**Application for Insurance Coverages for Health Care Organizations**

Coverage provided by

Name of Insurance Company

to Which Application is Made:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSTRUCTIONS:

1. Please type or print clearly in ink.
2. Answer all questions completely for desired coverages. If any questions do not apply, please print “N/A” in the space provided.
3. If applicant needs more space, continue on a separate sheet of your firm’s letterhead and indicate question number. This form must be completed, signed and dated by a Principal or Officer of the firm.
4. PLEASE ATTACH ANY BROCHURES, LITERATURE OR DESCRIPTIVE MATERIALS PROVIDED TO CLIENTS.
5. Attach current annual financial statements.

Check here to apply for the following Coverages:

Professional Liability General Liability

Products Liability Fidelity Bond

Non-owned Auto Liability

1. **APPLICANT INFORMATION**
2. Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if more than one entity/subsidiary, please attach description and % owned for each)

For Profit Not for Profit Partnership Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street PO Box

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip County (Required)

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. FEIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ d) Total # of Employees:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Total Annual Gross Receipts: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ f) Date Business Established:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Required: Attach Principal’s resume if in business less than 3 years)

1. Type of Firm (check all that apply):

Home Health Care Provider Visiting Nurse Agency Supplemental Staffing

Infusion Therapy Provider Nurse Registry Medical Equipment Supplier

Companion Agency Closed Pharmacy Hospice

Other (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **HIRING/SCREENING AND CREDENTIALING PROCEDURES** (may not be applicable in all states)
2. Are employees’/contractors’ references contacted before the employees/contractors are hired/placed? Yes No

How are references checked? Written Verbal Both

1. Does the applicant review criminal background screening results for all clinical employees/contractors Yes No

prior to hire/placement?

If yes, at what level are criminal searches conducted? (check those applicable)

County State Federal Felony Misdemeanor Convictions

1. Does the applicant verify certification and/or professional licensure status of employees and independent Yes No

contractors?

1. Has the applicant formalized a drug and alcohol screening program requiring all employees/contractors to Yes No

satisfy drug and alcohol testing prior to hire/placement and is there a procedure for screening suspect

employees/contractors when drug or alcohol abuse is alleged?

1. Are all employees/contractors required to sign a formal confidentiality statement? Yes No
2. **RISK MANAGEMENT/QUALITY IMPROVEMENT**
3. Is the applicant licensed in all states in which it is operating? Yes No
4. Has the applicant’s license ever been suspended, revoked, voluntarily surrendered, or subject to probate Yes No

in any state?

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant utilize a formal written Quality Improvement and Risk Management Program? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the overall responsibility for risk management assigned to one individual in your firm? Yes No

If yes, please give name and title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please describe how risk management is monitored:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant have a formalized training and education program requiring staff attendance at Yes No

mandatory in-servicing?

1. If the applicant provides advanced skilled care (i.e. ventilator, chemotherapy, radiation therapy, etc., what are the clinical expertise requirements and/or professional training for staff that will provide these services?)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If the applicant enters into contractual agreements, is there a review process requiring the following elements? N/A

* Hold harmless and indemnification clauses favorable to the applicant Yes No
* Insurance requirements Yes No
* Confidentiality clause Yes No
* Terms and renewal conditions clearly outlined Yes No
* Termination clause Yes No
* Defined roles and responsibilities Yes No

Please attach copies of all agreements.

1. **CLAIMS HISTORY**
2. Have any claims/suits been made within the last five (5) years against the applicant? Yes No

If yes, please attach a copy of insurance company loss reports for each claim or suit. Specify date, description, amount paid and amount outstanding for each claim.

1. Is the applicant aware of any circumstances which may result in any claim or suit being made (including Yes No

requests for medical records)?

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has any insurance company or Lloyd’s declined, canceled or refused to renew any of the applicant’s professional liability or related insurance? Yes No

**Note: Missouri applicants do not reply**

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Attach five years currently valued loss runs for all desired lines of coverage
2. **PREVIOUS PROFESSIONAL LIABILITY INSURANCE (PAST 3 YEARS)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Company | Limits of Liability | Effective Dates | Annual Premium | Claims Made  Form or Occurrence Form | Retroactive Date (Claims Made Only) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. **PREVIOUS GENERAL LIABILITY INSURANCE (PAST 3 YEARS)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Company | Limits of Liability | Effective Dates | Annual Premium | Claims Made  Form or Occurrence Form | Retroactive Date (Claims Made Only) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. **PREVIOUS PRODUCTS LIABILITY INSURANCE (PAST 3 YEARS)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Company | Limits of Liability | Effective Dates | Annual Premium | Claims Made  Form or Occurrence Form | Retroactive Date (Claims Made Only) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**PROFESSIONAL LIABILITY SECTION**

