Ironshore Specialty Insurance Company
One state Street Plaza
7th Floor
New York, NY 10004
(877) IRON411

LIFE SCIENCES
Application for Products Liability Insurance

When filling out this application, all questions must be answered completely. If a question is not applicable to the operations in question, please answer "not applicable" or "N.A." If the answer to a question is none, state "none" or "0". If more space is required to completely answer a question, please attach a separate sheet of paper and identify the question it responds to. Leave no spaces blank.

Before submitting the application, please provide the following documents electronically or in hard-copy to your broker:

- ☐ Most recent audited financial statements, annual report, or 10K
- ☐ Carrier-produced loss run showing date of loss, description of loss, total incurred, etc.
- ☐ Copy of Product Brochures and instructions
- ☐ Copy of all Adverse Incident Reports for any product involved in Litigation for the last 5 years.
- ☐ Copy of protocals and Informed Consent if company is involved in any clinical trials.

I. APPLICANT INFORMATION	
Applicant	
Address	
Other Applicants: *(Explain Relationship)*	
Additional locations	
Web site	
Years in business	
Parent corporation	
Coverage by parent company afforded to you?	☐ Yes ☐ No
Retro Dates of Additional Insureds:	
Form of Business	☐ Individual ☐ Corporation ☐ Joint Venture ☐ LLC ☐ Other
Identify entities acquired within the last 5 years	
Has applicant operated under a different name? *(explain)*	☐ Yes ☐ No

Insurance Contact Name:

Insurance Contact Email and Telephone No.:

Estimated Gross Sales for Upcoming Year:	Domestic:	Foreign:
Manufactured by you:	$	$
Distributed by you:	$	$

List the countries outside of the U.S. where products are manufactured or distributed:	
Is Worldwide coverage needed?	☐ Yes ☐ No
Estimated Payroll for upcoming year:	$
Source(s) of revenue	☐ Manufacturing ☐ Licensing/Royalties ☐ Distributing ☐ Inter-Company ☐ Other

II. COVERAGE INFORMATION

Policy Period Requested	From: To:
Limits of Liability Requested	Per Occurrence: $: Aggregate: $:
Deductible/SIR Requesting	$ ☐ Deductible ☐ SIR
First commercial insurance purchase?	☐ Yes ☐ No

Year	Policy Term	Type of Coverage: GL or Products liability	Carrier	Limits	Deductible / SIR Amount	Premium
Current Year				$	$	$
Prior Year				$	$	$
2 Years Prior				$	$	$

Has a carrier ever canceled or non-renewed you liability Insurance? ☐ Yes ☐ No

If yes, please explain:

III. LOSS HISTORY

Please provide a recently valued, carrier produced loss run showing date of loss, description of loss, total incurred, number of open claims, number of closed claims, etc.

1. List Total incurred losses for the last 5 years Valuation Date: $____

	Policy Term:	Total Incurred For Policy Term:
Current Year:		$
One Year Prior:		$
Two Years Prior:		$
Three Years Prior:		$
Four Years Prior:		$

2. Describe all incurred losses of $10,000 or more:

____

3. Are you aware of any incidents or circumstances involving or arising out of your products or operations which are likely to result in a claim: ☐ Yes ☐ No

If yes, please explain: ____

4.Please describe your claims escalation process:

____

IV. PRODUCT INFORMATION

Please attach brochures and/or product listing if available.

Please list the top TEN (by sales) MANUFACTURED products as follows:

Product Name	USE	Year on Market	Manufacturing Location	Annual Gross Receipts
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$
7.				$
8.				$
9.				$
10.				$

Do you manufacture the complete product for each item listed above? ☐ Yes ☐ No

If not, please specify any component parts purchased to complete the product:

Are all manufactured products for sale FDA or foreign agency equivalent approved? ☐ Yes ☐ No

If not, please identify each product and specify the reason they are not approved:

Please provide the following breakdown as a percentage of gross receipts:

% Patent:	%	% Generic:	%	% Injectible:	%
% Prescription:	%	% Over the Counter	%		

Please list the top TEN (by sales) DISTRIBUTED products as follows:

Product Name	USE	Year on Market	Distribution Location	Annual Gross Receipts % of Revenue
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$
7.				$
8.				$
9.				$
10.				$

Please provide sales revenue (current and four prior years):

Year Ending:	In the U.S.	Outside of the U.S
Current Year:	$	$
One Year Prior:	$	$
Two Years Prior:	$	$
Three Years Prior:	$	$
Four Years Prior:	$	$

