Atlantic Specialty Insurance Company *(Stock company owned by the **OneBeacon Insurance Group**)* One Beacon Lane Canton, MA 02021	OneBeacon PROFESSIONAL INSURANCE®

MANAGED CARE ERRORS AND OMISSIONS LIABILITY APPLICATION

THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS AND CONDITIONS, ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. CLAIM EXPENSES ARE PART OF AND NOT IN ADDITION TO THE LIMIT OF LIABILITY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES WILL BE REDUCED AND MAY BE EXHAUSTED BY CLAIM EXPENSES, AND CLAIM EXPENSES WILL BE APPLIED AGAINST THE RETENTION. WE WILL HAVE NO OBLIGATION TO PAY JUDGMENTS, SETTLEMENTS OR CLAIM EXPENSES ONCE THE APPLICABLE LIMIT OF LIABILITY IS EXHAUSTED.

APPLICATION INSTRUCTIONS: Whenever used in this Application the term "you" means the entity or individual identified in response to Question 1 of PART I TELL US WHO YOU ARE ("Applicant") and all other entities and individuals proposed for this insurance.

PART I. TELL US WHO YOU ARE

1. Name of Applicant:
2. Address:
   City: State: ZIP:
   Website: Telephone:
3. Risk Manager or Contact person and title:
   Email address: Telephone:

4. Your Corporate Structure:
   ☐ For-Profit Private Company ☐ Publicly Traded
   ☐ Not-for-Profit Taxable Corp. ☐ Not-for-Profit Tax-Exempt Corp.
   ☐ Partnership ☐ Limited Liability Company
   ☐ Joint Venture ☐ Other (describe)

5. Date you were incorporated: _____ Date you began operations: _____
   State(s) where you operate:

6. Within the past 36 months or within the next 12 months, have you or do you expect to:
   a) Merge, acquire or consolidate with another entity? ☐ Yes ☐ No ☐ NA
   b) Enter into any new business activities or services? ☐ Yes ☐ No ☐ NA
   If "Yes" to either of the above, please explain and describe the essential terms of each such transaction. (If needed, use an attachment to this Application):

7. If you are seeking coverage for any other entities (e.g., subsidiaries, joint ventures, or partnerships), list each entity below and **include all exposure data**. If needed, list additional entities on a separate attachment. (Please note that coverage for these entities is not automatically included. The policy, if issued, will determine actual coverage.)

Name & Address	Relationship	Description of Operations	Tax Status	Percent Owned

8. You are:

☐ HMO (If so, please indicate: ☐ Staff Model ☐ Network/IPA Model ☐ Combined [both]
☐ PPO ☐ PHO ☐ IPA ☐ Peer Review
☐ Third Party Administrator ☐ Utilization Review Organization ☐ MSO
☐ Medical Group or Clinic ☐ Accountable Care Organization ☐ Medical Home
☐ Other (describe):

PART II. GIVE US YOUR NUMBERS

A. ENROLLMENT:

Note: Wherever used, "enrollees" means covered lives, not just covered employees and not member months.

ENROLLMENT TYPE	ENROLLEES LAST 12 MONTHS As of / /	ENROLLEES ESTIMATE NEXT 12 MONTHS As of / /
HMO		
PPO		
Indemnity		
POS		
ASO		
IPA		
Medicaid		
Medicare		
Vision, Dental, PBM, STD, LTD or Other Carve-Out		
Other (please describe)		
Total Enrollment		

B. REVENUE:

	LAST 12 MONTHS As of / /	ESTIMATE NEXT 12 MONTHS As of / /
Total Revenue (all operations)		
PPO Revenue		
Utilization Review/ Case Management Revenue		
MSO Revenue		
PHO Revenue		
IPA Revenue		
Carve-Out Revenue		
TPA/ Claims Administration Revenue		

C. NUMBER OF HEALTH CARE PROVIDERS:

Provider type	LAST 12 MONTHS As of / /	ESTIMATE NEXT 12 MONTHS As of / /
Contracted Physicians		
Employed Physicians		

