Print Form

IRONSHORE your safe harbour	IRONSHORE COMPANIES 175 Powder Forest Drive Weatogue, CT 06089	MANAGED CARE ERRORS & OMISSIONS LIABILITY NEW BUSINESS APPLICATION

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS, ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR WITHIN THE TIME PERIOD SET FORTH IN THE POLICY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES, SETTLEMENTS, OR JUDGMENTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY DEFENSE EXPENSES AND DEFENSE EXPENSES SHALL BE APPLIED AGAINST THE RETENTION. READ THE ENTIRE APPLICATION BEFORE SIGNING.

ALL APPLICANTS MUST COMPLETE PART I OF THIS APPLICATION

PART I. GENERAL INFORMATION, OPERATIONS AND STRUCTURE

1.	Name of **Applicant**: (Note: Wherever used, **Applicant** means this entity and any other entities listed in response to question 3)		
	Address:		
	City:	State:	ZIP:
	Website:	www.	Telephone No: ( ) -
	Contact Person:		Title:
	Email Address:		Telephone No: ( ) -
	Name of Risk Manager (*if different from contact person*):		Email Address:

2.	**Applicant** is:	☐ For-Profit Corporation	☐ Not-for-Profit Tax-Exempt Corporation
		☐ Not-for-Profit Taxable Corporation	☐ Limited Liability Company
		☐ Partnership	☐ Joint Venture
		☐ Other (describe):	
	Date of Incorporation:	Date Operations Began:	
	State(s) where **Applicant** operates:		

3. If coverage is desired for any other entities (e.g., subsidiaries, joint ventures, or partnerships), please list each such entity below. If required, list additional entities or provide any additional information on a separate attachment. Please note that coverage for such entities is not automatically available; the terms and conditions of the policy, if issued, will determine actual coverage.

Name and Address	Relationship to Applicant	Description of Operations	Tax Status	Percent Owned

4.	Applicant is:	☐ HMO (network or IPA model)	☐ HMO (staff model)	☐ HMO (combined network and staff)
		☐ PPO	☐ PHO	☐ IPA
		☐ MSO	☐ Third Party Administrator	☐ Utilization Review Organization
		☐ Peer Review Organization	☐ Medical Group or Clinic	☐ Other:

5.	Is Applicant licensed by federal, state or local government? ☐ Yes ☐ No If "Yes", identify the licensing government:
	In what capacity or capacities does the Applicant do business with the state or federal government (i.e., TPA for government employee health plan, offers a Medicare plan, etc.):
	Is the Applicant accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? ☐ Yes ☐ No If "Yes", identify the accrediting or certifying organization(s) and expiration date of the accreditation:
	Has the Applicant's license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? ☐ Yes ☐ No If "Yes", please explain:

6.	REVENUES	Last 12 Months (actual):	Next 12 Months (projected):
	Total Gross Revenues:	$	$
	If this revenue does not match that in the attached audited financials, please explain.		
	Total Gross Revenues from ASO/TPA enrollees:	$	$
	Percent of Gross Revenues from at risk agreements:	%	%
	Note: Wherever used, at risk means capitation, withhold or bonus.		

7.	ENROLLMENT:	Last 12 Months (actual):	Next 12 Months (projected):
	Total Number of Enrollees: *(Note: wherever used, enrollees means covered lives not just covered employees and not member months.) If enrollees are in more than one state, please provide breakdown by state on a separate attachment.*		
	Breakdown of enrollees by type: *(Note: total of enrollees by type should equal total, above)*		
	ASO / TPA enrollees* **(include enrollees managed as HMO, PPO, etc. but for whom the Applicant is not taking risk)*		
	HMO enrollees		
	PPO enrollees		
	POS enrollees		
	Indemnity enrollees		
	Medicare enrollees		
	Medicaid enrollees		
	Other enrollees:		
	For Other, please describe:		

8. HEALTH CARE PROVIDERS:

Total number of physicians under contract:

Total number of employed physicians:

Total number of independent contractor physicians:

Does **Applicant** require and verify that all contracted health care providers (physicians, hospitals, and others) maintain medical malpractice insurance with minimum limits of $1,000,000 / $3,000,000? ☐ Yes ☐ No

If "No", what minimum limits are required?

Does **Applicant** have any provider agreements in which the **Applicant** assumes responsibility for overseeing the quality of the services provided by the health care providers? ☐ Yes ☐ No

9. Please provide details of insurance / self-insurance / reinsurance currently in force (if none, so state):

Type of Coverage	Insurance Carrier(s)	Limits	Deductible / Retention	Premium	Policy Period	If Claims Made, Retroactive Date
Medical Malpractice						
D&O *						
EPLI *						

* Would the **Applicant** be interested in proposals for these coverages? ☐ Yes ☐ No

10. Stock ownership of **Applicant**:

Total number of common shareholders:

Total number of common shareholders who control more than 5% of the **Applicant's** outstanding stock:

Number of **Applicant's**:

Full – time employees: | Part – time employees:

Has the **Applicant** been involved in within the past 36 months, or does the **Applicant** contemplate being involved in within the next 12 months, any of the following, whether or not such transactions were or will be completed?