V. DISTRIBUTION AND/OR MANUFACTURERS

Are any distributed products manufactured and/or packaged outside of the U.S. or its possessions? ☐ Yes ☐ No

If yes, please specify each products, country of origin and percentage of gross receipts:

Are all manufactured products for sale FDA or foreign agency equivalent approved? ☐ Yes ☐ No

If not, please identify each product and specify the reason they are not approved:

_____

Are all manufactured and distributed products for sale in the United States classified as Class I, II or II medical devices under US code Title 21 Sec. 360c, as amended or foreign agency equivalent? ☐ Yes ☐ No

If not, please identify each product and specify the reason they are not approved:

_____

Are any products distributed in its original packaging directly to consumers? ☐ Yes ☐ No

Are any products repackaged or relabeled? ☐ Yes ☐ No

If so, please list products:

_____

Are you affiliated in any manner with any of your suppliers or distributors? ☐ Yes ☐ No

If yes, please describe the nature of affiliation:

_____

Does the Manufacturer purchase product liability insurance? ☐ Yes ☐ No

Specify Limit: $_____

Please provide the following breakdown as a percentage of gross receipts:

% Patent:	%	% Generic:	%	% Injectible:	%
% Prescription:	%	% Over the Counter	%		

VI. REGULATORY ISSUES

Are any raw materials received from China, India or any other foreign country? ☐ Yes ☐ No

If so, what quality control procedures do you have in place to monitor the quality of any imported materials used in your product: _____

Please provide sales revenue (current and four prior years):

Year Ending:	In the U.S.	Outside of the U.S
Current Year:	$	$
One Year Prior:	$	$
Two Years Prior:	$	$
Three Years Prior:	$	$
Four Years Prior:	$	$

Have any products been voluntarily or involuntarily recalled for any reason? ☐ Yes ☐ No

If yes, please specify date of recall, products involved, USFDA Class I, II or III and reason for recall.

_____

Have any products been discontinued? ☐ Yes ☐ No

If yes, please list and explain:

_____

Will any products been introduced in the next 12 months? ☐ Yes ☐ No

If yes, please list and explain:

Has any product ever been subject to inquiry or investigation by any government agency concerning its efficacy, adequacy of labeling hazardous contents &/or safety? ☐ Yes ☐ No

If yes, explain:

When was the most recent on-site FDA inspection? Month: _____ Year: _____

Was a 483 issued? If Yes, attach 483 with your response. ☐ Yes ☐ No

Please provide copies of any and all ADVERSE INCIDENT REPORTS for any product involved in ANY litigation within the past 3 years.

Please attach any Dear Doctor letters that were issued for any product within the past 5 years.

Who are the members of your safety surveillance team and to whom does the team report?

Does your safety surveillance team have contact with and/or report to your outside board of directors? ☐ Yes ☐ No

Who has the authority to suspend a trial, approve a label change, or withdraw a product from the marketplace? Do you have written procedures to address and communicate these actions?

Under what circumstances do you use independent parties to analyze your processes or data?

What steps, if any, would you take if you became aware of a pervasive off-label use of your products?

Do manufacture or distribute any of the following drugs, ingredients or products?

	"X" if Yes	Name of Product	Years on Market	% of Gross Receipts	Manufacturing Location
Diet Products	☐			%	
Nutritional Products	☐			%	
PPA	☐			%	
Ephedra	☐			%	
Vaccines	☐			%	
Accutane or Isotrentinoin	☐			%	
Diethylstillbestrol or DES	☐			%	
Contraceptives	☐			%	
L-Tryptophan	☐			%	
Hormone Replacements	☐			%	
SSRI's (Selective Seratonin Reuptake Inhibitors)	☐			%	
Antidepressants	☐			%	
Nefazadone	☐			%	

Statins/Fibrates	☐			%	
COX-2 Inhibitors	☐			%	
Latex or Latex Compounds	☐			%	
Thimerosol Products	☐			%	
Silicone	☐			%	
Mercury	☐			%	
Thalidomide	☐			%	
Non-FDA Approved Products	☐			%	

