Print Application | Clear Application

PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

SLEEP CENTERS AND LABORATORIES

Applicant:_____
Location Address:_____
Mailing Address (if different than above):_____
Phone Number:_____ Fax Number:_____
FEIN:_____ Years in Business:_____
Applicant is an: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other:_____
Description of Operations:_____
Risk Management Contact:_____ Risk Management's Phone:_____
Risk Management Email:_____

SUBMISSION REQUIREMENTS

- Completed, signed, and dated PHLY Sleep Center and Laboratories Supplemental
- Completed ACORD Applications
- Currently valued company loss runs for this policy period plus three year's prior
- Copy of the current license

SECTION I – GENERAL INFORMATION

1. List all the states the Applicant is licensed to do business in:_____
2. Has the Applicant's license ever been suspended, revoked or restricted? ☐ Yes ☐ No
3. Please provide a listing of all subsidiaries, description of operations and percentage of ownership:

Name	Description	% Owned
		%
		%
		%
		%

4. Prior Insurance:

Insurance Carrier	Policy Period	Policy Number	Limits of Liability	Premium Amount	Coverage type (Occurrence / Claims Made)

5. Has the Applicant's insurance coverage ever been canceled or refused renewal? ☐ Yes ☐ No
6. Within the past five years, has the applicant acquired, sold or discontinued any operations? ☐ Yes ☐ No
7. Is this an overnight facility? ☐ Yes ☐ No
   If yes, how many beds?_____
8. Does the applicant perform any treatment or services on the applicant's premises? ☐ Yes ☐ No
   If yes, please describe:

   _____
9. Is the Applicant's facility accredited? ☐ Yes ☐ No
   If yes, by whom?_____
10. Is the Applicant certified for Medicare reimbursement? ☐ Yes ☐ No
11. Total Annual Gross Receipts (last 12 months) $_____
    Total Annual Gross Receipts (next12 months) $_____
12. Gross Receipts by Category:
    Sleep Studies $_____
    Rental/Sale of Equipment $_____
    All other (describe)_____ $_____

Print Application Clear Application

13. Number of Treatments/Procedures:

Treatment/Procedure	Last Year	Prior Year

14. Does the Applicant sponsor any sporting, fundraising or social events? ☐ Yes ☐ No
If yes, please explain:

15. Does the Applicant sell, rent or lease any medical supplies and/or equipment? ☐ Yes ☐ No
If yes, please explain:

16. Is the Applicant named as an additional insured or vendor on the manufacturer's policy for any/all products? ☐ Yes ☐ No

SECTION II – CONTRACTUAL AGREEMENTS

1. Is the Applicant's organization:
☐ privately owned / "freestanding" or ☐ affiliated / owned by another organization
If affiliated / owned by another organization please select one of the following:
☐ Hospital ☐ University ☐ Nursing Home ☐ Other entity (explain)_____
2. Does the Applicant enter into contractual agreements (i.e. hospitals, nursing homes)? ☐ Yes ☐ No
3. Do contractual agreements contain/hold harmless or indemnification clauses favorable to the applicant? ☐ Yes ☐ No
4. Is the Applicant required to name any other entity as an additional insured? ☐ Yes ☐ No
If yes, please list the name and address of each entity and the business relationship.

5. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? ☐ Yes ☐ No
If yes, please attach an explanation (including name of physicians, details of financial relationship and type of referrals).
"Financial Relationship" means all ownership of investment interests, compensation arrangements and medical directorships with applicant.

SECTION III – COVERAGE REQUEST

1. Professional Liability: ☐ Occurrence ☐ Claims Made *Prior Acts Date:_____
(Attach copy of Prior Claims Made Policy Declaration if requesting Prior Acts)
2. If the Applicant checked off claims-made, please check the appropriate box below:
☐ Applicant has purchased the Extended Reporting Period Endorsement on their prior policy.
Name of carrier:_____

☐ Applicant understands that they elected not to purchase the Extended Reporting Period Endorsement on their previous claims-made policy, and they also have elected not to purchase the prior Acts Coverage on the new policy. They understand that they will be uninsured for the period in which their prior claims-made policy existed. Furthermore, the Applicant understands that because of this there will be a gap in the Applicant's insurance coverage.