**\*(THIS SECTION MUST BE COMPLETED)\***

1. **EMPLOYEES – ANNUAL STAFFING:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employee Type** | **# Full Time** | **# Part Time** | **Annual Hours** | **Annual Payroll** |
| Nurse (RN) |  |  |  |  |
| LPN/LVN |  |  |  |  |
| Nurse Practitioner |  |  |  |  |
| Physical Therapist |  |  |  |  |
| Respiratory Therapist |  |  |  |  |
| Speech Therapist |  |  |  |  |
| Occupational Therapist |  |  |  |  |
| Social Worker |  |  |  |  |
| Pharmacist |  |  |  |  |
| Home Health Aide/CNA |  |  |  |  |
| Homemakers |  |  |  |  |
| Sitter/Companion |  |  |  |  |
| Physician |  |  |  |  |
| X-Ray Technicians |  |  |  |  |
| Medical Directors |  |  |  |  |
| Pharmacy Ass’t/Techs |  |  |  |  |
| Doula |  |  |  |  |
| Other (specify) |  |  |  |  |

1. **INDEPENDENT CONTRACTORS – ANNUAL STAFFING:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Contractor Type** | **# 1099s** | **Annual Hours** | **Amount Paid per 1099s** |
| Nurse (RN) |  |  |  |
| LPN/LVN |  |  |  |
| Nurse Practitioner |  |  |  |
| Physical Therapist |  |  |  |
| Respiratory Therapist |  |  |  |
| Speech Therapist |  |  |  |
| Occupational Therapist |  |  |  |
| Social Worker |  |  |  |
| Pharmacist |  |  |  |
| Home Health Aide/CNA |  |  |  |
| Homemakers |  |  |  |
| Sitter/Companion |  |  |  |
| Physician |  |  |  |
| X-Ray Technicians |  |  |  |
| Medical Directors |  |  |  |
| Pharmacy Ass’t/Techs |  |  |  |
| Doula |  |  |  |
| Other (specify) |  |  |  |

\*If applicant offers services in more than one state, please provide total annual hours and payroll by state

1. **TYPES OF LOCATIONS WHERE SERVICES ARE PROVIDED (TOTAL MUST EQUAL 100%)**

Private Homes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Clinics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Nursing Homes/Assisted/ Doctor’s Offices\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Independent Living\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Laboratories\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Hospitals\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Prison Facilities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Schools\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **TYPES OF SERVICES PROVIDED (TOTAL MUST EQUAL 100%)**

Personal Care/Companion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Training/Certification Program

Rehabilitation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Open to the General Public\_\_\_\_\_\_\_%

Infusion Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Hospice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Blood Transfusion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Supplemental Staffing (Medical)\_\_\_\_%

Pain Management\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ % Supplemental Staffing (Non-Med)\_\_\_%

Chemotherapy­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Respite Care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Surgical Nursing/Operating Techs\_\_\_\_\_\_\_\_% Social Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Describe Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meals on Wheels\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Obstetrical Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Medical Equipment Supplier\_\_\_\_\_\_\_%

Adult Day Care\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Infant/Pediatric Care\_\_\_\_\_\_\_\_\_\_\_\_\_%

Child Day Care\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Retail Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Respiratory Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Closed Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Clinical Trials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Compounding\*\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Radiation Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Mail Order Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_%

Laboratory Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Clinics Owned/Operated\_\_\_\_\_\_\_\_\_\_\_%

Doula\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Other (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Firms providing day care may be required to complete a supplemental application

\*\*Compounding questionnaire required

**GENERAL UNDERWRITING SECTION**

**(Please complete for ALL lines of coverage)**

1. **OWNED OR LEASED PREMISES**

Please attach a separate list of all other locations owned, rented and operated with occupancy of each. List: address of each location, state if you own or lease the location, and describe the occupancy of each building.