VII. RISK MANAGEMENT PRACTICES	
Do you have a loss prevention or loss control program? If yes, please provide the name of the person in charge, title and who they report to: ____	☐ Yes ☐ No
Do you have a written products recall plan?	☐ Yes ☐ No
Do you maintain complete inventory records, including details or shipment?	☐ Yes ☐ No
Are serial and/or batch numbers identified on the finished products and on shipment records?	☐ Yes ☐ No
Are any products sold Sterile? If yes, do you sterilize or contract out? If you contract out, do you receive a hold harmless agreement from each contractor?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Do any of your manufactured or distributed products come with written statements, instructions or brochures? If yes, please attach copies.	☐ Yes ☐ No
Has a medical device notification or safety alert been issued? If yes, please describe in detail: ____	☐ Yes ☐ No
Are all written promotional materials, contract, guarantees, manuals for instruction and similar materials reviewed by legal counsel?	☐ Yes ☐ No
Do you or your employees provide direct patient care? Do they carry individual medical malpractice insurance?	☐ Yes ☐ No ☐ Yes ☐ No
Do you operate an inpatient medical facility?	☐ Yes ☐ No
Are any of your manufactured or distributed products currently involved in clinical research on human subjects? If yes, you must complete the SUPPLEMENTAL CLINICAL TRIAL APPLICATION.	☐ Yes ☐ No
Is any post market surveillance being conducted by the company on any of its products? If yes, please describe in detail: ____	☐ Yes ☐ No
Are your operating policies and procedures audited annually? Provide an overview of your audit procedures. To whom does the audit team report? Who receives a copy of the audit report?	☐ Yes ☐ No

Do you have a compliance officer? If yes, to whom does the officer report? ☐ Yes ☐ No
Do you have an Enterprise Risk Management program? ☐ Yes ☐ No
Please describe how you monitor your contractual obligations for confidentiality agreements and granting of additional insured status.

VIII. SALES AND MARKETING INFORMATION
Please describe the extent of your direct to consumer advertising. How do you ensure your advertisements to consumers are both balanced and informative?
Under what circumstances does someone other than a senior officer or an attorney in your legal department have the authority to sign contracts?
Are all contract changes required to be writing and signed by both parties? ☐ Yes ☐ No
How do you ensure that your internal and external sales and marketing representatives inform customers about product warnings, contraindications, labeling, and use?
Do you allow any off-label information dissemination by sales representatives? Do other employees provide off-label information? ☐ Yes ☐ No If yes, what is your system for managing and documenting these activities?
Do you allow employees to advertise direct product comparisons against competitors' products? ☐ Yes ☐ No If yes, which employees are authorized to make these comparisons? How do you ensure competitors' products are not disparaged?
How often do you train your sales and marketing staff on products liability exposures?
If you had evidence that your internal and/or external sales and marketing staff was not in compliance with local, state, provincial, regional, or federal laws, how would you handle it?

To what extent is your marketing group involved with scientific educational programs? Is your grant-giving function independent of your sales and marketing department?

____

IX. THIS SECTION TO BE COMPLETED WHEN THE COMPANY IS ENGAGED IN ACTIVE CLINICAL TRIALS.

A. CLINICAL TRIALS / BIOEQUVALENCE STUDIES

Please provide the following:

Protocol Name / Number	# of Subjects to be Enrolled during Policy Period	# of Subjects Already Enrolled	Trial Phase	Indication	Product Name	Location of Trial Site

Are you the sponsor of the investigation? ☐ Yes ☐ No

If no, please identify the sponsor: ____

Do you indemnify the sponsor? ☐ Yes ☐ No

Does the sponsor indemnify you? ☐ Yes ☐ No

Do you require the sponsor to carry product liability insurance? ☐ Yes ☐ No

Please specify limit: ____

Does the sponsor require that you carry liability insurance? Please specify limit: _____	☐ Yes ☐ No
Do you manufacture the product, device or drug to be tested? If no, please identify the manufacturer: _____ Please describe the nature of the relationship: _____	☐ Yes ☐ No
Do you indemnify the manufacturer? Does the manufacturer indemnify you?	☐ Yes ☐ No ☐ Yes ☐ No
Who will administer the clinical trial or bio-study? _____	
Do you indemnify the administrator? Does the administrator indemnify you?	☐ Yes ☐ No ☐ Yes ☐ No

