAN SERVICE RISKS WITH LIMITED PROGRAMS/OPERATIONS WITH REVENUES < \$2,000,000)

Applicant Name:

Mailing Address:

City:

State:

Zip:

Total Staff (including office, janitorial, maintenance, etc.):

Full Time:

Part Time:

SIC#:

FEIN#:

Website Address:

Non-Profit

For-Profit

Annual Revenue: \$

Is the Applicant's organization more than 25% owned by a private equity fund structure?

Yes

No

If yes, provide name of private equity firm:

Number of years this facility has been: In Operation:

Under Present Management:

Risk Management Contact:

Phone Number:

Email:

SUBMISSION REQUIREMENTS

- ACORD Applications, including Crime & Umbrella
- Statement of Values
- Photographs of the Applicant's location(s)
- Loss runs for current year and three (3) prior years
- Brochure, newsletter and website information
- Financial Statement if For-Profit

SECTION I – LIFE SAFETY

Do all of the Applicant's facilities (buildings) have the following Life Safety Features?

If no, please indicate which location numbers.

Location Number(s):

- | | | |
|--|-----|----|
| 1. Fire Alarms? | Yes | No |
| 2. Smoke Detectors? | Yes | No |
| Hard Wired? Yes No Battery Operated? | Yes | No |
| 3. Emergency Lighting? | Yes | No |
| 4. Sprinklers? | Yes | No |
| 5. Are evacuation routes posted throughout the building? | Yes | No |
| 6. In the event of an evacuation, have the Applicant established a central meeting point outside the building? | Yes | No |
| 7. Are exit signs illuminated? | Yes | No |
| 8. How often are fire drills held? | Yes | No |
| 9. Are there at least two exit doors per building? | Yes | No |
| 10. Are exit doors equipped with panic hardware? | Yes | No |
| 11. Is smoking permitted inside the premises? | Yes | No |

SECTION II - AUTOMOBILE

- What percentages of employees/volunteers use their own vehicles regularly (daily/weekly) for agency business? Employees: % Volunteers: %
Describe use:
- Does the Applicant require employees and volunteers to carry and show evidence of personal insurance? Yes No
- What limits are required? Yes No
- Does the Applicant run MVRs on employees? Yes No
If yes, how often?
- Does the Applicant have a driver safety training program? Yes No
- Does the Applicant's Agency transport clients? Yes No
- Is training provided for new employees prior to their transporting clients? Yes No
- Does the Applicant's agency transport clients/consumers for other private or governmental agencies? Yes No
If yes, please explain:
If yes, for a fee? Yes No
- Does the Applicant's organization utilize GPS fleet telematics devices? Yes No
If yes, please check off the fleet telematics being utilized:
Plug in Hard wired Mobile Phone Other:
- What percentage of the Applicant's fleet is provided with these fleet telematics devices? %

SECTION III – GENERAL LIABILITY

1. Please provide a narrative of the Applicant's operations:

2. Annual Operating Budget: \$ _____ Annual Payroll: \$ _____
3. Number of clients/customers per year: _____ N/A
4. Number of Students: _____ N/A
5. If providing residential services, provide number of beds at each location: _____
6. Does the Applicant have sheltered workshops? Yes No
 Indicate location number: _____
 Describe the work being performed: _____

7. Does the Applicant have mobile work forces, i.e. janitorial services? Yes No
 Landscaping services? Yes No
 Other: _____
 If yes, please provide payroll: Janitorial \$ _____ Landscaping \$ _____ Other: \$ _____
 Is Workers Compensation carried for clients? Yes No
8. Does the Applicant have a day care program? Yes No
 Indicate location number(s): _____
 Maximum number of children supervised: _____ Ratio of children to Staff: _____ Age Range: _____
9. Does the Applicant provide any foster care or adoption services? Yes No
 If yes, please explain and indicate # of placements for each: _____

10. What percentage of total operations does this represent? _____ %
 Are any locations leased to others? Yes No
 Indicate location number: _____ Square Feet: _____
11. Does the Applicant have any swimming pools? Yes No
 Indicate Building or location number: _____
 Diving Board/Slide? Yes No
 Are all Swimming Pools / Spas compliant with the Virginia Graeme Baker Pool and Spa Safety Act? Yes No
 If no, provide time table and action plan: _____