1. Are any services provided on your premises (i.e. clinics, day care, infusion, etc.)? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does the applicant own or operate any bed/board facilities? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List all entities to be name as Additional Insureds with names and insurable interest:

|  |  |
| --- | --- |
| 1. Name | 1. Name |
| Address | Address |
| Interest | Interest |

1. Has applicant sold, acquired, or discontinued any operations in the past five years? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRODUCTS LIABILITY SECTION**

1. **MEDICAL EQUIPMENT/SUPPLIERS** (Attach product listing for all products sold, leased or rented and website address if applicable) **Note:** If applicant has locations in more than one state, please provide information on a per state basis.
2. Does the applicant SELL any medical supplies and/or equipment? Yes No

Total Annual Sales: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant provide pharmaceutical products? Yes No

Total Annual Sales: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant RENT or LEASE any medical supplies and/or equipment? Yes No

Total Annual Rental/Leased Receipts: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant REPAIR or DO MAINTENANCE on any medical supplies or equipment? Yes No
2. Total Annual Repair/Maintenance Receipts: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Total Annual Repair/Maintenance Payroll: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have answered “NO” to a) thru d), please skip the remainder of this section. If you have answered “YES” to a) thru d), please complete the remainder of this section.**

CATEGORY I. EXPENDABLE ITEMS – Intended for one time usage and disposed (ie. adhesive tape, bandages, hypodermic needles, etc.) DO NOT INCLUDE PHARMACEUTICAL SALES.

Annual Sales: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CATEGORY II. NON-EXPENDABLE ITEMS – Excluding diagnostic treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids (ie. walkers, strollers, canes, crutches, wheelchairs, etc.), prosthetic devices and I.V. stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.

Annual Sales: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual Lease/Rental Receipts: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 life monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines or sending devices.

Annual Sales: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual Lease/Rental Receipts: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CATEGORY IV LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment/devices whose malfunction, failure or improper function could result in death or serious deterioration in health condition. (Please attach list of Category IV equipment/devices).

Annual Sales: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual Lease/Rental Receipts: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: Total amount of Annual Sales in Categories I-IV must equal amount in Section I. a) above.

Total amount of Annual Lease/Rental Receipts in Categories II-IV must equal amount in Section I. c) above.

1. Does the applicant manufacture any products? Yes No
2. Is the applicant named as an additional insured/vendor on the manufacturer’s policy for any/all products? Yes No

Note: required for any Category IV products. Provide copies of Certificates for Category IV.

1. Does the applicant obtain certificates of insurance from their products suppliers? Yes No
2. Does or has the applicant ever distributed or directly imported products from a foreign manufacturer? Yes No
3. If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. If yes, does the foreign manufacturer have a United States location? Yes No
5. Does the applicant modify any product in any way from its intended use? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant do any repackaging or re-labeling of items obtained from suppliers? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the manufacturer’s label remain on the equipment? Yes No
2. Does the applicant maintain a written quality control program? Yes No
3. Does the applicant perform preventative maintenance on all equipment according to a written schedule? Yes No
4. Is all equipment checked and its condition documented prior to its release? Yes No
5. Are serial numbers of the finished product shown on shipment invoices and complete records kept of Yes No

inventory shipments?

1. Does the applicant use the services of EPA approved contractors for disposal of hazardous waste materials? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant have any exposure to nuclear or radioactive materials? Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. For oxygen, oxygen-related equipment, life sustaining or critical life monitoring equipment or devices describe the 24-hour service, 365-day/year program that exists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does the applicant distribute oxygen cylinders? Yes No

If yes, are they pre-filled or do you fill them at your premises?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant follow FDA and DOT regulations for the sterilization and transportation of oxygen? Yes No
2. Is the applicant required to provide a vendor’s liability endorsement to any 3rd party? Yes No
3. ***When the applicant has oxygen transfilling exposure:***

Applicant has indicated an exposure with filling oxygen on premises. For this exposure confirm the following:

1. Confirm the applicant is FDA approved for transfilling oxygen tanks Yes No
2. Certificates of Analysis are required & purity test is conducted upon every delivery at risk’s site Yes No
3. Lot numbers are received and/or created for both the received product and during filling so that it Yes No

can be traced back to the supplier at any time?

1. Are the employees that are performing transfilling properly trained and certified? Yes No
2. Do oxygen operations take place in a separate room? Yes No
   1. If yes, is this room restricted only to the applicant’s employees and not the general public? Yes No
   2. Is this room clearly marked as restricted to only employees and also marked “NO SMOKING”? Yes No
3. Is a home assessment conducted prior to delivery and set up of any oxygen and its related equipment Yes No

in a patient’s home?