D. MANAGED CARE ACTIVITIES:

Please check the managed care activities or services which you perform or subcontract. If you plan on offering any of these services over the next 12 months, please include those as well. Please check all that apply. (Note: not all checked services may be covered):

Activity or Service	You Perform or Subcontract	You Perform for Others for a Fee
Credentialing or peer review of health care providers	☐	☐
Utilization review	☐	☐
Drafting practice guidelines/Critical Pathways	☐	☐
Case management	☐	☐
Disease management	☐	☐
Handling and adjusting of enrollees' health care benefit claims	☐	☐
Application or enrollment processing for enrollees of health care plans	☐	☐
Billing/other processing of enrollees' claims under health care plans	☐	☐
Advertising, marketing, or selling health care plans/products	☐	☐
Establishing health care provider networks to provide managed care	☐	☐
Actuarial services for health care plans	☐	☐
Assisting customers in securing reinsurance	☐	☐
Services for automobile liability or disability	☐	☐
Third party administration (TPA) services	☐	☐
Employee Assistance Program (EAP)	☐	☐
Nurse call line	☐	☐
OTHER (DESCRIBE):	☐	☐
	☐	☐
	☐	☐

IF YOU ARE AN **IPA**, **PHO** OR **MEDICAL GROUP** OR **CLINIC** AND **DO NOT** HAVE CLAIM HANDLING OR UTILIZATION REVIEW RESPONSIBILITIES SKIP PART III D. E. & F.

PART III. TELL US HOW YOU DO IT

A. GENERAL OPERATIONS:

1. Are you licensed by federal, state, or local government? ☐ Yes ☐ No ☐ NA
   If "Yes," identify the licensing government: _____
2. Are you accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? ☐ Yes ☐ No ☐ NA
   If "Yes", identify the accrediting/certifying organization: _____
3. Has your license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? ☐ Yes ☐ No ☐ NA
   If "Yes," please explain: _____
4. Do you have a formal risk management program? ☐ Yes ☐ No ☐ NA
5. Are any of your operations subcontracted?
   - Credentialing ☐ Yes ☐ No ☐ NA
   - Utilization Review ☐ Yes ☐ No ☐ NA
   - Claim Handling ☐ Yes ☐ No ☐ NA
   - Other ☐ Yes ☐ No ☐ NA

6. Are written contracts used for all subcontracted work? ☐ Yes ☐ No ☐ NA
   If "No," please explain:
7. Do you require all subcontractors to carry their own errors and omissions insurance? ☐ Yes ☐ No ☐ NA
   If "Yes," what are required minimum limits?
   If "No," please explain:
8. Do you indemnify the subcontractor? ☐ Yes ☐ No ☐ NA
9. Does the subcontractor indemnify you? ☐ Yes ☐ No ☐ NA
10. Are any of your operations subcontracted outside of the United States? ☐ Yes ☐ No ☐ NA
    If "Yes," please describe:_____

B. HEALTHCARE REFORM:

1. Have you ever provided customer rebates based on Medical Loss Ratio obligations? ☐ Yes ☐ No ☐ NA
   If "Yes," how often?

2. Do you have written policies and procedures surrounding the disbursement of Medical Loss Ratio rebates? ☐ Yes ☐ No ☐ NA
3. Do you publish your Medical Loss Ratio calculation process? ☐ Yes ☐ No ☐ NA
4. Have you ever been sanctioned, fined, investigated or sued for non-compliance related to your Medical Loss Ratio requirements? ☐ Yes ☐ No ☐ NA
5. Do you have an individual that is responsible for compliance with health care reform? ☐ Yes ☐ No ☐ NA
6. Have you ever been sanctioned, fined, investigated or sued for Medicare/Medicaid fraud? ☐ Yes ☐ No ☐ NA
   If "Yes," please explain:
7. Have you made changes to your policies and procedures to comply with all healthcare reform acts? ☐ Yes ☐ No ☐ NA
8. Do you offer quality incentives to providers? ☐ Yes ☐ No ☐ NA
9. Do you disclose and explain the provider incentives to members? ☐ Yes ☐ No ☐ NA
   If "Yes," please provide details re: how and where the information is disclosed:

10. Do you have or plan to form a Medical Home facility? ☐ Yes ☐ No ☐ NA
    If "Yes," please provide details:_____

C. CREDENTIALING:

1. Do your written credentialing procedures comply with JCAHO or NCQA standards and all applicable laws? ☐ Yes ☐ No ☐ NA
2. Does legal counsel review and make recommendations before any final decision which adversely affects a provider's privileges or credentials? ☐ Yes ☐ No ☐ NA
3. Are providers allowed a hearing or appeal prior to termination? ☐ Yes ☐ No ☐ NA
4. Do you clearly express grounds for termination of providers in your contracts? ☐ Yes ☐ No ☐ NA
5. Do you require and verify that all contracted health care providers maintain medical malpractice insurance with minimum limits of $1,000,000/$3,000,000? ☐ Yes ☐ No ☐ NA
   If "No," what minimum limits are required?
6. Do you perform on-site visits of contracted health care providers? ☐ Yes ☐ No ☐ NA
   If "Yes," how often?
7. Do you disclose your reimbursement policies for non-par providers on your website? ☐ Yes ☐ No ☐ NA
   If "No," please explain:
8. Do your subscribers have access to non-par provider rates? ☐ Yes ☐ No ☐ NA
   If "No," please explain:
9. Do you have a provider tiering program? ☐ Yes ☐ No ☐ NA
   If "Yes," please provide details on tiering criteria and appeal process:_____

D. UTILIZATION REVIEW: **SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.**

1. Do you have written policies and procedures for utilization review, including for denials and appeals? ☐ Yes ☐ No ☐ NA
2. Do your written Utilization Review Procedures:
   a) Follow NCQA or URAC standards and comply with all applicable laws? ☐ Yes ☐ No ☐ NA
   b) Require physician review of all proposed denials? ☐ Yes ☐ No ☐ NA
   c) State that enrollees must be notified of all denials and appeals in writing including the identity of the person who makes decisions regarding appeals? ☐ Yes ☐ No ☐ NA
   d) Require consultation with legal counsel when considering appeals? ☐ Yes ☐ No ☐ NA
   e) Allow for a physician to override a practice guideline? ☐ Yes ☐ No ☐ NA
   f) Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers? ☐ Yes ☐ No ☐ NA
   g) Utilize same specialty reviewers for benefit/coverage denials? ☐ Yes ☐ No ☐ NA
   h) Adhere to government mandated external review requirements in the states where you operate? ☐ Yes ☐ No ☐ NA
   i) Utilize the external review process in states where it is not mandated? ☐ Yes ☐ No ☐ NA

E. CLAIM HANDLING: **SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.**

1. Do you utilize profit sharing, risk sharing, or other financial incentives in compensation arrangements with claim handlers or adjusters? ☐ Yes ☐ No ☐ NA

F. ADVERTISING/MARKETING/SALES: **SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.**

1. Do all contracts, sales literature, brochures and marketing materials:
   a) Expressly identify covered and non-covered procedures? ☐ Yes ☐ No ☐ NA
   b) Expressly refer to all contracted providers as independent contractors? ☐ Yes ☐ No ☐ NA
   c) Make statements or warranties as to the quality of health care, breadth of plan? ☐ Yes ☐ No ☐ NA
   d) Go through legal counsel review and approval prior to their use? ☐ Yes ☐ No ☐ NA

PART IV. TELL US WHAT YOU HAVE

Limits of Liability desired: (Each Claim/ Aggregate)

☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$2,000,000
☐ $3,000,000/$3,000,000 ☐ $5,000,000/$5,000,000 ☐ $10,000,000/$10,000,000
☐ $15,000,000/$15,000,000 ☐ $20,000,000/$20,000,000 ☐ Other: $

Retention Desired:

☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000
☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $500,000
☐ $1,000,000 ☐ $2,500,000 ☐ Other: $

Please provide details of insurance/self-insurance/reinsurance currently in force (if none, please state):