Merger, acquisition, or consolidation with another entity? ☐ Yes ☐ No

Sale, distribution or divestiture of any assets or stock, other than in the ordinary course of business? ☐ Yes ☐ No

Any registration for a public offering or private placement of securities? ☐ Yes ☐ No

Any new joint ventures? ☐ Yes ☐ No

Any new business activities or services? ☐ Yes ☐ No

Any new Medicare or Medicaid contracts? ☐ Yes ☐ No

If "Yes" to any of the above, please explain and describe the essential terms of each such transaction either here or as an attachment to this application:

11.	ANTITRUST MARKET POSITION:	
	Does Applicant contract with more than 25% of the physicians in any given field of practice (including without limitation primary care, family practice or any specialty) within its geographic service area? If "Yes", please explain:	☐ Yes ☐ No
	Do the Applicant's members control more than 25% of the hospital beds or specialty services within its geographic area? If "Yes", please explain:	☐ Yes ☐ No
	Does Applicant have exclusive contracts with any physicians, hospitals or other providers? If "Yes", please explain:	☐ Yes ☐ No
	Has the Applicant obtained advice from antitrust legal counsel (particularly related to mergers, acquisitions and network development)? If "Yes", please explain:	☐ Yes ☐ No
	Has the Applicant received an opinion from the Federal Trade Commission (FTC) confirming that their activities (such as developing joint ventures or new plans) will not violate antitrust laws? If "Yes", please explain:	☐ Yes ☐ No
	Does the Applicant have any provider agreements that contain "Most Favored" pricing clauses? If "Yes", please explain:	☐ Yes ☐ No
	Does the Applicant have any provider agreements that contain non-compete clauses? If "Yes", please explain:	☐ Yes ☐ No

12. ACTIVITIES OR SERVICES:

Please indicate those managed care activities or services which the Applicant performs or subcontracts now or intends to begin performing or subcontracting within the next 12 months (Note: not all checked services may be covered):

Activity or Service	Yes	No	Yes, For Others For a Fee
Credentialing or peer review of health care providers	☐ (Complete Part II)	☐	☐ (Complete Part II)
Utilization Review	☐ (Complete Part III)	☐	☐ (Complete Part III)
Drafting practice guidelines / clinical pathways	☐	☐	☐
Case management	☐	☐	☐
Disease management	☐	☐	☐
Handling and adjusting of enrollees health care benefit claims	☐ (Complete Part IV)	☐	☐ (Complete Part IV)
Application or enrollment processing for enrollees of health care plans	☐	☐	☐
Billing / other processing of enrollees claims under health care plans	☐	☐	☐
Advertising, marketing, or selling health care plans / products	☐ (Complete Part V)	☐	☐ (Complete Part V)
Establishing health care provider networks to provide managed care	☐	☐	☐
Actuarial services for health care plans	☐	☐	☐
Assisting customers in securing reinsurance	☐	☐	☐

	Activity or Service *(continued)*	
	Banking services such as debit cards for health care spending accounts (please describe)	
	Providing, developing or licensing computer hardware or software to others either as a part of the Applicant's basic services or for a fee (please describe):	
	Services for automobile liability or disability plans (please describe):	
	Third party administration (TPA) for health care plans (please describe):	
	Employee Assistance Program (EAP) services (please describe):	
	Nurse call line (please describe):	
	Any other services (please describe):	

13.	RISK MANAGEMENT:		
	Does the Applicant have a formal risk management program (i.e., a formal overall approach to avoiding situations that might give rise to a claim)?	☐ Yes	☐ No
	Does the Applicant have someone designated as a legislative or executive inquiry ombudsman (i.e., someone who investigates all problems or complaints once they rise to a certain level)?	☐ Yes	☐ No
	Does the Applicant have contracts with any employers or other member groups in which the Applicant assumes any of the employer's liability, fiduciary obligations or decision-making? If "Yes", please explain and attach a copy of the contract.	☐ Yes	☐ No
	Does the Applicant subcontract for services such as Utilization Review or handling or processing of claims to any organization where the subcontracted services are performed outside of the United States? If "Yes", please explain.	☐ Yes	☐ No
	Does the Applicant have any programs which afford members the opportunity to have medical services performed in countries outside of the United States? If "Yes", please explain.	☐ Yes	☐ No
	HIPAA:		
	Has the Applicant modified its policies and procedures such that they are consistent with all of the elements of HIPAA?	☐ Yes	☐ No
	Does the Applicant have a plan for ongoing HIPAA privacy training?	☐ Yes	☐ No
	Does the Applicant have a policy and procedure to address the responsibilities of its Business Partners under HIPAA?	☐ Yes	☐ No
	Compliance:		
	Does the Applicant have a written Corporate Compliance program? If "Yes", how long has it been in place?	☐ Yes	☐ No
	Does the Applicant have an employee hotline as part of the Compliance program? If "Yes", how many calls per month are made to the hotline?	☐ Yes	☐ No