1. When oxygen is provided in the home are “NO SMOKING” signs provided to the patient? Yes No
2. Is the proper use of oxygen reviewed with the patient and the caregiver and sign-off required by all Yes No

parties (patient, caregiver and employee)?

1. ***When applicant has oxygen exposure but tanks are prefilled:***

Applicant has indicated an exposure with pre-filled oxygen on premises. For this exposure, confirm the following:

1. Do oxygen operations take place in a separate room? Yes No

* 1. If yes, is this room restricted only to the applicant’s employees and not the general public? Yes No
  2. Is this room clearly marked as restricted to only employees and also marked “NO SMOKING”? Yes No

2. Is a home assessment conducted prior to delivery and setup of any oxygen and its related equipment Yes No

in a patient’s home?

1. When oxygen is provided in the home are “NO SMOKING” signs provided to the patient? Yes No
2. Is the proper use of oxygen reviewed with the patient and the caregiver and sign-off required by all Yes No

parties (patient, caregiver and employee)?

1. **MAINTENANCE AND/OR REPAIR OF EQUIPMENT**
2. Does the applicant SELL used equipment? Yes No

If yes, please list the gross revenue derived from this operation: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the applicant REPAIR used equipment? Yes No

If yes, please list the gross revenue derived from this operation: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list all types of equipment you repair:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Are manufacturer’s recommendations followed for all repair of equipment? Yes No
2. Does the applicant sell, install or maintain stair gliders or vehicle lifts? Yes No

If yes, provide a list of equipment you sell and/or lease or rent.

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**FIDELITY COVERAGE SECTION**

1. **LIMIT REQUESTED:**  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Note: minimum limit is $10,000)
2. **INTERNAL CONTROLS:**
3. Is countersignature of checks required? Yes No

If no, who signs the checks? (Name and Title)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are bank accounts reconciled by someone who is not authorized to deposit or withdraw from the account? Yes No

If no, is reconciliation of bank accounts done by the owner? Yes No

1. Is the applicant audited at least annually by an independent Certified Public Accountant? Yes No

Does the audit include an inventory audit? Yes No

1. If an audit is not conducted, is an annual review or compilation prepared by an outside party? Yes No
2. **PREVIOUS FIDELITY INSURANCE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Company | Limits of Liabililty | Effective Dates | Annual Premium | Third Party Liability Provided |
|  |  |  |  |  |

**NON-OWNED AUTOMOBILE SECTION**

1. Does the applicant have any company owned vehicles? Yes No
2. How many of the applicant’s employees drive their own vehicles during the course of business, other than driving to and from a single work site? Please include those employees which drive to multiple worksites in a single work day.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does the applicant require ***Employees*** to carry their own automobile liability insurance coverage? Yes No
4. Do any of the applicant’s employees drive ***Client*** owned vehicles during the course of your business? Yes No

If so, how does the applicant verify ***Client*** owned automobile liability insurance coverage is in force?

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e) Does the applicant review Motor Vehicle Reports as a condition of employment? Yes No

If yes, how frequently is this review conducted?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What standards are applied to qualify an acceptable employee driver?

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f) Do any of the applicant’s employees provide client transportation services? Yes No

g) Does the applicant require participation in a safe/defensive driver training/education program? Yes No

1. Has the applicant ever been notified of a claim arising from an automobile incident involving an employee Yes No

driver who was driving during the course of providing services for your business?

If yes, provide details on a separate sheet including incurred claim cost.

**THIS SECTION TO BE COMPLETED BY ALL APPLICANTS**

I/WE hereby declare the above statements and particulars are true to the best of my/our knowledge, and that I/we have not concealed or misstated any material facts, and I/we agree this application shall be the basis of the contract with the Company. If a policy is issued, this application will be attached to and become part of the policy.

**FRAUD WARNINGS**

**NOTICE TO APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ALABAMA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO COLORADO APPLICANTS**: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NOTICE TO KANSAS APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWEDLGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN 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 MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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

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

**NOTICE TO MAINE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR

MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS:** ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY 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 MINNESOTA APPLICANTS:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF 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 OHIO APPLICANTS**: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS**: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO VERMONT APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO

PENALTIES UNDER STATE LAW.

It is understood and agreed that the completion of this application does not bind the company to issue, nor the applicant to purchase the insurance.

Applicant Firm Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please type or print name and title)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Must be signed and dated by Principal or Officer of Firm)

Agent/Broker Information:

Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent/Broker Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent/Broker License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_