**Nextassure Insurance Service**
*Next Level of Insurance*

# Allied Healthcare Application

**Effective Date Requested:**_____ **Date Quotation Desired:**_____

| **Coverage Requested:** | **Limits Requested**: |
|---|---|
| ☐ Professional Liability | ☐ $_____ Each Claim/ $_____ Aggregate<br>☐ Other:_____ |
| ☐ General Liability<br>(submit the GL supplemental application) | |
| ☐ Umbrella Liability<br>(submit the Umbrella application) | |

**Instructions:**

- Please type or print clearly.
- Answer **ALL** questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.
- Provide any supporting information on a separate sheet using your letterhead and reference the applicable question number.
- Check all Yes or No answers.
- If any questions do not apply – please indicate with "N/A".
- This form must be completed, dated and signed by a principal of your facility.
- "Applicant" is defined to include the corporate entity, and its employees, volunteers, directors, officers and all others intended for this insurance coverage.

**Supporting Information:**

Along with this completed and signed application, prospective insureds must also submit the following information:

1. Loss Experience Details:
   - **a.** Historical Period: All years of practice
   - **b.** Incurred loss amounts: Breakdown of paid and outstanding loss amounts for indemnity and expenses.
   - **c.** Loss descriptions: For all losses with incurred loss amounts
   - **d.** Scope of Coverage: Loss experience for all insureds and coverages to be considered under this application
2. Copy of the applicant's resume/curriculum vitae
3. Current insurance policy declarations page
4. Most recent accrediting agency and state licensure report
5. Names of all entities to be covered under this policy
6. Safety program and Incident Reporting plan
7. Risk management and quality improvement plan
8. Job description of Risk Manager
9. Hold harmless agreements involving clinical services
10. Marketing brochures and literature
11. Descriptive materials provided to clients
12. Sample copies of staffing contract and patient service agreements

.

**The requested information is necessary before a quotation can be obtained.**

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Email: sales@nextassure.com Web: www.nextassure.com California License # OK39127

## I. Contact Information

| | | | |
|---|---|---|---|
| Applicant Name: | | | |
| Date Business First Established: | | Employer Federal Tax ID Number: | |
| Mailing Address: | | | |
| Practice Address: | | | |
| County of Practice: | | | |
| Contact Name: | | | |
| Contact Phone Number: | | | |
| Contact Fax Number: | | | |
| Contact Email Address: | | | |
| Website Address: | | | |

## II. Operations

1. Organizational Structure

| A. Choose One | B . Choose One |
|---|---|
| ☐ Individual<br>☐ Partnership<br>☐ Corporation<br>☐ Joint Venture<br>☐ Limited Liability Co. | ☐ Profit<br>☐ Non-profit<br>☐ Charitable<br>☐ Government |

| | | |
|---|---|---|
| C. Have there been any changes in ownership or management in the past 12 months? | ☐ Yes | ☐ No |
| D. Identify the number of owners for the corporation or partnership | | |

E. Percentage of receipts obtained for the following payor categories:

Medicare: _____%
Medicaid: _____%
Other public aid:_____%
Private pay:_____%

2. Description of Operations: (check all that apply)

| | | |
|---|---|---|
| ☐ Home Health Care Firm | ☐ Retail Pharmacy | ☐ School / Students |
| ☐ Visiting Nurse Agency | ☐ Closed Pharmacy | ☐ Mental Health Facility |
| ☐ Supplemental Staffing | ☐ Hospice | ☐ Medical Equipment Supplier |
| ☐ Infusion Therapy Firm | ☐ Imaging Center | ☐ Surgical Technicians / Assistants |
| ☐ Nurse Registry | ☐ Physical Therapy | ☐ Other (specify): _____ |

3. Services Provided

| Service | Percentage of total revenue | Service | Percentage of total revenue |
|---|---|---|---|
| ☐ Personal Care or Companion | | ☐ Tracheotomy Care | |
| ☐ Respiratory Therapy | | ☐ Respiratory Care | |
| ☐ Rehabilitation | | ☐ Infant Care | |
| ☐ Radiation Therapy | | ☐ Adult Day Care | |
| ☐ Infusion Therapy | | ☐ Pediatric Care | |
| ☐ Hospice | | ☐ Child Day Care | |
| ☐ Supplemental Staffing | | ☐ Medical Equipment Supplier | |
| ☐ Skilled Care in Nursing Homes | | ☐ Retail Pharmacy | |
| ☐ Obstetrical Services | | ☐ Closed Pharmacy | |
| ☐ Training Consultants | | ☐ Other Services (please specify) | |
| ☐ Meals on Wheels | | | |