14.	INDIVIDUAL HEALTH INSURANCE POLICIES:		
	Does the Applicant offer individual health insurance policies? (If "No", skip to the next section)	☐ Yes	☐ No
	Does the Applicant offer applications for individual health insurance policies in languages other than English?	☐ Yes	☐ No
	Does the Applicant have policies and procedures which outline how and/or when an agent may assist an applicant for an individual health insurance policy in completing the application for such coverage?	☐ Yes	☐ No

	Does the **Applicant** have written policies and procedures for policy rescission which include an appeal to an independent, external third party?	☐ Yes ☐ No
	If "No", please explain:	
	If "Yes", does the **Applicant** abide by the decisions of the independent third party?	☐ Yes ☐ No
	Does the **Applicant** utilize any financial incentives in its compensation arrangements with people involved in making rescission decisions?	☐ Yes ☐ No

APPLICANT: PLEASE COMPLETE THE FOLLOWING SECTIONS WHICH CORRESPOND TO "YES" ANSWERS IN QUESTION 12 ABOVE. IF NO CORRESPONDING SECTIONS ARE INDICATED, PLEASE PROCEED TO PART VI.

PART II. CREDENTIALING OR PROVIDER SELECTION OF HEALTH CARE PROVIDERS

15.	Total revenue for credentialing / peer review services performed for others for a fee:	Last 12 months (actual):	Next 12 months (projected):
		$	$

16.	Who does the credentialing of contracted health care providers?	**Applicant**:	☐ Yes ☐ No
		Subcontractor:	☐ Yes ☐ No
		Other:	☐ Yes ☐ No
	If credentialing is subcontracted:	Does the **Applicant** review or audit the process?	☐ Yes ☐ No
		Is subcontractor required to maintain errors and omissions insurance?	☐ Yes ☐ No
		What minimum limits are required?	
		Does the **Applicant** indemnify the subcontractor?	☐ Yes ☐ No
		Does the subcontractor indemnify the **Applicant**?	☐ Yes ☐ No
17.	Does the **Applicant** have written policies and procedures in place for provider selection, credentialing, re-credentialing, and making decisions which adversely affect a provider's credentials?		☐ Yes ☐ No
	Do the written credentialing procedures follow JACHO or NCQA standards and comply with all applicable laws?		☐ Yes ☐ No
	Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials becomes final?		☐ Yes ☐ No
	Are all providers offered a hearing or appeal prior to termination?		☐ Yes ☐ No
	If "No", please explain:		
	Are grounds for termination of providers clearly expressed by **Applicant** in its contracts?		☐ Yes ☐ No
18.	Is complete documentation maintained on all terminations?		☐ Yes ☐ No
	If "Yes", how long?		
19.	Does the **Applicant** have pay for performance programs and/or tiered networks for its providers?		☐ Yes ☐ No
	If "Yes",	Are the standards for these programs made available to providers?	☐ Yes ☐ No
		Is there an appeals process which is clearly outlined to all providers?	☐ Yes ☐ No

PART III. UTILIZATION REVIEW

20.	Total revenue for utilization review services performed for others for a fee:	Last 12 months (actual):	Next 12 months (projected):
		$	$
	Who does utilization review?	Applicant: ☐ Yes ☐ No	
		Subcontractor: ☐ Yes ☐ No	
		Other: ☐ Yes ☐ No	
	Percentage of benefits denied / avoided in the utilization review process (e.g. denial rate):	Last 12 months (actual):	Next 12 months (projected):
		%	%
	Number of full-time reviewers:		
	Number of part-time reviewers:		
	Number of part-time reviewers expressed as full-time equivalents (FTE's):		
	If utilization review is subcontracted: Does the Applicant review or audit the process? ☐ Yes ☐ No Is subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No What minimum limits are required? Does the Applicant indemnify the subcontractor? ☐ Yes ☐ No Does the subcontractor indemnify the Applicant? ☐ Yes ☐ No		
21.	Does the Applicant have written policies and procedures in place for utilization review, including denials and appeals, which follow NCQA or URAC standards and comply with all applicable laws? ☐ Yes ☐ No If "No", please explain:		
	Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals? ☐ Yes ☐ No Does the Applicant utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers? ☐ Yes ☐ No Does the Applicant have an external review process in all states where it operates? ☐ Yes ☐ No If "Yes", does the Applicant abide by the external review decisions in all cases? ☐ Yes ☐ No If "No", please explain:		
	What percentage of decisions which go through the external review process are ultimately decided in favor of the enrollee?	Last 12 months (actual):	Next 12 months (projected):
		%	%