12. Have all buildings built prior to 1971 been inspected for lead paint? Yes No
 If no, what is the plan for abatement: _____

13. Are counseling services/therapy offered for the following target classes:
 Sexual Offenders? Yes No Sexual Predators? Yes No
 Fire Starters Yes No

SECTION IV – PROFESSIONAL LIABILITY

1. Does the Applicant’s current insurance program provide Professional Liability coverage? Yes No
 If yes, Occurrence or Claims Made – Retroactive date: Limit of Liability: \$
 Carrier: Effective Date:
2. Annual Staffing – Employees, Independent Contractors and Volunteers
 Total number of: Full time employees: Part Time Employees: Volunteers:
 Contracted Intellectually/ Developmentally Disabled (IDD) Shared Living- Host Homes:

Staffing	# of Employees		# of Contracted		Total Annual Volunteer Hours Worked
	FT	PT	FT	PT	
Psychologist					
Medical Director (Admin Only)					
Nurse Practitioner					
Physician Assistant					
Pharmacist					
Paramedic EMT					
Psychiatrist					
Physician-Hospice					
Pediatrician					
Physician-No Surgery					
Dentist					
Optometrists/Ophthalmologist					
Licensed Social Worker					
Sociologist					
Registered Nurse (RN)					
Licensed Practical Nurse (LPN)					
Physical Therapist					
Optician					
Orthotics & Prosthetics (O&P) Certified Practitioner					
Counselor (Guidance, Vocational)					
Social Worker					
Occupational Therapist					
Speech Therapist					
Clergy / Rabbi / Pastor					
O&P Certified Technician					
Teacher					
Nutritionist / Dietician					
Residential Manager					
Home Health Aide					
IDD In-Home Companion Care Provider					
Day Care Worker					
O&P Certified Fitter					
O&P Certified Assistant					
Adoptions					
Foster Care					
*Other (describe):					
*Other (describe):					

F/T = Full Time – over 20 hours per week/ P/T = Part Time – up to 20 hours per week.

*Please describe “other” staff positions not listed in the above chart in the provided area.

3. **If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**

4. **If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least \$1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.**

5. Do the physicians carry their own malpractice insurance? N/A Yes No
 Indicate Company: _____ Limits of Liability: \$ _____
6. Has the Applicant's operations/facilities ever been accredited / certified by CARF, JCAHO, ECFA, COA, ACHC or similar organization created to serve the Human/Behavioral /HealthCare Services Industry? Yes No
 If yes:
 Name of Accrediting Organization: _____
 Date of Accreditation/Certification: _____
 Term of Accreditation/Certification: _____

SECTION V – CONSULTANTS / INDEPENDENT CONTRACTORS **N/A**

1. Please indicate which of the following contracted service providers are utilized:
 Dentist Nurse Practitioner Optometrist Physicians Psychiatrist
 Other: _____
2. Are there written agreements with independent contractors? Yes No

SECTION VI – ABUSE & MOLESTATION

1. Does the Applicant's current insurance program include Abuse and Molestation Coverage? Yes No
 If yes, Occurrence or Claims Made – Retro Date: _____ Limit of Liability: \$ _____
 Carrier: _____ Effective Date: _____
2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? Yes No
3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if the Applicant has incident of abuse? Yes No
4. Are there written complaint procedures and are they displayed prominently? Yes No
 If yes, explain: _____
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? Yes No
6. Are formal written procedures in place for hiring? Yes No
7. Do volunteers work directly with clients? Yes No
8. Is there formal staff training for volunteers and staff on child/sexual abuse, including how to recognize the signs? Yes No
 If yes, how often is formal training conducted? _____
9. What procedures are in place to make sure no relationship occurs between staff and clients? _____
10. Are there procedures prohibiting closed door one-on-one meetings / counseling? Yes No
11. Is there more than one person responsible for the welfare of any single patient? Yes No
12. Have any incidents resulted in an allegation of sexual abuse? Yes No
 Was the case settled? Yes No Was the case taken to trial? Yes No
 Amount paid for damages to the victim: \$ _____
13. Does the Applicant run criminal background checks on employees? Yes No
14. Does the Applicant run criminal background checks on volunteers? Yes No

