Atlantic Specialty Insurance Company

*(Stock company owned by the **OneBeacon Insurance Group**)*

HEALTHCARE ORGANIZATION
MANAGEMENT LIABILITY APPLICATION

NOTICE: THE LIABILITY COVERAGE SECTIONS OF THE HEALTHCARE ORGANIZATION MANAGEMENT LIABILITY POLICY PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. IN NO EVENT WILL THE UNDERWRITER BE LIABLE FOR "DEFENSE EXPENSES" OR OTHER "LOSS" IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

APPLICATION INSTRUCTIONS

Whenever used in this Application, the term "**Applicant**" shall mean the organization identified in response to Question 1 of Section I General Information.

I. GENERAL INFORMATION

1. Name of **Applicant** _____
2. Address of **Applicant**: _____
   City: _____ State: _____ Zip Code: _____ Telephone: _____
   Website: _____

3. State of incorporation: _____ Date of incorporation: _____

4. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:
   Name: _____ Title: _____
   E-Mail Address: _____ Phone: _____ Fax: _____

5. Individual responsible for Human Resources or employment law matters:
   Name: _____ Title: _____
   E-Mail Address: _____ Phone: _____ Fax: _____

II. SPECIFIC INFORMATION

1. Please indicate below which coverages are being requested.
   Note: The requested coverage is not automatically provided. The terms and conditions of the coverage section, if issued, will determine actual coverage.

Coverage Included	Limit of Liability Requested	Retention/Deductible Requested
☐ Directors and Officers Liability	$ _____	$ _____
☐ Employment Practices Liability	$ _____	$ _____
☐ Fiduciary Liability	$ _____	$ _____
☐ Crime	$ _____	$ _____

2. Describe nature of **Applicant's** business:

_____

3. **Applicant** is a: ☐ Not-For-Profit Tax Exempt Organization (Applicable Federal or State Revenue Code _____)
   ☐ Not-For-Profit Taxable Organization
   ☐ For-Profit Corporation
   ☐ Partnership
   ☐ Limited Liability Company
   ☐ Other (please describe): _____

4. Is the **Applicant** owned or operated by a state, city, town or county or by an agency, authority or other governmental or quasi-governmental entity established by state or local law? ☐Yes ☐No
   If "Yes," by whom? _____

5. Complete if **Applicant** has stock or other equivalent ownership instrument:
   (i) Total number of common shareholders: _____
   (ii) Total number of common shares outstanding: _____
   (iii) Total number of common shares owned by officers: _____
   (iv) Total number of shares owned by directors who are not officers: _____
   (v) If any shareholder owns 5% or more of shares, designate name and percentage:
   _____

6. Does the **Applicant** have any publicly traded securities or debt? ☐ Yes ☐ No
   If "Yes," please attach complete details.

7. Please complete the following information:
   (a) Revenues: Previous twelve (12) months: _____
   Projected next twelve (12) months: _____
   (b) Employees: Previous twelve (12) months: _____
   Projected next twelve (12) months: _____
   (c) Total Assets: _____

8. What percentage of revenues does the **Applicant** or any of its **Subsidiaries** receive from government sources?
   ☐None ☐Less Than 50% ☐Greater than 50% to 60%
   ☐Greater than 60% to 70% ☐Greater than 80%

9. Please list all direct and indirect **Subsidiaries**. If included as an attachment herein, check here ☐. If not applicable, please check here ☐.

Name	Nature of Business	Percentage of Ownership	Date Acquired or Created	Domestic or Foreign and Country of Incorporation	Tax Status

Is the **Applicant** requesting coverage to be extended for all listed **Subsidiaries**? ☐Yes ☐No

10. Please list all **Affiliates** or other entities for which the **Applicant** requests coverage (other than **Subsidiaries** above). If included as an attachment herein, check here ☐. If not applicable, please check here ☐.

Name	Nature of Business	Percentage of Ownership	Date Acquired or Created	Domestic or Foreign and Country of Incorporation	Tax Status

11. Has the **Applicant** in the past eighteen (18) months completed or agreed to, or does it contemplate during the next twelve (12) months, any of the following, whether or not such transactions were or will be completed:

(a)	Reorganization or arrangement with creditors under federal or state law?	☐ Yes ☐ No
(b)	Branch, location, facility, office, or subsidiary closings, consolidations or layoffs?	☐ Yes ☐ No
(c)	Mergers, acquisitions or divestitures?	☐ Yes ☐ No
(d)	Branch, location, facility, office or subsidiary closing, consolidations or layoffs?	☐ Yes ☐ No
(e)	Registration for a public or private offering of securities?	☐ Yes ☐ No
(f)	Issuance of any debt or non-taxable bonds?	☐ Yes ☐ No
(g)	Entering into any new government contracts?	☐ Yes ☐ No
(h)	Conversion from non-profit to for-profit status?	☐ Yes ☐ No

If "Yes" to any part of Question 11, please describe the essential terms of each such transaction as an attachment.

