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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME MEDICAL EQUIPMENT SUPPLEMENTAL APPLICATION

Pages 1 – 2 and the Fraud Statement must be completed on all submissions.

1. If you would like a quote for Abuse & Molestation, complete Page 3.
2. If you would like a quote for Professional Liability, complete Page 3 - 6.

Applicant Name:_____
DBA:_____
(If more than one entity/subsidiary, please attach description and % owned for each)

☐ For Profit ☐ Non-Profit ☐ Partnership ☐ Other (specify):_____
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: _____

Address: _____
City:_____ State:_____ Zip: _____
Telephone:_____ Fax: _____
Date business established:_____ # of years under present management: _____
Federal Employer Tax I.D. Number: _____
Website address (if available): _____
Name and phone number of person to contact for inspection: _____
Risk Management Contact:_____ Risk Management's Phone: _____
Risk Management Email:_____

SUBMISSION REQUIREMENTS

- PHLY Home Medical Equipment Dealer Supplemental Application
- ACORD Applications (Applicant Information, including Crime and Umbrella)
- Currently valued insurance company loss runs for the current policy period and four prior years

SECTION I - APPLICANT INFORMATION

1. Limits of liability desired:
   ☐ $500,000/$1,000,0000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000
   ☐ Other: $_____ Occurrence / $_____ Aggregate
2. Has the Applicant ever carried insurance that was on a Claims Made basis? ☐ Yes ☐ No
   If yes, what is the Retro Date?_____
3. Total annual Gross Revenues: $_____
   Total receipts from Retail: $_____
   Total receipts from Rentals: $_____
   Total receipts from Wholesale: $_____
   Total receipts from Professional Services: $_____
4. Is the Applicant a member of any State Association? ☐ Yes ☐ No
   If yes, please provide the name of the State Association: _____
5. Is the Applicant a member of any other industry association(s)? ☐ Yes ☐ No
   Please specify: _____
6. Does the applicant manufacture or directly import any products? ☐ Yes ☐ No
   If yes, please explain:

_____

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Products Offered: (percentages must equal 100%)			
Product		**Product**	
☐ Antibiotics Therapy	____%	☐ Oxygen regulators and valves	____%
☐ Apnea monitors	____%	☐ Parenteral Therapy	____%
☐ Apnea monitors - infant	____%	☐ Pharmacy Sales	____%
☐ Auto conversions / modifications	____%	☐ Photo therapy equipment - infants	____%
☐ Beds, commodes	____%	☐ Scooters	____%
☐ Blood Cleansing or recirculation equipment	____%	☐ Safety bar / Grab bar installation	____%
		☐ Safety bar / Grab bar sales	____%
☐ Chemotherapy	____%	☐ Sleep apnea Studies	____%
☐ CPAP / BIPAP	____%	☐ Stair lift - installation	____%
☐ CPM	____%	☐ Stair lift – sales	____%
☐ Diabetic Shoes	____%	☐ Tens Units	____%
☐ Enteral Therapy	____%	☐ Ventilators	____%
☐ Infant beds or cribs	____%	Do you instruct on the use of ventilators? ☐ Yes ☐ No	
☐ Liquid Oxygen	____%	☐ Walkers, crutches, canes	____%
☐ Medical gas piping	____%	☐ Wheel chair - motorized	____%
☐ Nebulizers	____%	☐ Wheel chair – manual	____%
☐ Orthotics & prosthetic sales or fitting	____%	☐ Other:_____	____%
☐ Oxygen Concentrators	____%	☐ Other:_____	____%
☐ Oxygen Cylinders	____%	ABOVE MUST TOTAL 100%:	____%

7. Is the Applicant named as an Additional Insured – Vendor on the manufacturer's or supplier's policy for products? ☐ Yes ☐ No
8. Does the Applicant obtain certificates of insurance from their product suppliers? ☐ Yes ☐ No
9. Has the Applicant ever distributed or directly imported products from a foreign manufacture? ☐ Yes ☐ No
10. Does the Applicant modify any product in any way from its intended use? ☐ Yes ☐ No
    If yes, please explain:

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11. Does the Applicant repackage or re-label any items obtained from suppliers? ☐ Yes ☐ No
12. Do the manufacture's labels remain on the equipment? ☐ Yes ☐ No
13. Are serial numbers of the finished product shown on invoices and complete records of inventory kept? ☐ Yes ☐ No
14. Does the Applicant contract or subcontract labor for any installation, service or repair of any equipment? ☐ Yes ☐ No
    If yes, please explain.