SECTION VII – ADULT DAY CARE

Type of Day Care:	# of Total Clients Served	% of Services
Type I: Adult day social care provides social care and social activities such as meals, recreation and some basic health-related services such as having a nurse on staff to check pressure (Light exposures).		%
Type II: Adult day health care offers more intensive health, therapeutic, and social services for individuals with moderate to severe medical and cognitive problems including an incidental exposure (up to 25%) of clients with Alzheimer's. Activities within this category also include social activities for clients that require more intense health, therapeutic and medical care. (Moderate to heavy exposures)		%
Type III: Alzheimer's specific adult day care provides social and health services to persons with Alzheimer's or related dementia. The predominant exposure in this category are clients with this diagnosis or organizations that have an Alzheimer's or related dementia exposure greater than an incidental as outlined within the Type II description.		%

For Type II and III, please outline the types of medical services provided:

SECTION VIII – CLAIMS MADE

N/A

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

Policy Effective Date:

Line of Business:

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? Yes No
 If yes, please provide details:

2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? Yes No
 If yes, please provide details:

SECTION IX - PLANNED EVENTS / FUND RAISERS**

N/A

** If Insured has more than ten (10) events planned for upcoming policy period, copy this page and add additional events.

QUESTIONS	EVENT #1	EVENT #2	EVENT #3	EVENT #4	EVENT #5
Describe the type of event*					
* Insert letter for type of event: A = Wine tasting B = Golf outing C = Other sporting event (specify) D = Picnic E = Banquet F = House tour G = Bingo H = Walkathon I = Fashion show J = Concert (specify) K = Other (specify)					
Date(s) the event is held.					
Daily hours of operation.					
Total anticipated revenue.	\$	\$	\$	\$	\$
Held at Applicant's premises? If not, specify where it is held.					
Number of participants.					
Number of staff members.					
Are certificates of insurance obtained from everyone providing products / services?					
If there will be drinking at the event, how does the Applicant control the amount allowed?					
Who provides / serves the alcohol? Liquor license required?					
Are the bartenders hired by the Applicant or by the place where the event is held?					
Do the bartenders know TIPS?					
If applicable, list all sporting activities to be a part of this event.					
What safeguards are in place to prevent spectator injury?					
Do participants sign a waiver?					
Do participants show proof of personal health insurance?					
QUESTIONS	EVENT #6	EVENT #7	EVENT #8	EVENT #9	EVENT #10
Describe the type of event*					
* Insert letter for type of event: A = Wine tasting B = Golf outing C = Other sporting event (specify) D = Picnic E = Banquet F = House tour G = Bingo H = Walkathon I = Fashion show J = Concert (specify) K = Other (specify)					
Date(s) the event is held.					
Daily hours of operation.					
Total anticipated revenue.	\$	\$	\$	\$	\$
Held at Applicant's premises? If not, specify where it is held.					
Number of participants.					
Number of staff members.					
Are certificates of insurance obtained from everyone providing products / services?					
If there will be drinking at the event, how does the Applicant control the amount allowed?					
Who provides / serves the alcohol? Liquor license required?					
Are the bartenders hired by the Applicant or by the place where the event is held?					
Do the bartenders know TIPS?					
If applicable, list all sporting activities to be a part of this event.					
What safeguards are in place to prevent spectator injury?					
Do participants sign a waiver?					
Do participants show proof of personal health insurance?					

WINTER WEATHER FREEZE PROTECTION

The Winter Weather Freeze Section is mandatory on all risks that have a prior winter freeze loss greater than \$25,000 or 10% of the building TIV in the past 5 years OR a location in states commonly experiencing freezing temperatures.