SECTION IV – STAFFING

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

Staffing	# of Employees		# of Contracted		Total Annual Volunteer Hours Worked
	FT	PT	FT	PT	
Psychologist					
Medical Director (Admin Only)					
Nurse Practitioner					
Physician Assistant					
Pharmacist					
Paramedic EMT					
Psychiatrist					
Physician-Hospice					
Pediatrician					
Physician-No Surgery					
Dentist					
Optometrists/Ophthalmologist					
Licensed Social Worker					
Sociologist					
Registered Nurse (RN)					
Licensed Practical Nurse (LPN)					
Physical Therapist					
Optician					
Orthotics & Prosthetics (O&P) Certified Practitioner					
Counselor (Guidance, Vocational)					
Social Worker					
Occupational Therapist					
Speech Therapist					
Clergy / Rabbi / Pastor					
O&P Certified Technician					
Teacher					
Nutritionist / Dietician					
Residential Manager					
Home Health Aide					
Day Care Worker					
O&P Certified Fitter					
O&P Certified Assistant					
Adoptions					
Foster Care					
*Other (describe): _____					
*Other (describe): _____					

F/T = Full Time – over 20 hours per week/ P/T = Part Time – up to 20 hours per week.
*Please describe "other" staff positions not listed in the above chart in the provided area.

2. **If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**
3. **If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least $1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.**

4. Please provide the following information for the Medical Director and Physicians that provide services at the Applicant's facility:

Name	Insurance Carrier	Policy Limits	State/Lic. #	Specialty / Board Certified	Employee or Contractor	Hours per month

5. Check all the following that apply if obtained, verified, and filed as part of each employee screening and hiring process:
   ☐Application ☐Education / Competency ☐Multi-Sate Registry
   ☐Drug / HIV / Hep.Testing ☐Licenses / Annual Confirmation
6. Does the Applicant question prospects about previous claims or suits? ☐Yes ☐No
7. Are the Applicant's employees required to actively participate in continuing education? ☐Yes ☐No
8. Does the Applicant verify any pending license suspensions, revocations, or pending disciplinary actions? ☐Yes ☐No

SECTION V – ABUSE AND MOLESTATION

1. Does the Applicant's current insurance program include Abuse and Molestation Coverage? ☐Yes ☐No
   If yes, ☐Occurrence or ☐Claims Made – Retro Date:_____ Limit of Liability: $_____
   Carrier:_____ Effective Date: _____
2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? ☐Yes ☐No
3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if the Applicant has incident of abuse? ☐Yes ☐No
4. Are there written complaint procedures and are they displayed prominently? ☐Yes ☐No
   If yes, explain:_____
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? ☐Yes ☐No
6. Are formal written procedures in place for hiring? ☐Yes ☐No
7. Do volunteers work directly with clients? ☐Yes ☐No
8. Is there formal staff training on child/sexual abuse, including how to recognize the signs? ☐Yes ☐No
9. What procedures are in place to make sure no relationship occurs between staff and clients?
   _____
10. Are there procedures prohibiting closed door one-on-one meetings / counseling? ☐Yes ☐No
11. Is there more than one person responsible for the welfare of any single patient? ☐Yes ☐No
12. Have any incidents resulted in an allegation of sexual abuse? ☐Yes ☐No
    Was the case settled? ☐Yes ☐No Was the case taken to trial? ☐Yes ☐No
    Amount paid for damages to the victim: $_____
13. Does the Applicant run criminal background checks on employees? ☐Yes ☐No
14. Does the Applicant run criminal background checks on volunteers? ☐Yes ☐No

SECTION VI – RISK MANAGEMENT

1. What management body oversees the quality of patient care? (i.e. medical directory, advisory board, etc.)
   _____
2. Does the Applicant have a formal written quality assurance and risk management program? ☐Yes ☐No
   If yes: Person Responsible:_____ Title: _____

Print Application Clear Application

3. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers.
   a. Test result interpretation in lab's name: ☐ Yes ☐ No
   b. Consultation in lab's name: ☐ Yes ☐ No
   c. Therapy or any treatment procedures: ☐ Yes ☐ No
   d. Medical, genetic or drug research: ☐ Yes ☐ No
   e. Any type of environmental analysis: ☐ Yes ☐ No
   f. Solely mobile in nature: ☐ Yes ☐ No
   g. Any services to the public (health fairs, shopping mall exhibits, etc.) ☐ Yes ☐ No