PART IV. HANDLING AND ADJUSTING OF ENROLLEE'S HEALTH CARE BENEFIT CLAIMS:

22.	Total revenue for claims handling and adjusting services performed for others for a fee:	Last 12 months (actual):	Next 12 months (projected):
		$	$
23.	Number of claims processed:	Number of part-time adjusters expressed as full-time equivalents (FTE's):	
	Number of full-time claim adjusters:		
	Number of part-time claim adjusters:	Percentage of claims denied: %	
	Who does the handling and adjusting of claims for health care benefits:	Applicant: ☐ Yes ☐ No	
		Subcontractor: ☐ Yes ☐ No	
		Other: ☐ Yes ☐ No	

	If claim handling and adjusting are subcontracted:	
	Does the **Applicant** review or audit the process?	☐ Yes ☐ No
	Is subcontractor required to maintain errors and omissions insurance?	☐ Yes ☐ No
	What minimum limits are required?	
	Does the **Applicant** indemnify the subcontractor?	☐ Yes ☐ No
	Does the subcontractor indemnify the **Applicant**?	☐ Yes ☐ No
	Does the **Applicant** utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with claims handlers or adjusters?	☐ Yes ☐ No

PART V. ADVERTISING / MARKETING / SALES		
24.	Do all contracts, sales literature, and brochures expressly identify covered and non-covered procedures?	☐ Yes ☐ No
	Do contracts, sales literature, and brochures expressly refer to all contracted health care providers as independent contractors?	☐ Yes ☐ No
	Do any contracts, sales literature, or brochures make statements or warranties as to the quality of health care, breadth or plan, providing all the needed care or being the "best" plan, etc.?	☐ Yes ☐ No
	Does the **Applicant's** legal counsel review and approve all contracts, sales literature, brochures, advertisements, and other marketing materials prior to their use?	☐ Yes ☐ No
	If enrollee satisfaction surveys are conducted, please attach or describe the results from the most recent survey:	
25.	Does the **Applicant** offer now or plan to offer Medicare Advantage or other government sponsored health care plans?	☐ Yes ☐ No
	If "Yes", does the **Applicant** have policies and procedures that assure compliance with government imposed standards for marketing such plans?	☐ Yes ☐ No

PART VI. CLAIMS INFORMATION

26. During the past five (5) years, no claims such as would fall within the scope of the proposed insurance have been made against the **Applicant** or any individual or entity proposed for coverage, except as follows (include loss payments and defense costs):

If answer is "none", so state:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 26 IS EXCLUDED FROM THE PROPOSED INSURANCE.

27. During the past five (5) years, neither the **Applicant** nor any individual or entity proposed for coverage, has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument, except as follows:

If answer is "none", so state:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 27 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 27 IS EXCLUDED FROM THE PROPOSED INSURANCE.

28. 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 or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance, except as follows:

If answer is "none", so state:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 28 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VII. ATTACHMENTS

29. Please attach copies of the following documents. These documents shall become a part of this Application:

a. Applicant's last 2 audited or accountant–prepared financial statements with notes
b. If the Applicant is newly formed, Pro-Forma financial statements and Business Plan
c. Current loss run(s)
d. Applicant's by-laws
e. Applicant's organization chart
f. Written utilization review procedures, including procedures for denials of benefits and appeals
g. Written credentialing and peer review procedures
h. Sample contract(s) with health care providers (physicians, hospitals, and others)
i. Sample contract(s) with enrollee(s) or membership handbook
j. Sample TPA or ASO contract(s), and
k. Sample sales literature, brochures, advertisements, and other marketing materials (including enrollee packet)

PART VIII. SIGNATURES

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance by the Underwriter upon the Application, and the Application will be the basis of the contract.

The information contained in and submitted with this Application is on file with the Underwriter, and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant will immediately notify the Underwriter, and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand;

a) the policy, if issued, shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Underwriter in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period or within the time period set forth in the policy; and

b) the limit of liability available under the policy if issued, to pay damages, settlements, or judgments shall be reduced, and may be exhausted by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

NOTICE TO 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 AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING – IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATON 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 EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MAINE, 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 MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO MINNESOTA, OHIO, AND ARKANSAS APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO 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 OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY

FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Applicant (signature):		
By (Chairman and / or President – Print Name)	Title:	Date:

NOTE: This Application must be signed by the Chairman or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.