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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

RESIDENTIAL CARE SUPPLEMENTAL APPLICATION

Applicant Name:_____
E-mail Address:_____ Website Address:_____
☐ For-Profit ☐ Non-Profit Annual Budget: $_____ Annual Payroll: $_____
SIC code:_____ FEIN:_____
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:_____
Year business established:_____ Years under present management:_____
Name of executive director / administrator:_____ Number of years at facility:_____
Risk Management Contact:_____ Phone:_____ Email:_____

REQUIREMENTS FOR SUBMISSION

- Completed ACORD applications
- Copy of facility evaluation
- Copy of the current license
- Currently valued company loss runs for this policy period plus three year's prior

SECTION I – GENERAL INFORMATION

1. Are ALL operated residential facilities licensed? ☐ Yes ☐ No
2. Has Applicant's license ever been suspended, revoked, or placed under conditional status? ☐ Yes ☐ No
3. Date of last state inspection:_____
   Any inspection violations/deficiencies noted? ☐ Yes ☐ No
   Provide date compliance completed:_____
4. Have there been any claims that allege negligence or failure to comply with any regulatory / license guideline? ☐ Yes ☐ No
   If yes, please explain on a separate sheet of paper.
5. Any mergers or operations under another name within the past five (5) years? ☐ Yes ☐ No
6. Primary funding source: ☐ Private ☐ SSI/SSP ☐ Other:_____
7. Does the Applicant operate any locations not included in this application? ☐ Yes ☐ No
   If yes, describe:_____
8. List all association memberships or affiliations:
   _____
9. Are counseling services/therapy offered for the following target classes: Fire Starter? ☐ Yes ☐ No
   Sexual Offenders? ☐ Yes ☐ No Sexual Predators? ☐ Yes ☐ No

SECTION II – MANAGEMENT PRACTICES

1. Does the Applicant have sign in/out procedures for:
   Staff? ☐ Yes ☐ No Clients/Residents? ☐ Yes ☐ No Visitors/Public? ☐ Yes ☐ No
2. Describe precautions utilized to prevent unauthorized access to facility(s):
   _____
3. Service Level / Client to Staff Ratio Definitions (select all that apply):
   ☐ These clients do not live in licensed residential care homes as they are very high functioning. Most hold jobs or attend day programs. (Level 1 – CA Only)
   ☐ 6 to 1 staff ratio (6 residents to 1 staff person minimum). Residents want or need a little supervision – only reminders to do things. Supervision for safety reasons only. Most residents attend day programs or attend sheltered workshops. (Level 2 – CA Only)
   ☐ 3 to 1 staff ratio. Behavior issues maybe involved (i.e. not listening, assistance with physical needs such as toileting, bathing). Most residents attend day programs or sheltered workshops. (Level 3 – CA Only)
   ☐ Direct assistance needed for physical and/or behavioral issues. Most residents attend day programs or sheltered workshops. Care, supervision, and professionally supervised training for persons with deficits in self-help skills, and/or severe impairment in physical coordination and mobility, and/or severely disruptive or self-injurious behavior. Service level 4 subdivided into levels 4 (a) through 4(i), in which staffing levels are increased to correspond to escalating severity of disability levels. (Level 4 – CA Only)
      ☐ Has a 3 to 1 staff ratio (additional hours may be required if over 3 residents in home (Level 4 (a-e) – CA Only)
      ☐ Has a 2 to 1 staff ratio (Level 4 (f-i) – CA Only)

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SECTION III – RESIDENTIAL FACILITIES

(photocopy this section for each additional location)

RESIDENTS	# BEDS	RESIDENTS	# BEDS	RESIDENTS	# BEDS
Acute Skilled Care		Inpatients Crisis Center		Respite Care	
Aged		Low Income Housing		Transitional Housing	
Group Home		Shelter-Abuse Victims		Youth Homes	
Hospice		Shelter-Homeless		Other (specify):_____	
Independent Living		Shelter-Other:_____		Other (specify):_____	