   If the Applicant answered "No" to any of the above questions, please provide an explanation:

_____

SECTION VII – PREMISES / LIFE SAFETY

1. Central Station Alarm System for: Fire, Smoke and Break-in? ☐ Yes ☐ No
2. Monitored 24 hours a day? ☐ Yes ☐ No
3. Are all stairs covered with anti-slip treads? ☐ Yes ☐ No
4. Are handrails provided on all stairways? ☐ Yes ☐ No Hallways? ☐ Yes ☐ No
5. Are parking lots free of debris and are surfaces smooth? ☐ Yes ☐ No
6. Is exterior of building well lit? ☐ Yes ☐ No
7. Are the edges of curbs, sidewalks and steps color-coded to identify raised surfaces? ☐ Yes ☐ No
8. Who is responsible for the maintenance of building, such as snow/ice removal? _____
9. Are all areas of buildings with wet pipe sprinkler systems (hidden or unhidden) maintained at a minimum temperature of 40° F, and / or provided with proper insulation or heat tracing to prevent pipe freeze-ups? ☐ Yes ☐ No

SECTION VIII– TESTING RESULTS

1. Who is interpreting or analyzing the results? Who employs this individual?

_____

2. Is there a fee for the service? ☐ Yes ☐ No
3. Are tests administered by a certified Polysomnographic Technologist (PST)? ☐ Yes ☐ No
   Does the PST score the test? ☐ Yes ☐ No
4. Where is the testing done? (check all that apply):
   ☐ DME Facility ☐ Hospital ☐ Patient's Home ☐ Sleep Lab
   a. Please enclose a list of facility locations
   b. How many patients stay overnight at one time? _____
   c. What is the ratio of staff to patients? _____
5. Are professional employees and/or independent contractors required to carry their own insurance? ☐ Yes ☐ No
   a. Does Applicant keep Certificates of Insurance on file? ☐ Yes ☐ No
   b. Does Applicant request to be added on as an additional insured on their policy? ☐ Yes ☐ No
6. Are any drugs or medications provided, used, sold or prescribed? ☐ Yes ☐ No
   a. If Yes, please describe: _____
   b. If yes, prescribed by whom? _____

SECTION IX – CLAIMS

IMPORTANT: *This section must be completed in its entirety.* ***Any*** *malpractice claims or suits in which Applicant has been involved in during the past seven (7) years must be reported.* ***Any*** *incidents or circumstances of which the Applicant is aware of that are likely to give rise to a claim must be reported. Provide copies of suit papers or claimant letters. If the claim is closed, provide copies of settlement or judgment documents or order of dismissal. If reporting more than one incident, suit or claim, photocopy this form for each.*

1. Name of Patient: _____
2. Allegation/Incident: _____
3. Incident Date: _____ Report Date: _____

Print Application Clear Application

4. Was suit filed? ☐ Yes ☐ No
5. Jurisdiction? _____
6. Names of Co-Defendants: _____ ☐ N/A
7. Insurance Carrier(s) covering claim: _____
8. Policy Period(s): _____
9. Final outcome of claim (*This information may be obtained by inquiry of your current or past insurer. Please note that you must personally contact your insurance carrier.)*
   ☐ **Open**: (still pending) Indemnity reserve placed by insurer: $_____
   Defense cost reserve placed by insurer: $_____
   ☐ **Closed**:
   Method of closing: ☐ Dismissed ☐ Withdrawn ☐ Judgment ☐ Settlement
   Total Expenses: Amount of settlement or judgment: $_____ Defense cost: $_____
10. Please provide summary of clinical facts. Applicant's summary must provide an adequate description of their care and treatment of the patient to allow proper evaluation. Please include the following: (Use additional sheets if necessary.)
    a. Patient age and sex: _____
    b. Initial patient condition and diagnosis: _____
    c. Condition and diagnosis at time of incident: _____
    d. Dates and description of treatment rendered: _____
    e. Condition of patient subsequent to treatment: _____
    f. Copies of patient's records and progress notes as appropriate.

SECTION X – CLAIMS MADE

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

☐ N/A (Please proceed to signature section)

Policy Effective Date: _____
Line of Business: _____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? ☐ Yes ☐ No
   If yes, please provide details:

   _____
2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? ☐ Yes ☐ No
   If yes, please provide details:

   _____

Print Application Clear Application

WINTER WEATHER FREEZE PROTECTION

The Winter Weather Freeze Section is mandatory on all risks that have a prior winter freeze loss greater than $25,000 or 10% of the building TIV in the past 5 years OR a location in states commonly experiencing freezing temperatures.