4. Specialty Services

| | | |
|---|---|---|
| A. Does the Applicant provide Pediatric Care? | ☐ Yes | ☐ No |
| i. How many employees provide pediatric services? | | |
| ii. What type of services are provided? | | |
| iii. Do you take on tracheotomy/ventilator dependent patients? If yes what is the percentage? | | |
| iv. What is the level of specialized training and experience required? | | |
| v. What percentage of nurse providers meet this requirement? | % | |
| If Apnea Monitors are used: | | |
| i. Number of Monitors owned by Applicant: | | |
| ii. Does the Applicant rent this equipment to others? | ☐ Yes | ☐ No |
| iii. What are the qualifications of the individuals providing this service? | | |
| B. Does the Applicant provide Psychiatric Care? | ☐ Yes | ☐ No |
| i. What are the qualifications of the nursing staff providing psychiatric care? | | |
| ii. Who is responsible for assessing a patient's mental status and developing a treatment plan for home care? | | |
| C. Does the Applicant provide Home Healthcare Services? | ☐ Yes | ☐ No |
| i. Total Revenue from Home Healthcare services? | | |
| ii. Does the Applicant provide any 24-hour services? | ☐ Yes | ☐ No |
| iii. Does the Applicant provide any "live-in" services? If yes, please provide the following information: The percentage of patients that utilize this service. The percentage of Alzheimer, quadriplegic, mentally incapacitated patients. The description of services provided. | ☐ Yes | ☐ No |
| iv. Current number of patients treated in their homes:<br>Total Number of Patients:_____<br>Percentage under 18 years of age:_____%<br>Percentage Adult (19-65):_____% | | |

| | | |
|---|---|---|
| Percentage Senior (over 65):_____% | | |
| v. Does the Applicant provide a flu shot program? | ☐ Yes | ☐ No |
| vi. Are employees required to complete daily work reports? | ☐ Yes | ☐ No |
| vii. Do all patients receiving any level of skilled care have a current and regularly updated physician treatment plan on file? | ☐ Yes | ☐ No |
| D. Does the Applicant provide Supplemental Staffing services? | ☐ Yes | ☐ No |
| i. Total revenues derived from Supplemental Staffing services? $_____<br>Percentage of total revenues by specialized service (must total 100%)<br>☐ Nursing Homes: _____%<br>☐ Hospitals: _____%<br>☐ Clinics: _____%<br>☐ Physician Offices: _____%<br>☐ Adult Day Care Facilities: _____%<br>☐ Psychiatric Facilities: _____%<br>☐ Industrial Facilities: _____%<br>☐ Hospice: _____%<br>☐ Other: _____% Please specify:_____ | | |
| ii. If Supplemental Staffing is provided to Hospitals, please specify services:<br>Percentage of total revenues by specialized service (must total 100%)<br>☐ Obstetrical: _____%<br>☐ Psychiatric: _____%<br>☐ Intensive Care Unit: _____%<br>☐ Neonatal: _____%<br>☐ Emergency Department: _____%<br>☐ Medical/Surgical Unit: _____%<br>☐ Pediatric: _____%<br>☐ Coronary Care Unit: _____%<br>☐ All other units: _____% | | |
| iii. Do you require that agreements you enter into to provide temporary or supplemental staffing to client facilities include the following provisions:?<br>Mutual indemnification and hold harmless agreement?<br>Please provide a copy of the standard contract.<br>Require third parties to carry liability insurance with limits of at least $1M/$3M?<br>Require the third party to provide the Applicant with a certificate of insurance? | ☐ Yes<br><br>☐ Yes | ☐ No<br><br>☐ No |
| E. Does the Applicant provide Mental Health Program Services and utilization? | ☐ Yes | ☐ No |
| i. Outpatient Group Counseling<br>Number of Groups per week: _____<br>Number of persons per group: _____<br>How often does each group meet per week?_____ | ☐ Yes | ☐ No |
| ii. Individual Counseling<br>Number of clients seen weekly:_____ | ☐ Yes | ☐ No |
| iii. Partial Hospitalization/Day Treatment Program<br>Number of patients attending per day_____ | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Number of hours attended daily_____ | | |
| iv. Weekend DUI Intervention Program<br>Number of groups per year: _____<br>Average number of patients attending per day:_____ | ☐ Yes | ☐ No |
| v. Drug Testing/Collections Services<br>Number of drug tests or collections done annually: _____<br>If Yes, please attach a copy of procedures for collection. | ☐ Yes | ☐ No |
| vi. Methadone Maintenance Program<br>If yes, please contact your Agent | ☐ Yes | ☐ No |
| vii. Crisis Hotline<br>Number of calls received annually:_____ | ☐ Yes | ☐ No |
| viii. Any of the following Services: | | |
| Training/Staff Development/Program Design/Consultation | ☐ Yes | ☐ No |
| Legal/Financial Referrals | ☐ Yes | ☐ No |
| Credentialing/Peer Review | ☐ Yes | ☐ No |
| Other Third Party Administration | ☐ Yes | ☐ No |