These states include but are not limited to: AL, AR, AZ, CO, CT, DE, DC, GA, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY

- | | | | | |
|----|--|-----|----|-----|
| 1. | Can the Applicant reliably confirm that all areas of the Applicant's building with fire sprinkler piping and/ or domestic water lines can be maintained at 45° F or higher?
This includes exterior accessed sprinkler riser rooms, as well as attics, crawl spaces, and stairwells if they have water lines in them. | Yes | No | N/A |
| | a. If not, select all freeze protection measures currently in place:
Temperature monitoring and remote heating control system (Wi-Fi temperature controls)
PHLYSense
Other water detection/ notification/ alarm system
Backup electrical generator, ensuring building heat at all times
Insulation around water pipes in cold areas*
Heat tracing for water pipes in cold areas*
Antifreeze fire sprinkler system in cold areas*
Space heaters or heated forced air in attics, crawl spaces, stairwells with fire sprinklers
Other: | | | |
| | * Cold areas are defined as portions of a building that cannot be maintained at all times reliably at or above 45° F. | | | |
| 2. | Fire Protection and Testing | | | |
| | a. Is the building provided with an Automatic Fire Sprinkler System (AS)? | Yes | No | N/A |
| | i. If yes, what type of sprinkler system is installed? Wet-Pipe Dry-Pipe Both | | | |
| | ii. If yes, approximately what percentage (%) of the building is sprinklered? % | | | |
| | iii. If yes, has the system been tested & inspection by qualified sprinkler contractor within past 12 months & includes a formal winterization review? | Yes | No | N/A |
| | iv. If yes, are the alarms tied to a 24 hour UL listed monitoring company? | Yes | No | N/A |
| 3. | Emergency Water Response (domestic and AS water lines) | | | |
| | a. Are water shutoff valves (domestic and AS water lines) marked and readily accessible? | Yes | No | N/A |
| | b. Are water shutoff valves exercised (closed and reopened) at least annually? | Yes | No | N/A |
| | c. Is the staff qualified to respond and shut off the water main during normal business hours and off hours? | Yes | No | N/A |
| 4. | Automatic Water Shutoff Devices | | | |
| | a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? | Yes | No | N/A |
| 5. | Unused/ Vacant Spaces | | | |
| | a. Does Applicant have a formal process to turn off and drain domestic water lines for these spaces? | Yes | No | N/A |
| 6. | Seasonal Occupancies ONLY: | | | |
| | a. Is there a full-time caretaker/ maintenance personnel on the premise? | Yes | No | N/A |
| | If yes, select required duties of the caretaker:
Regular walkthroughs of the building
i. How often each day?
Trained in the location(s) of water shut off valve(s)
Inspects taps and leaves them dripping in freeze weather events
Shuts off or drains pipes during freezing temperatures
Monitors building temperatures ensuring heat is maintained at required levels
Responds to power outages
i. List of required procedures | | | |
| | b. If no caretaker is present, has the building been properly winterized including water turned off, pipes drained, heat maintained, proper pipe insulation, etc.? | Yes | No | N/A |



CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:
Address of Applicant:
City: State: Zip:
Website: www:
Nature of Operations:

1. Annual sales or revenue: \$
2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? Yes No
If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
 - a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
 - b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
 - c. Credit or Debit Card Information
3.
 - a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? Yes No
 - b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? Yes No
 - c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? Yes No
 - d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? Yes No

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

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 THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). **(NOT APPLICABLE IN AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NY, OH, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, LA, MD, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON (IN ALABAMA, MAYBE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF).

APPLICABLE IN CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN DISTRICT OF COLUMBIA: 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.

APPLICABLE IN FLORIDA 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.

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS 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.

APPLICABLE IN MAINE: 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.

APPLICABLE IN NEW JERSEY: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN NEW MEXICO: 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.

APPLICABLE IN OHIO: 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.

APPLICABLE IN OKLAHOMA: 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.

APPLICABLE IN PENNSYLVANIA: 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.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON: 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.

APPLICABLE IN VERMONT: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

APPLICABLE IN NEW YORK: 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. THIS APPLIES TO AUTO INSURANCE.

NAME (PLEASE PRINT/TYPE)

TITLE

(MUST BE SIGNED BY THE PRESIDENT, BOARD CHAIR, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER

(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER

(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)