III. BUSINESS PRACTICES INFORMATION

1. Does the **Applicant** or any **Subsidiary** have any exclusive contracts with any providers? ☐ Yes ☐ No
   If "Yes," please provide details by separate attachment.

2. Does the **Applicant** or any of its **Subsidiaries** control more than twenty percent (20%) of the market share in any given geographical area of: (a) providers in any given field of practice; (b) hospital beds; (c) healthcare services; or (d) if the **Applicant** provides managed care products or services, the market share of health plan members? ☐ Yes ☐ No
   If "Yes" to Question 2(a), (b), (c) or (d), please provide market share percentages by separate attachment.

3. Is any of the **Applicant**'s or any of its **Subsidiary's** medical malpractice exposure self-insured or insured by means of a funded trust, captive, subsidiary, or reciprocal risk sharing operation? ☐ Yes ☐ No
   If "Yes," please provide details of the insurance program by separate attachment and attach a copy of the most recent actuarial study.

4. Does the **Applicant** or any **Subsidiary** contract with a third party to manage, operate, or administer its facility or operations? ☐ Yes ☐ No

5. Does the **Applicant** or any **Subsidiary** have a plan for ongoing training on HIPAA and other privacy laws? ☐ Yes ☐ No

6. Does the **Applicant** or any **Subsidiary** perform provider selection? If "No," skip to Question 7. ☐ Yes ☐ No
   (a) Are written policies and procedures in place for provider selection? ☐ Yes ☐ No
   (b) Is legal counsel consulted before any adverse recommendation or decision becomes final? ☐ Yes ☐ No
   (c) Within the last two (2) years has the **Applicant** or any **Subsidiary** closed or restricted staff admissions and/or privileges of a provider for reasons other than professional competence, including but not limited to, a conflict of interest? ☐ Yes ☐ No
   If "Yes," how many? _____
   (d) Are there any formal plans for future staff admission/privilege closings or restrictions? ☐ Yes ☐ No
   If "Yes," please provide details by separate attachment.

7. **Applicant** and/or **Subsidiary** Accreditation:
   ☐ American Hospital Association ☐ JCAHO ☐ NCQA ☐ Other: _____
   (a) Has the **Applicant**'s license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? ☐ Yes ☐ No
   (b) Has the JCAHO, NCQA or any other certifying or accrediting body found any **Applicant** to be out of substantial compliance with its certifying or accrediting standards? ☐ Yes ☐ No
   (c) Has any federal or state regulatory authority criticized or noted deficiencies in any of the **Applicant**'s operations, procedures or finances? ☐ Yes ☐ No

8. Has the **Applicant** or any of its **Subsidiaries** voluntarily disclosed to any governmental entity or is it aware of any violations or potential violations of the following:
   (a) Civil False Claims Act? ☐ Yes ☐ No
   (b) Physician Ownership and Self-Referral Act (The Stark Act)? ☐ Yes ☐ No
   (c) Any similar law or regulation? ☐ Yes ☐ No

   If "Yes" to any of the above 8(a) - (c), please attach the complete details.

IV. DIRECTORS AND OFFICERS LIABILITY INFORMATION
Complete if coverage is requested.

1. Attach a complete list of all Directors and Officers of the **Applicant** and its **Subsidiaries** by name, affiliation, and date of nomination.

2. Are Board members elected? ☐ Yes ☐ No
   If "No," please attach complete details.

3. Has the **Applicant** or any **Subsidiary** experienced changes to its Board or to its Key Executives over the past year? If "Yes," please attach complete details. ☐ Yes ☐ No

4. Does the Board hold meetings more than 3 times per year? ☐ Yes ☐ No

5. Does the **Applicant** participate in a risk management program? ☐ Yes ☐ No

6. Does the **Applicant** have any of the following committees? Please check all that apply.
   ☐ Audit ☐ Compensation ☐ Nomination

7. Has the **Applicant**, any of its **Subsidiaries** or any person proposed for coverage been the subject of, or been involved in, any of the following during the past five (5) years:

	Organization	**Persons**
(a) Anti-trust, copyright or patent litigation?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Civil, criminal or administrative proceeding alleging violation of any federal or state securities laws?	☐ Yes ☐ No	☐ Yes ☐ No
(c) Any other criminal actions?	☐ Yes ☐ No	☐ Yes ☐ No

   If "Yes" to any of the above in Question 7, please attach the complete details.