Do you use the services of a Contract Research Organization? If yes, Name of CRO: _____	☐ Yes ☐ No
Does the CRO draft the protocol?	☐ Yes ☐ No
Does the CRO draft the informed consent?	☐ Yes ☐ No
Is liability coverage sought for the CRO?	☐ Yes ☐ No
Do you audit the CRO's performance?	☐ Yes ☐ No
Have any clinical trials been placed on hold or cancelled? If yes, please provide details: _____	☐ Yes ☐ No
How many clinical studies or bio-studies have you commenced in the last 5 years? _____	
Do you compensate your test subject? If yes, please provide the maximum amount paid to subjects: $_____	☐ Yes ☐ No

Do any of clinical trials or bio-studies involve:

	"X" if Yes	Name of device, drug or product	Indication for use
Animal Tissue	☐		
Birth Control	☐		
Food Supplements	☐		
Hormones	☐		

Human Plasma	☐		
Implants	☐		
SSRIs or Antidepressants	☐		
Steroids	☐		
Vaccines	☐		
Weight Reduction	☐		

Do you or any of your clinical trials or bio-studies specifically target the following subject patient populations:

Pediatric Population:	☐ Yes	☐ No
Pregnant Women:	☐ Yes	☐ No
HIV/AIDS patients:	☐ Yes	☐ No
Hepatitis patients:	☐ Yes	☐ No
Hospice patients:	☐ Yes	☐ No

Are you or any of your employee's members of the Institutional Review Board for your clinical trials or bio-studies?	☐ Yes ☐ No

With respect to CLINICAL INVESTIGATORS:

Do you allow them to enroll their own patients?	☐ Yes ☐ No
Do you allow them to contact subjects directly via databases?	☐ Yes ☐ No
Do you allow them to pay subject referral fees?	☐ Yes ☐ No
Do you pay them subject enrollment bonuses?	☐ Yes ☐ No
Do you audit their performances?	☐ Yes ☐ No

Do you use any foreign-made components in your clinical trials or bio-studies?	☐ Yes ☐ No
If yes, are they FDA Approved?	☐ Yes ☐ No
Are you of any of your clinical trials or bio-studies being conducted in foreign countries that require local, admitted paper?	☐ Yes ☐ No
If yes, please list the countries: _____	

VIII. REGULATORY / OPERATIONS WITH RESPECTS TO CLINICAL TRIALS

Have any of your clinical trails or bio-studies been discontinued, suspended, or placed on hold in the last 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Have any of you employees or clinical investigators been cited for regulatory violations involving your trial activities? If yes, please explain: _____	☐ Yes ☐ No
How do you ensure compliance applicable local, state, provincial, regional, and federal laws and IRB or Ethics committee requirements regarding human clinical trials? _____	
How do you determine if there may be a conflict of interest with any Clinical Investigators or employees? Do you incorporate financial disclosures in your informed consent documents and processes? _____	
Please describe your processes for selecting your Clinical Investigators. How do you audit your Clinical Investigators? Please describe your training and monitoring processes for clinical Investigators _____	
Have you had any evidence of serious regulatory non-compliance or fraud by your clinical investigators and their staff in the last 5 years? If yes, please explain: _____	☐ Yes ☐ No
Do you put your informed consent documents through well-established readability testing, (e.g. the Fleisch-Kincaid Grade Level Scoring)?	☐ Yes ☐ No

Are you in compliance with FDA requirements for financial disclosures? If no, please explain: _____	☐ Yes ☐ No
Has the product, device or drug to be studied received FDA approval and/or CRmark (European equivalence)? If no, please explain: _____	☐ Yes ☐ No
Do you incorporate financial disclosures from your clinical Investigators in your in formed consent documents or process? If no Please explain: _____	☐ Yes ☐ No
Does the CRO draft the protocol?	☐ Yes ☐ No
Does the CRO draft the informed consent?	☐ Yes ☐ No
Is liability coverage sought for the CRO?	☐ Yes ☐ No
Do you audit the CRO's performance?	☐ Yes ☐ No
Have any clinical trials been placed on hold or cancelled? If yes, please provide details: _____	☐ Yes ☐ No
Do your employees provide direct patient care?	☐ Yes ☐ No
Do they carry individual medical malpractice insurance?	☐ Yes ☐ No
Do you operate an inpatient medical facility?	☐ Yes ☐ No

The undersigned agrees that by signing below he/she agrees that the statements contained in this application shall form the basis on which the policy is issued and the applicant warrants all such statements to be true to the best of its knowledge and belief.

Signature of Authorized Representative	
Printed Name of Authorized Representative	
Title	
Date	

Signature of Producer	
Printed Name of Producer	
License #:	
Date	

FRAUD WARNINGS

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.

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 IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

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 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.