IRONSHORE COMPANIES

175 Powder Forest Drive
Weatogue, CT 06089

MISCELLANEOUS MEDICAL FACILITIES AND PROVIDERS INSURANCE APPLICATION

Answer all questions completely. If any questions do not apply, print "NA" in the space.
Do not use this application for Hospitals or Long-Term Care facilities.

APPLICANT

Applicant Name:	Telephone Number: ( ) - Facsimile Number: ( ) -
Doing Business As:	State of Domicile:
Mailing Address:	

City:	County:	State:	ZIP:

Website:	www.	Annual Revenues:

Applicants Legal Structure: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC — Tax Status: ☐ For Profit ☐ Not for Profit

Do you conduct any business over the internet? ☐ Yes ☐ No If "Yes" please attach a detailed description of your services.

Please list names, locations, and descriptions of all legal entities, including subsidiaries for which the Applicant is a part.

Loc. #	Business Name and Address	Description	Date Acquired	Ownership Percent	Retroactive Date
				%	
				%	
				%	
				%	
				%	

Please describe any acquired or sold entities in the past 5 years:

Number of years this facility has been: Operating: Owned by Present Owners: Managed by Present Management:	List of licenses held by your facility including type and expiration date:

List all accreditations (JCAHO, DHHS, etc.) and association memberships held by your facility and include a copy of the most recent report:

Have you sold, discontinued, or acquired any operations in the past 5 years, or do you plan to do so in the upcoming year?

Do you plan to add any new procedures, products, or services in the upcoming year?

COVERAGE/ LIMITS/ DEDUCTIBLES

Requested Policy Effective Date:	Requested Policy Expiration Date:	Are you currently enrolled in a Patient's Compensation Fund? ☐ Yes ☐ No	Are you requesting General Liability Coverage? ☐ Yes ☐ No
Limits of Liability Professional Liability: ☐ $1,000,000 Each Person/ $3,000,000 Total Limit ☐ $ _____ Each Medical Incident/ $ _____ Total Limit ☐ $ _____ Umbrella Limits (Complete ACORD Application)		Are you requesting Prior Acts? ☐ Yes – Requested Retroactive Date is _____ ☐ No	Deductible (Event Deductible/ Total Deductible) ☐ No Deductible ☐ $10,000/ None ☐ $25,000/ None ☐ $50,000/ None

PROFESSIONAL LIABILITY EXPOSURES

Health Care Services Provided: Check each box that applies and provide projected exposure information for the next twelve months. If you have multiple locations, provide exposure information for each location separately.

Service	Exposure
	Daily Census
☐ Adult Day Care	_____
	Beds
☐ Adult Group Home	_____
Ambulance	Transfers
☐ Ambulance - Emergent	_____
☐ Ambulance – Non-Emergent	_____
	Donations
☐ Blood/ Plasma Bank	_____
	Visits
☐ Cancer Treatment Centers (Non-Radiological)	_____
Cardiac Catheterization Labs	Visits
☐ Cardiac Catheterization Labs - Diagnostic	_____
☐ Cardiac Catheterization Labs - Intervention	_____
	Visits
☐ Crisis Stabilization Center	_____
☐ Developmental Disability Rehabilitation	_____
☐ Dialysis Center	_____
☐ Emergicenter	_____
☐ Gammaknife	_____
☐ Health Dept. – Incl. Community Health Centers	_____
Home Health Center	Visits
☐ Home Health Center- DME	_____
☐ Home Health Center- Intravenous Therapy	_____
☐ Home Health Center- Personal	_____
☐ Home Health Center- Rehabilitation	_____
☐ Home Health Center- Respiratory	_____
☐ Home Health Center- Skilled	_____
☐ Home Health Center- All Other	_____
☐ Hospice Care- Outpatient Only	_____
Organ Bank	Receipts
☐ Organ Bank – Direct Processing	_____
☐ Organ Bank – No Direct Processing	_____
Pharmacies	Receipts
☐ Pharmacies - Contract	_____
☐ Pharmacies - Infusion (No Administration)	_____
☐ Pharmacies – Infusion and Delivery	_____
☐ Pharmacies - Retail	_____
Rehabilitation	Visits
☐ Rehabilitation – All Other (Speech, Art, Clay, etc.)	_____
☐ Rehabilitation – Cardiac	_____
☐ Rehabilitation – Physical/ Occupational	_____
	Hours
☐ Schools - Healthcare Providers Excl. Physicians	_____
	Visits
☐ Sleep Center	_____
	Visits
☐ Student Health Center	_____
Substance Abuse	Visits
☐ Substance Abuse - Counseling - Outpatient Only	_____
☐ Substance Abuse - Skilled Medical	_____
Surgicenter	Visits
☐ Cardiology	_____
☐ Colon & Rectal	_____
☐ Endoscopy/Colonoscopy	_____
☐ Dentist engaged in Oral Surgery	_____
☐ Dermatology	_____
☐ Endocrinology	_____
☐ Gastroenterology	_____
☐ General Surgery	_____
☐ Gynecology	_____

PROFESSIONAL LIABILITY EXPOSURES (cont.)