8. Other than those identified in response to Question 7, during the last five (5) years, has the **Applicant**, any **Subsidiary** or any person proposed for coverage been named as a party in any civil action or administrative, alternative dispute resolution or investigative proceeding in his or her capacity as a director, officer, trustee or member of any duly constituted committee of any entity? ☐ Yes ☐ No
   If "Yes," please attach the complete details.

V. EMPLOYMENT PRACTICES LIABLITY AND THIRD PARTY LIABILITY INFORMATION
Complete if coverage is requested.

1. Enter the TOTAL number of Employees (by type) in the boxes below for the **Applicant** and any of its **Subsidiaries** .
   Note: Seasonal, Temporary and Leased Employees are to be included as Part-Time Employees (Non-Union if Domestic).
   Number of Employees in ALL STATES/JURISDICTIONS:

	Domestic		Foreign
	Union	Non-Union	
Full Time			
Part Time			
Total Number of Independent Contractors			
Total Number of Volunteers:			

2. Enter the TOTAL number of Employees (by type) in the boxes below for the **Applicant** and any of its **Subsidiaries**.
Note: Seasonal, Temporary and Leased Employees are to be included as Part-Time Employees (Non-Union if Domestic).
Number of Employees located in CALIFORNIA ONLY:

	Domestic	
	Union	Non-Union
Full Time		
Part Time		
Total Number of Independent Contractors		
Total Number of Volunteers:		

3. Enter the TOTAL number of Employees (by type) in the boxes below for the **Applicant** and any of its **Subsidiaries**.
Note: Seasonal, Temporary and Leased Employees are to be included as Part-Time Employees (Non-Union if Domestic).
Number of Employees located in DC, FLORIDA, MICHIGAN & TEXAS ONLY:

	Domestic	
	Union	Non-Union
Full Time		
Part Time		
Total Number of Independent Contractors		
Total Number of Volunteers:		

4. For the past 3 years, what has been the annual percentage of turnover rate of all employees (all locations)?

   Year _____, _____% Year _____, _____% Year _____, _____%

5. Does the **Applicant** have a Human Resources or Personnel Department? ☐ Yes ☐ No
   If "No," who manages the HR function? Please provide complete details.

6. Does the **Applicant** have written procedures in place regarding:
   (a) Equal Opportunity Employment: ☐ Yes ☐ No
   (b) Anti-discrimination: ☐ Yes ☐ No
   (c) Anti-harassment: ☐ Yes ☐ No
   (d) Compliance with the ADA ☐ Yes ☐ No
   (e) Compliance with the 1991 Civil Rights Act ☐ Yes ☐ No
   (f) Employee disciplinary actions ☐ Yes ☐ No
   (g) Terminations, layoffs and early retirements ☐ Yes ☐ No
   (h) Employee appraisals/review ☐ Yes ☐ No
   If "No" to any of the above, please attach a full explanation.

7. Does the **Applicant** have a manual of its human resources procedures? ☐ Yes ☐ No
   If "Yes," has Legal Counsel reviewed the HR manual in the last two (2) years? ☐ Yes ☐ No

8. Does the **Applicant** have an employee handbook? ☐ Yes ☐ No
   If "Yes," is the employment handbook distributed to all employees or maintained on an Internet location informing employees of their employment rights? ☐ Yes ☐ No

9. Is there a formalized process in place for reporting complaints/harassment? ☐ Yes ☐ No
   If "Yes," are employees advised that this action will not result in a retaliatory action? ☐ Yes ☐ No

10. Does the **Applicant** provide formal anti-discrimination and anti-harassment training for all of its employees? ☐ Yes ☐ No

11. Are employment issues relating to terminations, discrimination, sexual harassment, layoffs, transfers, or promotions handled by the Human Resources Department, outside counsel and/or the Legal Department? ☐ Yes ☐ No
If "No", please attach complete details.

12. During the past 3 years, has the **Applicant**, any **Subsidiary** or any person proposed for coverage been involved in any capacity in any of the following matters?
(a) EEOC, NLRB or other similar administrative proceeding? ☐ Yes ☐ No
(b) Employment-related civil suit? ☐ Yes ☐ No
If "Yes" to either of the above in Question 12, please attach a full description of the details.

VI. FIDUCIARY LIABILITY COVERAGE INFORMATION

Complete if coverage is requested.

