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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 DEALERS PROGRAM - ORTHOTICS & PROSTHETIC SUPPLEMENTAL APPLICATION

Pages 1 – 5 must be completed.

Would Applicant like a quote for Abuse & Molestation? ☐ Yes ☐ No If yes, please complete section V on page 6.
Would Applicant like a quote for Automobile? ☐ Yes ☐ No If yes, please complete section VI on page 6.

Applicant Name: _____
DBA: _____
(If more than one entity/subsidiary, please attach description and % owned for each)
☐ For Profit ☐ Non-Profit ☐ Partnership ☐ Other (specify): _____
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: _____

SUBMISSION REQUIREMENTS

- PHLY Home Orthotics & Prosthetic 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: $_____

SECTION II - GENERAL LIABILITY AND PROFESSIONAL LIABILITY INFORMATION

1. Please indicate the estimated annual sales (reimbursements) for each of the following types of operations:

Description	Location # 1 Estimated Annual Sales	Location #2 Estimated Annual Sales	Location #3 Estimated Annual Sales
Practitioner Patient Care: includes all items the Applicant makes, fits, alters or adjusts for individual patients.	$	$	$
Manufacturing: includes items manufactured by Applicant and sold to distributors or facilities. No patient contact.	$	$	$
Wholesale Distribution: includes all items purchased from others that Applicant resells to another facility or distributor.	$	$	$
Retail Countersales: includes items sold directly to customers with no alteration or re-labeling. Includes but is not limited to crutch tips, stump socks, shoes, etc.	$	$	$
Other- describe:	$	$	$

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2. a. Please indicate if the Applicant manufactures, distributes, sells or rents any of the following products by checking Yes or No. If the Applicant checks yes, please indicate the annual sales for that product.

	Yes	No	Annual Sales
Drugs, antibiotics, chemicals and apparatus used to administer them			$
Electrical equipment, Transcutaneous Electric Nerve Stimulators, etc.			$
Equipment or devices that pierce the skin or are implanted			$
Exercise equipment			$
Halos and Cranial Devices If yes, who performs attachment of these devices? ☐Patient Physician ☐O&P Practitioner			$
Hoists, lifts, ramps, glides and related equipment			$
Monitoring devices or diagnostic equipment			$
Orthotic/prosthetic devices primarily sold to sports professionals			$
Oxygen, respiratory support systems, respirators, etc			$
Surgical equipment			$
Traction and related equipment			$
Vehicle control devices			$
Wheelchairs			$

b. Please provide a specific description for any "Yes" responses indicated in question 2a. above and include product brochures with Applicant's submission.

c. Does the manufacturer supplying the equipment or devices provide the Applicant with vendor's coverage? ☐Yes ☐No

d. Does the Applicant replace the manufacturers label with theirs on any wholesale or retail products the Applicant distributes? ☐Yes ☐No

e. Does the Applicant perform maintenance and repair of the equipment themself? ☐Yes ☐No

3. Does the Applicant obtain certificates of insurance from manufacturers and distributors who supply the Applicant with component parts for the orthotic and prosthetic devices that the Applicant fabricates? ☐Yes ☐No

4. Are any products or supplies imported from other countries? ☐Yes ☐No
If yes, on a separate sheet please indicate what type of supplies or products and from which countries.

5. Does the Applicant use any independent contractors for their business (1099)? ☐Yes ☐No

6. Does the Applicant employ contract or subcontract labor for service or repair of products? ☐Yes ☐No

7. Does the Applicant render professional services directly to patients without physician referral? ☐Yes ☐No

8. Does the Applicant perform or assist in any surgical procedures? ☐Yes ☐No

9. Have there been any claims filed or losses paid, or is the Applicant aware of any incidents which might give rise to a suit against them, within the last three (3) years? (Please attach prior carrier loss history) ☐Yes ☐No

10. If the Applicant answered yes to any of the questions above, please explain:

11. 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).

12. 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:

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

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14. 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)
			$		
			$		
			$		
			$		
			$		

15. 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

16. Is the Applicant a member of any State Association? ☐ Yes ☐ No
If yes, please provide the name of the State Association: _____

17. Please indicate if the Applicant is a member of any of the following associations:
American Orthotic and Prosthetic Association ☐ Yes ☐ No
American Academy of Orthotics and Prosthetics ☐ Yes ☐ No
Pedorthic Footwear Association ☐ Yes ☐ No
Other- Describe:_____ ☐ Yes ☐ No

18. Please indicate the number of staff employed in each of the following capacities, number of years employed with the Applicant, and the number of individuals that are certified by The American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) or Board of Certification/Accreditation, International (BOC):
(Please send copies of certification.)

POSITION	# EMPLOYED	YEARS EMPLOYED	# CERTIFIED
Practitioner			
Assistant			
Fitter			
Technician			
Physical Therapist			

19. Please indicate which of the employees identified in question #4 above, are involved in continuing education:
_____

20. Please indicate if Applicant's business is accredited or certified by: ☐ ABC ☐ BOC ☐ Other:_____

21. Please indicate the % of orthotic and prosthetic devises that are fabricated by the following:
Employed Practitioners _____ % Employed Fitters _____ %
Employed Assistants _____ % Central Fabricating Facilities _____ %
Employed Technicians _____ % Other:_____ _____ %

SECTION III - PROFESSIONAL LIABILITY HIRING / SCREENING

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 IV - PROFESSIONAL LIABILITY RISK MANAGEMENT

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 contractors 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 Applicant's organization? ☐Yes ☐No
   If yes, please list name and title: _____
   If no, please describe how these functions are monitored:

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SECTION V - ABUSE AND MOLESTATION

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 the Applicant has 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 VI - AUTO INFORMATION

1. Does the Applicant own or lease any vehicles? ☐ Yes ☐ No
2. Does the Applicant need coverage for non-owned automobiles? ☐ Yes ☐ No
3. Does the Applicant have a program to monitor an employee's personal auto liability insurance program?
   a. At time of hire? ☐ Yes ☐ No
   b. Annually? ☐ Yes ☐ No
4. Does the Applicant run MVRs on all employees?
   a. At time of hire? ☐ Yes ☐ No
   b. Annually? ☐ Yes ☐ No
   c. Randomly (based on accidents or suspicions) ☐ Yes ☐ No
5. What action is taken if an "unacceptable" driver is identified?
6. Do all Applicant's employees or volunteers transport clients in their own automobiles (appointments or errands)? ☐ Yes ☐ No
7. Does the Applicant transport non-ambulatory clients? ☐ Yes ☐ No
8. Does the Applicant contract with an ambulance or livery service to transport clients? ☐ Yes ☐ No
9. How many drivers use personal vehicles for business? F/T*:_____ P/T**:_____ Vol.:_____
   *F/T = Full Time – over 20 hours per week
   **P/T = Part Time – up to 20 hours per week
10. What is the maximum and minimum age of drivers allowed to drive clients? Max: _____ Min: _____
11. Does the Applicant allow personal use of a company-owned vehicle? ☐ Yes ☐ No
12. Does the Applicant make sure travel logs are kept for all drivers? ☐ 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)