Imaging	Receipts	Surgicenter (cont.)	Visits
☐ Imaging - CT Scans	_____	☐ Hand Surgery	_____
☐ Imaging - MRI Facilities	_____	☐ Head and Neck Surgery	_____
☐ Imaging - Non-Invasive Radiology Services		☐ Neoplastic Surgery	
☐ Imaging - PET Scans	_____	☐ Neurology	_____
☐ Imaging - Therapeutic (Cobalt, X-Ray,Terahertz)	_____	☐ Ophthalmology Surgery	_____
☐ Imaging - X-Ray(Diagnostic)	_____	☐ Orthopedics, excluding back	_____
		☐ Ear, Nose, and Throat	_____
Laboratory	**Receipts**	☐ Pain Management	_____
☐ Laboratory - All Other	_____	☐ Plastic Surgery	_____
☐ Laboratory - Dental	_____	☐ Podiatrists	_____
☐ Laboratory - Medical/ Pathology/X-Ray	_____	☐ Urology	_____
☐ Laboratory - Ocular	_____	☐ Vascular	_____
☐ Laboratory - Pharmaceutical	_____	☐ Urology	_____
☐ Laboratory - Quality Control/ Reference	_____	☐ Vascular	_____
☐ Laboratory – Routine Clinical Pathology	_____		
	Visits	**Trauma Rehabilitation**	**Visits**
☐ Lithotripsy Centers	_____	☐ Trauma Rehabilitation – Skilled Medical	_____
	Hours	☐ Trauma Rehabilitation – Therapy	_____
☐ Med'l Registry/Staffing/Med'l Employee Contract	_____		Visits
	Visits	☐ Urgicenter	_____
☐ Mental Health Counseling Services - OP Only	_____		Visits
	Receipts	☐ Weight Loss Control	_____
☐ Optical Establishment	_____		

Visits: Count each patient each time they enter your facility for healthcare related services, regardless of the number department visited or the number of procedure/treatments performed within each department. For home care, count each patient each time you visit for health related services.
Annual Receipts: Use gross receipts. Do not adjust this figure for items such as profit, un-collectible accounts, or amounts billed, but not paid

Medical/Dental/Surgical Equipment

1. Owned:
   a. Briefly describe your preventative maintenance program:
   b. If you use a vendor, what limits of liability do you require? $_____Each Occurrence /$_____ Aggregate
      ☐ Do Not Require ☐ Not Applicable

2. Leased:
   a. Do you repair or sell used equipment of others? ☐ Yes ☐ No
      If "Yes", to above please describe in the Comments Section.
   b. Do you service the equipment that you sell or lease? ☐ Yes ☐ No
      If "No", to above who provides the preventative or corrective maintenance? _____
      What limits do you require them to carry? $_____ Each Occurrence /$_____ Aggregate ☐ Do Not Require
   c. Do you repackage or redesign the equipment you sell, rent, or lease? ☐ Yes ☐ No
      If "Yes", to above please describe in the Comments Section.
   d. Is any of the equipment sold with your company's label? ☐ Yes ☐ No
      If "Yes", to above please describe in the Comments Section.
   e. Do you have your own sales staff? ☐ Yes ☐ No
   f. If "Yes", to above are they trained by the manufacturer? ☐ Yes ☐ No
      Please attach a copy of your policies on Sales Staff Training, Preventative Maintenance, and Patient Education.

Comments Section:

GENERAL LIABILITY EXPOSURES – Complete this section if General Liability Coverage is requested.

1. Do you sell or lease any medical equipment or product to patients or other in connection with your operation?
   ☐ Yes ☐ No
   If "Yes" please complete the following information:
   Total Annual Sales $_____ Total Lease/ Rental Receipts:$_____

   a. Category I. Expendable Items – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.) Total Annual Sales $_____Total Lease/ Rental Receipts: $_____

   b. Category II. Non-Expendable Items – Excluding diagnostic or treatment equipment or devices. This category include but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lists or hoist, traction apparatus, ambulatory aids such as walker, stroller, canes crutches, wheelchairs, etc. an prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.
   Total Annual Sales $_____ Total Lease/ Rental Receipts:$_____

   c. Category III. Diagnostic or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.
   Total Annual Sales $_____Total Lease/ Rental Receipts:$_____

   d. Category IV. Life Sustaining or Critical Life Monitoring Equipment or Devices – This category includes dialysis or heart/lung machines, apnea monitors, or any other life dependent monitors or any other equipment or devices that if they malfunction/fail could result in death or serious deterioration in a health condition.
   Total Annual Sales $_____Total Lease/ Rental Receipts:$_____

2. Are you included under the Manufacturer's Products Liability Coverage? ☐ Yes ☐ No

3. Employee Benefits Liability Coverage? ☐ Yes (Number of Employees:_____) ☐ No

4. Please indicate any additional insured to be included under your facility's General Liability Coverage, including an explanation of their interest.