1. Please list the **Applicant**'s employee benefits plan(s) for which coverage is requested:

Plan names (Do not include health & welfare plans)	**Total assets** (market value)	**Type of plan***	**Under funded by more than 25%?** (DB only)	**Number of plan participants**

* Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP)

2. If any plan for which coverage is requested holds or invests in securities of the Sponsor Organization or of any subsidiary or affiliate, please provide details, including name of plan, number of shares held, and most recent share value. If no such securities, check here ☐

3. Are assets managed by an investment manager as defined in ERISA? ☐ Yes ☐ No
If "No," or if only some assets are invested by an investment manager as defined in ERISA, please provide details on an attachment.

4. How often is the performance of the plans' investment managers reviewed?
☐ At least semi-annually ☐ Less than semi-annually (Please describe) _____

5. How often do the fiduciaries establish or amend the investment manager's guidelines and goals for the plans?
☐ At least semi-annually ☐ Less than semi-annually (Please describe) _____

6. Do you follow a written procedure to determine the reasonableness of all plan fees, including revenue sharing arrangements? ☐ Yes ☐ No

7. Is any plan a multiemployer or multiple employer plan? ☐ Yes ☐ No
If "Yes", list and identify the types of plans on an attachment.

8. Please list all third party investment, actuarial, legal, administrative and benefits consulting service providers.
_____
If no such service providers, check here ☐

9. Are any plans NOT in compliance with plan agreements or ERISA? ☐ Yes ☐ No
If "Yes," please explain: _____

10. In the past two (2) years, has any plan(s) (or portion of a plan) been sold, transferred or terminated? ☐ Yes ☐ No
If "Yes," please attach details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance.

11. Past activities:
    (a) Has any fiduciary been:
        (i) accused, found guilty or held liable for a breach of trust? ☐ Yes ☐ No
        (ii) convicted of criminal conduct? ☐ Yes ☐ No
    (b) Have any claims (other than for benefits) been made during the past three (3) years against any benefit program or any current or past fiduciary(ies)? ☐ Yes ☐ No
    (c) Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any plan? ☐ Yes ☐ No

    If "Yes" to any of the above in Question 11, please attach a full description of the details.

VII. CRIME COVERAGE INFORMATION
Complete if coverage is requested.

1. Total number of employees of **Applicant** and its **Subsidiaries**: _____

2. Of the total employees listed above, how many employees handle, have access to or maintain records of money, securities or other property including, but not limited to, directors, officers, trustees and any person handling or having access to employee welfare or benefit plan assets? _____

3. Total number of locations of **Applicant** and its **Subsidiaries**: _____
   Domestic locations: _____ Foreign locations: _____ List Countries: _____

4. List all employee theft, forgery, computer fraud or other crime losses discovered by the **Applicant** in the last 5 years, itemizing each loss separately. Include date of loss, description and total amount of loss. (Attach additional pages if necessary.) _____

5. Please describe the services the **Applicant** and its **Subsidiaries** provide for clients (including, but not limited to, accounting, payroll or purchasing functions):
   _____

6. Does the **Applicant** or its **Subsidiaries** have access to client's funds/property (including money, securities, inventory, high value property, banking systems, wire transfer systems, computer systems and sensitive data, etc.)? ☐ Yes ☐ No
   (a) What type of property and dollar amount of value: _____
   (b) Number of employees who will be performing work for your client(s): _____
   (c) Total number of clients: _____

Audit/Internal Controls and Procedures:

7. Were any material weaknesses or significant deficiencies in internal controls identified by your CPA firm or internal audit staff during the current or prior year? ☐ N/A ☐ Yes ☐ No
   If "Yes," please include a description and corrective measures and implementation timeframe.

8. Is there an internal audit department? ☐ Yes ☐ No
   (a) Are all locations audited by the internal audit staff? ☐ Yes ☐ No
   (b) How often? _____

9. Are background checks performed on all new hires? Check all that apply:
   ☐Criminal ☐Prior Employment ☐Credit History ☐References ☐Drug Testing

10. Are mid-employment screenings performed when employees are promoted to sensitive positions? ☐ Yes ☐ No

11. Are newly hired employees provided with a copy of your organization's fraud policy identifying and explaining conflicts of interest and other prohibited behavior? ☐ Yes ☐ No

12. Are employees required to complete conflict of interest disclosure forms annually? ☐ Yes ☐ No
    (a) Is there a system or procedure in place for employees to report violations of your conflict of interest policy? ☐ Yes ☐ No