1. Annual number of clients by age group:
   Less than 18:_____ 18 - 35:_____ 36 - 65:_____ Over 65:_____
   Average Occupancy:_____
2. Annual number of clients by disability:
   24-hr Constant Care Required:_____ Alzheimer's/Dementia:_____ Blind:_____ Deaf:_____
   Developmental Disability:_____ Drug/Alcohol:_____ Emotional/Behavior:_____
   Intellectual Behavior:_____ Non-Ambulatory:_____ Traumatic Brain Injury:_____
3. Is specific training provided for all staff caring for these ailments? ☐ Yes ☐ No
4. Does the Applicant train staff to recognize the need for increased level of care and have procedures in place for properly reassigning clients to more suitable facilities? ☐ Yes ☐ No
5. Resident elopement/unauthorized leave prevention (check all that apply):
   ☐ Exit doors locked to residents ☐ Wristband sensor w/alarm ☐ Exit doors alarmed to residents
6. How often are residents checked or monitored to ensure that they are at the facility or have returned to the facility?_____
7. Specify number of: Male:_____ Female:_____ Co-ed:_____
8. Are residents separated? ☐ Yes ☐ No
   How are they separated?_____
9. Average length of stay:_____
10. Total number of rooms:_____ Number of bedrooms:_____
11. Does a physician screen clients prior to admission? ☐ Yes ☐ No
12. Does the Applicant require a signed release form for the release of records to other individuals or institutions? ☐ Yes ☐ No
13. Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aide? ☐ Yes ☐ No
14. Is the staff trained in non-violent crisis intervention? ☐ Yes ☐ No
    If yes, which protocol?_____
15. What type of method does the Applicant use for de-escalation?_____
    Is it approved? ☐ Yes ☐ No
16. What is the Applicant's physical restraint policy?
    _____
17. What is the ratio of resident to staff: Day:_____ Night:_____
18. What procedures are in place for clients who are permitted to leave the premises without supervision?
    _____
19. How many visits per month are made by a caseworker to a resident?_____
20. How does the Applicant provide for the resident's privacy and individual security?
    _____
21. How often are rooms inspected?_____
    Who inspects the room?_____
    Does the Applicant have written procedures? ☐ Yes ☐ No
    Does the Applicant keep a checklist? ☐ Yes ☐ No
22. How often are bed checks done? ☐ Random ☐ Scheduled
23. How is staff monitored?_____
24. Are there security cameras monitoring operations and residents? ☐ Yes ☐ No
25. Are resident's doors ever locked from the outside? ☐ Yes ☐ No

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26. Are residents allowed to cook their own meals? ☐ Yes ☐ No
If yes, in: ☐ Private or ☐ Common cooking areas
27. Does the Applicant own or operate a Nursing Home or Assisted Living Facility? ☐ Yes ☐ No
If yes, please explain:

28. Is there a pool? ☐ Yes ☐ No
If yes, who uses the pool: ☐ Visitors ☐ Staff ☐ Clients/Residents
Is the pool completely fenced in with a self-locking gate? ☐ Yes ☐ No
If yes, what is the height?_____
Is there a diving board? ☐ Yes ☐ No
Is the staff trained in water safety? ☐ Yes ☐ No

SECTION IV – PROFESSIONAL LIABILITY / STAFF

1. Does the Applicant create written job descriptions for each employee and share with staff? ☐ Yes ☐ No
2. Does the Applicant train and require all staff to report all incidents to management? ☐ Yes ☐ No
Is a written record of all incidents kept? ☐ Yes ☐ No
Does management investigate each incident and record findings in writing? ☐ Yes ☐ No
3. Does the Applicant's current insurance program include professional liability? ☐ Yes ☐ No
If yes, is it: ☐ Occurrence or ☐ Claims Made – Retro Date:_____ Limit: $_____
Carrier:_____ Effective Date:_____
4. What is the staff turnover ratio for the last twelve (12) months?_____
5. 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					

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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.

6. **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.**
7. **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.**

SECTION V - CONSULTANTS/INDEPENDENT CONTRACTORS

1. Please indicate which of the following contracted service providers are utilized:
   ☐ Dentist ☐ Nurse Practitioner ☐ Physicians ☐ Other:_____
   ☐ Home Health Aides ☐ Optometrist ☐ Psychiatrist
2. Does the Applicant's current insurance program include professional liability? ☐ Yes ☐ No
3. Are there written agreements with independent contractors? ☐ Yes ☐ No
4. Are certificates of malpractice/liability insurance obtained and maintained for all contracted service providers (independent contractors)? ☐ Yes ☐ No
5. Please indicate the limits of liability: $_____

SECTION VI – LIFE SAFETY

Do all the Applicant's facilities (buildings) have the following life safety features?