Business Name and Address:	Interest:

ADMINISTRATION AND STAFF

Medical Director

Does the Medical Director provide direct patient care? ☐ Yes ☐ No ☐ NA

Name of Medical Director	Specialty	Insurance Carrier/ Policy Number/ Policy Period	Check One:	Hours per Month*:	Financial Interest*:
			☐ Employee ☐ Contractor		

Physicians/ Surgeons

Name	Specialty	Insurance Carrier/ Policy Number/ Policy Period	Check One:	Hours per Month*:	Financial Interest*:
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		

*Hours/Month - Indicate the total number of hours per month, on average, that each individual works for your facility.
** Financial Interest – Provide the percent of Financial Interest in your Facility. (Owner, Stock, etc.)

Allied Health Care Professionals - indicate number of personnel in each applicable category

	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Aides						
Chiropractors						
Counselors						
Dentists						
Dietitians						
EMT's/ Paramedic's						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/ Clinics						
Occupational Therapists						
Oral Surgeon						
Pharmacists						
Physical Therapists						

Allied Health Care Professionals - indicate number of personnel in each applicable category (cont.)						
	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Physician/Surgeon/First Assistants						
Podiatrists						
Psychologists						
RNs/ LPNs/LVNs						
Social Workers						
Speech Therapists						
Technicians						
Other (describe):______						

Insurance Requirements - Please explain any 'No' answers in the Comments Section

1. Indicate if employed or contracted health care professionals carry professional liability insurance:
   a. Physicians or surgeons? ☐ Yes ☐ No
   b. Oral surgeons, dentists, nurse anesthetists, nurse practitioners, physician assistants, and nurse midwives? ☐ Yes ☐ No
   c. Allied health care professionals? ☐ Yes ☐ No

2. Indicate the minimum professional liability insurance limits required for employed or contracted:
   a. Physicians or surgeons: $_____Each Occurrence $_____ Aggregate
   b. Oral surgeons, dentists, nurse anesthetists, nurse practitioners, physician assistants, and nurse midwives: $_____Each Occurrence $_____ Aggregate
   c. Allied health care professionals: $_____Each Occurrence $_____ Aggregate

3. How often do you verify professional liability insurance limits? ______________________________

Comments Section:

Hiring/ Screening/ Training Procedures for Employees, Contractors and Volunteers

1. Does screening/ hiring procedures include the following:
   a. Educational background ☐ Yes ☐ No
   b. Previous employers/ employment history ☐ Yes ☐ No
   c. Personal references ☐ Yes ☐ No
   d. Hospital privileges ☐ Yes ☐ No
      i. How often do you update your list of specific privileges? _______________
   e. Pending license suspensions or revocations, or any pending disciplinary actions by other facilities? ☐ Yes ☐ No
      Criminal background check: ☐ County ☐ State ☐ Federal ☐ None
   f. Medical professional claims history ☐ Yes ☐ No
   g. Drug/alcohol abuse screening ☐ Yes ☐ No

2. If an individual has had a previous claim, license suspension, or revocation, does that impact your procedures for hiring that person? ☐ Yes ☐ No
   a. Are any additional criteria applied? ☐ Yes ☐ No

3. Are each of the above procedures followed and documented? ☐ Yes ☐ No
   If "No" to above please explain in the comments section.

4. Is training provided for new staff (e.g., aides, volunteers, technicians)? ☐ Yes ☐ No
   If "Yes" to above please describe in the comments section.

5. Are written job descriptions established for all employees and volunteers? ☐ Yes ☐ No

6. Before staff can provide care is a competency-based checklist used to assess and document their skills? ☐ Yes ☐ No

Comments Section:

CONTRACTUAL AGREEMENTS

1. Does Legal Counsel review all contractual agreements? ☐ Yes ☐ No
2. Have you agreed to hold harmless or indemnify others under the contract? ☐ Yes ☐ No
3. Please describe any services provided to other entities:

4. Please describe any contracted services provided to you:

ADMISSION/ DISCHARGE CRITERIA

Please describe any 'No' answers in the Comments Section

1. Is there an admission policy in place? ☐ Yes ☐ No
2. Is there a medical records policy in place? ☐ Yes ☐ No
3. Is there a discharge policy in place? ☐ Yes ☐ No
4. How long are medical records maintained? _____Years ☐ NA