13. Are employees' building access cards denied immediately upon termination and are all procurement, credit cards, etc. cancelled? ☐ Yes ☐ No

14. Are those who reconcile bank statements prohibited from:
    (a) Handling deposits in the accounts they reconcile? ☐ Yes ☐ No
    (b) Signing checks? ☐ Yes ☐ No

15. Does a second person review the reconciliation with supporting documentation on a monthly basis and initial their approval of the information? ☐ Yes ☐ No

16. Are checks signed only by the owner(s) of the company? ☐ Yes ☐ No

17. Are all checks countersigned? ☐ Yes ☐ No
    (a) If there is no countersignature, who signs the **Applicant**'s checks? _____
    (b) Over what amount is a dual signature required? $_____

18. Is an approved voucher or Positive Pay system used? ☐ Yes ☐ No
    (a) Are check signers instructed to require that all checks be accompanied by properly approved vouchers and/or invoices? ☐ Yes ☐ No

19. Are systems designed so that no employee can control a process from beginning to end (i.e. request a check, approve a voucher and sign a check)? ☐ Yes ☐ No

Purchasing, Vendor and Inventory Controls:

20. How often and by whom are physical inventory counts conducted? _____

21. Are inventory records computerized? ☐ Yes ☐ No

22. Are background checks performed on vendors in order to determine ownership and financial capability prior to doing business with them? ☐ Yes ☐ No

23. Do you have a system to detect payments to fictitious vendors? ☐ Yes ☐ No

24. Is an authorized vendor list utilized and updated annually for all purchases, with competitive bidding required over stated amounts? ☐ Yes ☐ No

25. Are vendors provided with a statement of your conflict of interest and gift policy (prohibiting gifts of any significant value)? ☐ Yes ☐ No

Funds Transfers/Computer System:

26. What is the daily average number and dollar volume of wire transfers? _____

27. Is approval by more than one person required to initiate a wire transfer? ☐ Yes ☐ No

28. Does the **Applicant**'s financial institution call an employee other than one who requested the transfer before acting on the request? ☐ Yes ☐ No

29. Does the **Applicant** receive hard copy confirmations on all wire transfers and are they sent directly to a department not authorized to initiate transfers? ☐ Yes ☐ No

30. Are computer system access codes and passwords changed at least every 60 days? ☐ Yes ☐ No

31. Do any non-employees have access to the computer systems? ☐ Yes ☐ No

VIII. CURRENT INSURANCE INFORMATION

Coverage Sections	The Applicant currently purchases this coverage (Yes)	(No)	Current Limit of Liability	Current Retention	Premium	Current Carrier
Directors & Officers and Organization Liability	☐	☐	$	$	$	
Employment Practices Liability and Third Party Liability	☐	☐	$	$	$	
Fiduciary Liability	☐	☐	$	$	$	
Crime	☐	☐	$	$	$	

IX. CLAIMS AND REPRESENTATIONS/PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES

1. During the past five (5) years, has the **Applicant** or any individual or entity proposed for coverage submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement?

   ☐ Yes ☐ No

   If yes, please provide details: _____

   NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. Is the **Applicant** or any individual or entity proposed for coverage aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No
   If yes, please provide details: _____

   NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

X. ATTACHMENTS

Please attach copies of the following documents for the **Applicant** and all **Subsidiaries** seeking coverage:

1. Last audited or accountant-prepared financial statement with notes;
2. Bylaws and Certificate of Incorporation; and
3. Organization chart.

XI. FRAUD WARNINGS

GENERAL: Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and civil penalties.

NOTICE TO ARKANSAS, MINNESOTA, AND 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, which is a crime.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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 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 employer or employee, insurance company, or self-insured program, files a statement of claim or an application containing any false or misleading information is guilty of a felony of the third degree.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

XII. DECLARATIONS AND SIGNATURES:

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

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

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

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

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Insurer under any policy of a Claim or potential Claim.

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

RETURN COMPLETED APPLICATION PLUS ANY SUPPLEMENTS AND ATTACHMENTS TO YOUR INSURANCE AGENT OR BROKER.

Date	Signature*	Title
_____	_____	_____ Chief Executive Officer

*This Application must be signed by the chief executive officer of the **Applicant** acting as the authorized representative of the person(s) and entity(ies) proposed for this insurance.

Produced By:

Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.:_____ Agent License No.: _____

Address _____

City: _____ State: _____ Zip Code: _____

Submitted By:

Agency: _____

Agency Taxpayer ID or SS No.:_____ Agent License No.: _____

Address _____

City: _____ State: _____ Zip Code: _____

Submit Form