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15. If oxygen is offered, does the applicant offer a 24 hour service program? ☐ Yes ☐ No
16. Does the Applicant service any products not sold or rented by you? ☐ Yes ☐ No
    If yes, please explain:

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17. Does the Applicant repair or perform maintenance on any medical supplies or equipment? ☐ Yes ☐ No
    If yes, please explain:

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18. Does the Applicant provide reconditioning service for mobility equipment? ☐ Yes ☐ No
    If yes, please explain:

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19. 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

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SECTION II - ABUSE AND MOLESTATION ☐ N/A

1. Does the Applicant current insurance program include Abuse and Molestation coverage? ☐ Yes ☐ No
   If yes, what are the limits? $_____
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 you have an incident of abuse? ☐ Yes ☐ No
4. Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No
   If no please explain:

   _____
5. Are there written procedures that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No
6. Is there formal staff training on sexual abuse, including how to recognize the signs? ☐ Yes ☐ No
7. Is there more than one person responsible for the welfare of any single patient? ☐ Yes ☐ No
8. Have any incidents resulted in an allegation of sexual abuse? ☐ Yes ☐ No
9. Was the case settled? ☐ Yes ☐ No
10. Was the case taken to trial? ☐ Yes ☐ No
11. Amount paid for damages to the victim: $_____
12. Does the applicant provide equipment, services or therapy to minors? ☐ Yes ☐ No

SECTION III - PROFESSIONAL LIABILITY ☐ N/A

Supplemental Services (Supplying health care providers to other facilities for a fee): IF "NO" check here: ☐

Type		Type	
Private Homes	%	Hospitals	%
Doctor's Offices	%	Nursing Homes	%
Assisted Living Facilities	%	Other: _____	%

Professional Liability Employees / Independent Contractors – Annual Staffing:

1. Annual Staffing – Employees, Independent Contractors and Volunteers
   Total number of: Full time employees:_____ Part Time Employees:_____ Volunteers:_____

Staffing	# of Employees		# of Contracted		Total Annual Volunteer Hours Worked
	FT	PT	FT	PT	
Psychologist					
Medical Director (Admin Only)					
Nurse Practitioner					
Physician Assistant					
Pharmacist					
Paramedic EMT					
Psychiatrist					
Physician-Hospice					
Pediatrician					
Physician-No Surgery					
Dentist					
Optometrists/Ophthalmologist					
Licensed Social Worker					
Sociologist					
Registered Nurse (RN)					
Licensed Practical Nurse (LPN)					
Physical Therapist					
Optician					
Orthotics & Prosthetics (O&P) Certified Practitioner					
Counselor (Guidance, Vocational)					
Social Worker					
Occupational Therapist					
Speech Therapist					

Clergy / Rabbi / Pastor					
O&P Certified Technician					
Teacher					
Nutritionist / Dietician					
Residential Manager					
Home Health Aide					
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.

2. **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.**
3. **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.**
4. Describe any additional contracted Home Health Care operations (if different from above types):

5. Describe any changes in operations planned within the next year:

6. Has the Applicant ever been under investigation or convicted by any state or local authorities, the FBI or Department of Justice? ☐ Yes ☐ No
   If yes, please explain:

7. Have any claims / suits been made within the last five years against the Applicant? ☐ Yes ☐ No
   If yes, please attach copy of insurance company loss reports for each claim or suit. (Specify date, description, amount paid and amount outstanding for each claim).
8. Is the Applicant aware of any circumstances which may result in any claim or suit made (including request for medical records)? ☐ Yes ☐ No
   If yes, please explain:

9. Has any company declined, canceled or refused to renew any of the Applicant's Professional Liability Insurance? ☐ Yes ☐ No
   If yes, please explain:

10. Previous Professional Liability Insurance (past five years):

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made only)
			$		
			$		
			$		
			$		
			$		

11. Limits of Liability Desired:
    ☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000
    ☐ Other: $_____ Occurrence / $_____ Aggregate

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SECTION IV - PROFESSIONAL LIABILITY HIRING / SCREENING ☐ N/A

1. Are all employees and contractors screened to rule out drug, alcohol and sexual abuse? ☐ Yes ☐ No
2. Check all methods used in hiring all employees or independent contractors:
   - Drug Testing ☐ Yes ☐ No
   - Criminal Background Checks – Federal ☐ Yes ☐ No
   - Criminal Background Checks – State ☐ Yes ☐ No
   - Reference Checks ☐ Yes ☐ No
   - Personal Interview ☐ Yes ☐ No
   - Sexual Abuse Registry ☐ Yes ☐ No
   - Validate Work History ☐ Yes ☐ No
   - Validate Education ☐ Yes ☐ No
   - Verify Current Certification / Professional License ☐ Yes ☐ No
   - Validate Driver's License ☐ Yes ☐ No
   - Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours) ☐ Yes ☐ No
3. How are references checked: ☐ Written ☐ Verbal ☐ Both
   If verbal only, please explain:

   _____

4. Are all of the above methods done prior to hiring? ☐ Yes ☐ No
   If "no", please explain:

   _____

5. Are job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No
6. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? ☐ Yes ☐ No
7. What is the average staff turnover rate: _____
8. Does the Applicant question prospective employees about any previous involvement as defendants in professional malpractice litigation? ☐ Yes ☐ No
   If no, please explain:

   _____

9. Does the Applicant verify if potential employees and or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them? ☐ Yes ☐ No

SECTION V - PROFESSIONAL LIABILITY RISK MANAGEMENT ☐ N/A

1. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? ☐ Yes ☐ No
   If no, please explain:

   _____

2. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? ☐ Yes ☐ No
3. Are employees required to carry their own individual professional liability coverage? ☐ Yes ☐ No
   Limits of Liability: $_____
4. Are independent contractor's required to carry their own individual professional liability coverage? ☐ Yes ☐ No
   Limits of Liability: $_____
5. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually? ☐ Yes ☐ No
6. Does the Applicant have formal HIPAA compliance procedures in place? ☐ Yes ☐ No
7. Has the Applicant developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures:
   a. Complete treatment plan prescribed by the physician, including follow up plans? ☐ Yes ☐ No
   b. Assessments of clients prior to and after accepting the clients? ☐ Yes ☐ No
   c. Client's care and home visits documented? ☐ Yes ☐ No
   d. Documentation of all homecare training? ☐ Yes ☐ No
   e. All changes in the condition of the client or incidents involving the client documented in the records and reported to the family and physician? ☐ Yes ☐ No
8. Is the overall responsibility for Risk Management assigned to one individual in your organization? ☐ Yes ☐ No

If yes, please list name and title:_____
If no, please describe how these functions are monitored:

_____

9. Does the Applicant have a formal incident report procedure in place? ☐Yes ☐No
10. Is there a peer or committee who review the incident reports to improve upon any allegations previously outlined in the surveys or reports? ☐Yes ☐No
11. Does the Applicant have formal documented training in place for the following:
    a. Crisis Management ☐Yes ☐No
    b. Disposal of Medical waste ☐Yes ☐No
    c. First Aid ☐Yes ☐No
    d. AED Training ☐Yes ☐No
    e. Infusion Therapy ☐Yes ☐No
    f. Safe lifting, transferring, and client handling ☐Yes ☐No
    g. Blood borne Pathogen ☐Yes ☐No
    h. Safe use of equipment ☐Yes ☐No
    i. Other (please list):_____
12. Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)? ☐Yes ☐No
13. Do all contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes include a hold harmless agreement? ☐Yes ☐No
14. Is the staff informed of AIDS/HIV Patients? ☐Yes ☐No
15. Do patient records include the following:
    a. A complete treatment plan prescribed by a physician, including follow-up plans? ☐Yes ☐No
    b. An "informed consent" document obtained and placed in the patient's medical record? (informed consent laws vary by state) ☐Yes ☐No
    c. Patient care home visits meticulously documented? ☐Yes ☐No
    d. Complete medical records maintained on all patients? ☐Yes ☐No
    e. Patient records kept on file (hardcopy of electronic) for a minimum of 6 years? ☐Yes ☐No
    f. All changes in condition and incidents documented to the physician and family? ☐Yes ☐No
    g. Is documentation of all homecare training provided? ☐Yes ☐No
    h. Medications & dosage, including documentation of administering medications? ☐Yes ☐No
    i. A copy of literature given to clients explaining services and fees? ☐Yes ☐No
    j. Termination of services and discharge criteria? ☐Yes ☐No
16. Does the Applicant conduct patient / client surveys? ☐Yes ☐No
17. Are the results of patient / client surveys used to improve day to day operations? ☐Yes ☐No
18. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? ☐Yes ☐No
19. Are medications kept in a locked area to prevent tampering? ☐Yes ☐No
20. Describe the organization's policy for disposal of controlled substances?

_____

SECTION VI – CLAIMS MADE ☐N/A

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

☐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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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

Underwritten by:
Philadelphia Indemnity Insurance Company

CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

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

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1. Annual sales or revenue: $_____

2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? ☐ Yes ☐ No
   If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
   - ☐ a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
   - ☐ b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
   - ☐ c. Credit or Debit Card Information

3. a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? ☐ Yes ☐ No
   b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? ☐ Yes ☐ No
   c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? ☐ Yes ☐ No
   d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? ☐ Yes ☐ No

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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)