Comments Section:

RISK MANAGEMENT/ QUALITY MANAGEMENT

1. Is there a written, formalized Risk Management/ Quality Management program? ☐ Yes ☐ No
2. Does the governing body periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No
3. Who coordinates the Risk Management program?
   a. Name:
   b. Title:
   c. Telephone Number:
   d. Email Address:
4. Is the Risk Manager accountable and solely responsible for Risk Management? ☐ Yes ☐ No
5. Is the Risk Manager responsible for reviewing incident reports? ☐ Yes ☐ No

POLICY AND LOSS INFORMATION

Losses- Please include loss runs and attach a detailed explanation to any "Yes" answers.

1. Are you aware of any accident, circumstance, or loss that has occurred that might give rise to a claim or suit in the future? ☐ Yes ☐ No
2. Have you had any professional claim or suits made against your facility during the last 5 years? ☐ Yes ☐ No
3. Have you or any of your staff been the subject of disciplinary or investigatory proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
4. Has any insurance company ever canceled, non-renewed, or declined to accept your professional or general liability insurance? ☐ Yes ☐ No
5. Have you been the subject of any license suspension or revocation or been placed under probation? ☐ Yes ☐ No

Provide the following information for Professional Liability Insurance for the current policy year and previous four years:

Policy Period	Carrier	Limits	Deductible/SIR	CM or OCC	Retro Date	Premium

PLEASE INCLUDE THE FOLLOWING INFORMATION:

1. COPY OF ALL MARKETING OR ADVERTISING BROCHURES USED BY FACILITY
2. LOSS HISTORY:
    a. CURRENT EVALUTED LOSS RUNS FOR A MINIMUM OF THE PAST 5 YEARS, INCLUDING CURRENT YEAR
    b. BREAKDOWN OF TOTAL INCURRED LOSSES (PAID AND OUTSTANDING FOR INDEMNITY AND EXPENSES
3. FULL DETAILS OF ALLEGATION ON ALL LOSSES PAID OR OUTSTANDING IN EXCESS OF $50,000
4. CURRENT AUDITED FINANCIAL STATEMENT
5. RISK MANAGEMENT AND QUALITY IMPROVEMENT PLAN

NOTICE TO THE APPLICANT
NOTICE: ANY PERSON WHO KNOWINGLY OR WITH INTENT TO DEFRAUD OR FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE, OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD. **NOTICE TO ARKANSAS, 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 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 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 MAINE, TENNESSEE, VIRGINIA, & 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, AND 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 OHIO 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.

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.

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.

NOTICE TO PUERTO RICO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS FALSE INFOMRATION IN AN INSURANCE REQUEST FORM, OR WHO PRESENTS, HELPS, OR HAS PRESETED A FRUADULENT CLAIM FOR THE PAYMENT OF A LOSS OR OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR TH SAME DAMAGE OR LOSS, WILL INCUR A FELONY, AND UPON CONVICTION WILL BE PENALIZED FOR EACH VIOLATION WITH A FINE OF NO LESS THAN FIVE THOUSAND DOLLARS ($5,000) NO MORE THAN TEN THOUSAND DOLLARS ($10,000); OR IMPRISONMENT FOR A FIXED TERM OF THREE (3) YEARS, OR BOTH PENALTIES. IF AGGRAVATED CIRCUMSTANCES PREVAIL, THE FIXED ESTABLISHED IMPRISONMENT MAY BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS; IF ATTENUATING CIRCUMSTANCES PREVAIL, IT MAY BE REDUCED TO A MINIMUM OF TWO (2) YEARS.

The undersigned represents that he or she is authorized to sign this application on behalf of the **Applicant** and further represents and acknowledges that all information contained in this Application, including any supplements and attachments, is true accurate, and complete; will be relied upon by the Company in determining whether to insure the **Applicant** and at what rate to insure it; and will be considered part of any policy that is issued. The undersigned further represents and acknowledges that the policy applied for provides coverage on a claims made and reported basis, and subject to the policy provisions, will apply to claims or suits that are first made and reported in writing to the company during the policy period unless an extended reporting period applies.

PRODUCER PROFILE		
Company Name:	Telephone Number: ( ) -	Facsimile Number: ( ) -
Business Address:	City, State, Zip:	Email Address:
Surplus lines Agent Name & Telephone Number:	Surplus Lines Agent's License Number:	State in which Surplus Lines Tax is Filed:
Surplus lines Agent Business Address:	Surplus lines Agent City, State, Zip:	New Jersey – Surplus lines Trans Number:
Producer Signature:	Producer Printed Name:	Date:

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.*