These states include but are not limited to: AL, AR, AZ, CO, CT, DE, DC, GA, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY

1. Can the Applicant reliably confirm that all areas of the Applicant's building with fire sprinkler piping and/ or domestic water lines can be maintained at 45° F or higher? ☐Yes ☐No ☐N/A
   This includes exterior accessed sprinkler riser rooms, as well as attics, crawl spaces, and stairwells if they have water lines in them.
   a. If not, select all freeze protection measures currently in place:
      - ☐Temperature monitoring and remote heating control system (Wi-Fi temperature controls)
      - ☐PHLYSense
      - ☐Other water detection/ notification/ alarm system
      - ☐Backup electrical generator, ensuring building heat at all times
      - ☐Insulation around water pipes in cold areas*
      - ☐Heat tracing for water pipes in cold areas*
      - ☐Antifreeze fire sprinkler system in cold areas*
      - ☐Space heaters or heated forced air in attics, crawl spaces, stairwells with fire sprinklers
      - ☐Other:

      _____

   * Cold areas are defined as portions of a building that cannot be maintained at all times reliably at or above 45° F.
2. Fire Protection and Testing
   a. Is the building provided with an Automatic Fire Sprinkler System (AS)? ☐Yes ☐No ☐N/A
      i. If yes, what type of sprinkler system is installed? ☐Wet-Pipe ☐Dry-Pipe ☐Both
      ii. If yes, approximately what percentage (%) of the building is sprinklered? _____%
      iii. If yes, has the system been tested & inspection by qualified sprinkler contractor within past 12 months & includes a formal winterization review? ☐Yes ☐No ☐N/A
      iv. If yes, are the alarms tied to a 24 hour UL listed monitoring company? ☐Yes ☐No ☐N/A
3. Emergency Water Response (domestic and AS water lines)
   a. Are water shutoff valves (domestic and AS water lines) marked and readily accessible? ☐Yes ☐No ☐N/A
   b. Are water shutoff valves exercised (closed and reopened) at least annually? ☐Yes ☐No ☐N/A
   c. Is the staff qualified to respond and shut off the water main during normal business hours and off hours? ☐Yes ☐No ☐N/A
4. Automatic Water Shutoff Devices
   a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? ☐Yes ☐No ☐N/A
5. Unused/ Vacant Spaces
   a. Does Applicant have a formal process to turn off and drain domestic water lines for these spaces? ☐Yes ☐No ☐N/A
6. Seasonal Occupancies ONLY:
   a. Is there a full-time caretaker/ maintenance personnel on the premise? ☐Yes ☐No ☐N/A
      If yes, select required duties of the caretaker:
      - ☐Regular walkthroughs of the building
        i. How often each day?_____
      - ☐Trained in the location(s) of water shut off valve(s)
      - ☐Inspects taps and leaves them dripping in freeze weather events
      - ☐Shuts off or drains pipes during freezing temperatures
      - ☐Monitors building temperatures ensuring heat is maintained at required levels
      - ☐Responds to power outages
        i. List of required procedures

      _____

   b. If no caretaker is present, has the building been properly winterized including water turned off, pipes drained, heat maintained, proper pipe insulation, etc.? ☐Yes ☐No ☐N/A

Print Application | Clear Application

PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

Underwritten by:
Philadelphia Indemnity Insurance Company

CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

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

---

1. Annual sales or revenue: $_____

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

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

Print Application Clear Application

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE (OR STATEMENT OF CLAIM) CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). **(NOT APPLICABLE IN AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NY, OH, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, LA, MD, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON (IN ALABAMA, MAYBE SUJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF).

APPLICABLE IN CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDLENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

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

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

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

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

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

APPLICABLE IN MAINE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

Print Application Clear Application

APPLICABLE IN NEW JERSEY: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

APPLICABLE IN OHIO: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

APPLICABLE IN OKLAHOMA: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

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

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

APPLICABLE IN VERMONT: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

APPLICABLE IN NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. THIS APPLIES TO AUTO INSURANCE.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, BOARD CHAIR, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)