Type of Coverage	Insurance Carrier(s)	Limits	Deductible/ Retention	Premium	Policy Period	If Claims Made, Retroactive Date
Managed Care Errors & Omissions						
Medical Malpractice*						
D&O*						
EPL*						
Fiduciary*						
Stop Loss*						
Insolvency*						
Crime*						
Network Security & Privacy *						
Other						

*Would you be interested in proposals for these coverages? If yes, please complete the appropriate section below:

OPTIONAL COVERAGES

For an option containing D&O and/or EPL, please fill out the following:

1. a. Stock ownership of the Applicant:
   Total number of authorized common shares: _____
   Total number of outstanding common shares: _____
   Total number of common shareholders: _____
   Total number of common shares owned by Applicant's directors and officers: _____
   b. As an attachment to this Application, please provide the names and number of shares for all persons or entities that presently own or control, or have stated the intention to acquire, of record or beneficially, more than 5% of Applicant's outstanding stock.
   c. Have there been any changes in Applicant's board of directors or senior management within the past 3 years for reasons other than death or retirement? ☐ Yes ☐ No ☐ NA
   If "Yes," please explain:

   d. Number of your: Full-time employees:_____
   Part-time employees:_____
   e. Within the past 36 months, have you or do you expect to:
   (1) Merge, acquire, or consolidate with another entity? ☐ Yes ☐ No ☐ NA
   (2) Sell, distribute, or divest of any assets or stock? ☐ Yes ☐ No ☐ NA
   (3) Register for a public offering or private placement of securities? ☐ Yes ☐ No ☐ NA
   (4) Form any joint venture? ☐ Yes ☐ No ☐ NA
   (5) Enter into any new business activities or services? ☐ Yes ☐ No ☐ NA
   If "Yes" to any of the above, please explain and describe the essential terms of each such transaction. (If needed, use an attachment to this Application):

For an option containing Network Security and Privacy please fill out the following:

1. Do you employ a Chief Information/Security Officer? ☐ Yes ☐ No ☐ NA
2. Do you have a corporate-wide privacy policy? ☐ Yes ☐ No ☐ NA
3. Have your privacy policies been reviewed and approved by an attorney? ☐ Yes ☐ No ☐ NA
4. How often are your policies reviewed and updated? _____
5. Do you have restricted employee access to private information? ☐ Yes ☐ No ☐ NA
6. Do you have internal training for employees concerning the handling of data security and private, personal and sensitive information? ☐ Yes ☐ No ☐ NA
7. In the past twenty-four (24) months, have you undergone an internal or external privacy audit? ☐ Yes ☐ No ☐ NA
   If "Yes", have all recommendations been implemented? ☐ Yes ☐ No ☐ NA
   If "No", please explain:
8. Do you collect, receive, process, transmit, or maintain private, sensitive, or personal information as part of your business activities? ☐ Yes ☐ No ☐ NA
   a. Is any of this information regulated by HIPAA, GLB, the Data Protection Act or any other law or regulation protecting private, sensitive, or personal information? ☐ Yes ☐ No ☐ NA
   b Do you have written procedures in place to comply with laws governing the handling or disclosure of such information, including any Red Flag Rules? ☐ Yes ☐ No ☐ NA
   c. Do you share private, sensitive, or personal information gathered from customers with third parties? ☐ Yes ☐ No ☐ NA
9. Do you have a vendor approval process? ☐ Yes ☐ No ☐ NA
10. Do you require that contracts with outside companies and vendors require they defend and indemnify you in the event there is any loss arising out of the release or disclosure of private, sensitive, or personal information due to the outside company's or vendor's negligence? ☐ Yes ☐ No ☐ NA
11. Do you have a written and tested:
    a. Disaster recovery plan? ☐ Yes ☐ No ☐ NA
    b. Business continuity plan? ☐ Yes ☐ No ☐ NA
    c. Computer security policy? ☐ Yes ☐ No ☐ NA
    d. Procedure to change default credentials? ☐ Yes ☐ No ☐ NA
12. Do you store sensitive data on laptops or web servers? ☐ Yes ☐ No ☐ NA
    a. If "Yes", is all data that is both "at-rest" and "in-transit" encrypted? ☐ Yes ☐ No ☐ NA
    b. If "No", please describe any offsetting measures:
13. Do you use security and firewall technology? ☐ Yes ☐ No ☐ NA
14. Is it your policy to up-grade all security software as new releases/improvements become available? ☐ Yes ☐ No ☐ NA
15. Do you use anti-virus software? ☐ Yes ☐ No ☐ NA
    a. Is anti-virus software installed on all of your computer systems, including laptops, personal computers, and networks? ☐ Yes ☐ No ☐ NA
16. Do you use intrusion detection software to detect unauthorized access to internal networks and computer systems? ☐ Yes ☐ No ☐ NA
17. Do you have a formal documented user and password procedure in place? ☐ Yes ☐ No ☐ NA
18. Do you limit access to network servers and hardware? ☐ Yes ☐ No ☐ NA
19. Do you provide remote access to your network? ☐ Yes ☐ No ☐ NA
    a. Is remote access restricted to Virtual Private Networks (VPNs)? ☐ Yes ☐ No ☐ NA
20. How often is private/personal/sensitive/valuable information archived?
    a. How long is the information stored?
    b. Is the information stored in an off-premises secondary site? ☐ Yes ☐ No ☐ NA
21. Do you terminate all associated computer access and user accounts when an employee leaves the company? ☐ Yes ☐ No ☐ NA
22. Are your internal networks and computer systems subject to third party audit and monitoring? ☐ Yes ☐ No ☐ NA
    a. If " Yes", when was the last audit?
    b. Have all improvements and recommendations been implemented? ☐ Yes ☐ No ☐ NA
    c. If "No", please explain:

PART V. TELL US ABOUT YOUR CLAIM HISTORY

1. During the past five (5) years, has any claim that would fall within the scope of the proposed insurance been made against you or against any entity or individual proposed for coverage? ☐ Yes ☐ No
   If yes, please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed):

   NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. During the past five (5) years, have you or any entity or individual proposed for coverage, submitted any claims or given notice of any act, error or omission, or course of conduct which you had reason to believe might or could reasonably be forseen 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 OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 AND ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISION OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

3. Are you or any entity or individual proposed for coverage, aware of any act, error or omission, or course of conduct which you have reason to believe may or could reasonably be forseen 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 OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION, OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 3 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VI. WHAT ELSE WE NEED

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application:

1. Currently valued loss runs (if you are currently insured elsewhere) including losses you may be handling within a self insured retention;
2. Your most current audited or accountant-prepared financial statements with notes;
3. If you are newly formed, Pro Forma financial statements;
4. Copies of all promotional or marketing materials that are not readily available on your website;
5. If operation is a start-up, business plans and resumes (including professional qualifications/designations) of all partners, principals and key employees.

If you want a D&O/EPL quote in addition to the above, please include these:

1. The names, occupations, and business affiliations of all your directors and officers.

PART VII. FRAUD WARNINGS

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, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NOTICE TO ALABAMA AND 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 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 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 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, NEW MEXICO AND RHODE ISLAND 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 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 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.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

PART VIII. 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 (togeth er referred to as the "A pplication") are true and complete. The information in this Application is materi al to the risk accepted by us. If a policy is issued i t will be in r eliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the mate rials submitted with it sh all become p art of the p olicy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connecti on with this Application. Our acceptan ce of this Ap plication or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwritin g purposes only and does not constitute notice to us un der any policy of a Claim or potential Claim.

If the information in thi s Application materially ch anges prior to the effecti ve date of the policy, you must notif y us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

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.

APPLICANT		
BY *(CEO, CFO or President)*	TITLE	DATE

NOTE: This Application must be signed by the CEO, CFO and/or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

PRODUCED BY *(Insurance Agent)*	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*	
EMAIL ADDRESS	

SUBMITTED BY *(Insurance Agency)*	INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*		

NOTE: For New Hampshire Applicants, producer's name and signature are required.

Submit Form