1. Fire alarms? ☐ Yes ☐ No
2. Smoke detectors: Hardwired ☐ Yes ☐ No Battery operated ☐ Yes ☐ No
3. Emergency lighting? ☐ Yes ☐ No
4. Ceiling sprinklers? ☐ Yes ☐ No
5. Are all areas of buildings with wet pipe sprinkler systems (hidden or unhidden) maintained at a minimum temperature of 40° F, and / or provided with proper insulation or heat tracing to prevent pipe freeze-ups? ☐ Yes ☐ No
6. Are evacuation routes posted throughout the building? ☐ Yes ☐ No
7. In the event of an evacuation, has the Applicant established a central meeting point outside the building? ☐ Yes ☐ No
8. Are exit signs illuminated? ☐ Yes ☐ No
9. How often are the fire drills held?_____
10. Are there at least two exit doors per building? ☐ Yes ☐ No
11. Are exit doors equipped with panic hardware? ☐ Yes ☐ No
12. Is smoking permitted inside the premises? ☐ Yes ☐ No
13. Are any non-ambulatory residents located above the 1st floor? ☐ Yes ☐ No
    If yes, provide number of residents and which floor they reside on._____
14. Does the property have aluminum wiring? ☐ Yes ☐ No
    If yes, has it been retrofitted with one of the following PHLY approved connectors by a licensed Electrician? (indicate which one): COPALUM? ☐ Yes ☐ No AlumiConn? ☐ Yes ☐ No

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SECTION VII – ABUSE & MOLESTATION ☐ N/A

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 on child/sexual abuse, including how to recognize the signs? ☐ Yes ☐ No
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 VIII - AUTOMOBILE ☐ N/A

1. Are all vehicles listed on the ACORD application registered to the applicant? ☐ Yes ☐ No
   If no, explain: _____
2. Are vehicles for more than 8 passengers equipped with an audible backup warning service? ☐ Yes ☐ No
3. How many drivers use personal vehicles for business? Volunteers: _____ F/T*: _____ P/T**: _____
   *F/T = Full Time – over 20 hours per week / **P/T = Part Time – up to 20 hours per week
4. Does the Applicant require employees and volunteers to carry and show evidence of personal insurance if they use their personal vehicle in the business? ☐ Yes ☐ No
5. What limits are required? $_____
6. Does the Applicant run MVRs on employees? ☐ Yes ☐ No If yes, how often? _____
7. Does the Applicant have a driver safety training program? ☐ Yes ☐ No
8. Are all drivers at least 21 years of age? ☐ Yes ☐ No
9. Do any drivers between the ages of 21 and 25 operate vehicles with eight (8) passenger seating capacity or greater? ☐ Yes ☐ No
10. Does the Applicant have a formal vehicle maintenance program in effect? ☐ Yes ☐ No
11. Does the Applicant transport clients? ☐ Yes ☐ No
    a. Is training provided for new employees and/or volunteers prior to their transporting clients? ☐ Yes ☐ No
    b. Are vehicles checked after passengers disembark to make sure no one is left behind? ☐ Yes ☐ No
    c. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? ☐ Yes ☐ No
    d. Does the Applicant require seat belts to be worn by all passengers? ☐ Yes ☐ No
12. Does the Applicant transport clients/consumers for other private or government agencies? ☐ Yes ☐ No
    If yes, please explain:

    _____
    If yes, for a fee? ☐ Yes ☐ No
13. 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: _____
14. What percentage of the Applicant's fleet is provided with these fleet telematics devices? _____ %

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SECTION IX – CLAIMS MADE

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.

☐ N/A (Please proceed to signature section)

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:

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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? ☐Yes ☐No ☐N/A
   This includes exterior accessed sprinkler riser rooms, as well as attics, crawl spaces, and stairwells if they have water lines in them.
   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

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 SUJECT 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 FRAUDLENT 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.

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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)