**III. Exposures**

| | | |
|---|---|---|
| 1. Describe the Management Services provided for others, if any. | | |
| 2. Gross Receipts:<br>Prospective Annual period:<br>Prior Year: | | |
| 3. Does the Applicant provide surgical services? | ☐ Yes | ☐ No |
| 4. Does the Applicant provide services to any of the following:<br>☐ Nursing home, Assisted Living Facility or other Long Term Care Facility<br>☐ Hospital<br>☐ Registry<br>☐ Supplemental Staffing Agency<br>☐ Prison<br>☐ High tech Services<br>☐ Methadone Clinics | | |
| 5. Does the Applicant engage in the following:<br>☐ Formal clinical research under the auspices of an institutional review board<br>☐ Administration of non-FDA approved pharmaceuticals (experimental drugs)<br>☐ Biomedical device research and development<br>☐ Animal Research<br>☐ Teaching Affiliations<br>☐ Revenue Affiliations (i.e. Joint Venture, PPO HMO, etc)<br>☐ Medical and/or Surgical experimentation that is not approved by an Institutional Review Board | | |
| 7. Will new services be provided in the next 12 months?<br>Will any services be discontinued in the next 12 months?<br>Have any services been discontinued in the last 24 months? | ☐ Yes<br>☐ Yes<br>☐ Yes | ☐ No<br>☐ No<br>☐ No |
| 8. Within the next 12 month period, does the Applicant plan to:<br>Obtain another operation or entity?<br>Add to the number of employees?<br>Expand the number of locations? | ☐ Yes<br>☐ Yes<br>☐ Yes | ☐ No<br>☐ No<br>☐ No |

| | | |
|---|---|---|
| 9. Does the Applicant act as or provide services for managed care organizations?<br>If Yes, does the Applicant take any risk under a capitation arrangement with these organizations? | ☐ Yes<br>☐ Yes | ☐ No<br>☐ No |
| 10. Does the Applicant own or manage any residential facilities? | ☐ Yes | ☐ No |
| 11. Does the Applicant prescribe medications to patients? | ☐ Yes | ☐ No |
| 12. Does the Applicant utilize recreational activities in the treatment of patients? | ☐ Yes | ☐ No |

**IV. Professional Employees and Staff**

| | | |
|---|---|---|
| 1. Is the Applicant responsible for the hiring and supervision of the Independent Contractors? | ☐ Yes | ☐ No |
| 2. Does the Applicant employ foreign trained professionals?<br>If Yes, what percentage of employees are foreign trained: _____% | ☐ Yes | ☐ No |

3. Complete the following for contracted physicians:

| Name | Specialty | Board Certified | Board Eligible | Hours worked weekly | Does Physician carry own Malpractice Ins? | Carrier, Limits & Effective Date |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

4. Census of Professional Employees/Independent Contractors

| **Professional Classification** | Total Number of Hours Worked Weekly | Number of Employees | | Number of Contractors | | Annual Payroll |
|---|---|---|---|---|---|---|
| | | FULL | PART | FULL | PART | |
| Addiction Counselor (NAADAC Program) (1) | | | | | | |
| Addiction Counselor (Non-NAADAC) | | | | | | |
| Addiction Interventionist | | | | | | |
| Administrative/Clerical | | | | | | |
| All other Aide, Assistant, or Technician | | | | | | |
| Art, Music, Dance, Pet, and Recreation Therapist | | | | | | |
| Audiologist | | | | | | |
| Auricular & Full Body Acupuncture Therapy and Counseling | | | | | | |
| Auricular Acupuncture Therapy and Counseling | | | | | | |
| Behavioral Analyst | | | | | | |
| Blood Bank Technician | | | | | | |
| Cardiology Technician | | | | | | |
| Case Workers and Case Manager | | | | | | |
| Certified Employee Assistance Professional | | | | | | |
| Certified Tech./ Assistant | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Companion | | | | | | |
| Cytotechnologist | | | | | | |
| Dental Assistant | | | | | | |
| Dental Hygienist | | | | | | |
| Dialysis Technician | | | | | | |
| Dietician/Nutritionist | | | | | | |
| EKG/EEG Technician | | | | | | |
| Health Educator | | | | | | |
| Home Health Aide | | | | | | |
| Homemaker | | | | | | |
| Intern Mental Health/Addiction Counselor | | | | | | |
| Lab Technician | | | | | | |
| Licensed or Certified Mental Health Counselor | | | | | | |
| LPN | | | | | | |
| Marriage and Family Therapists/Counselor | | | | | | |
| Massage Therapist | | | | | | |
| Medical Office Assistant | | | | | | |
| Medical Records Technician | | | | | | |
| Medical Technologist | | | | | | |
| MRI Technician | | | | | | |
| Nurse Aide | | | | | | |
| Nurse Practitioner | | | | | | |
| Nurse/RN | | | | | | |
| Occupational Therapist | | | | | | |
| Paramedics/EMTs (Eligible for Students Only) | | | | | | |
| Pastoral Counselor | | | | | | |
| Pathology Assistant | | | | | | |
| Patient Intake Technician | | | | | | |
| Personal Coach | | | | | | |
| Pharmacist (Mail Order, Nuclear) | | | | | | |
| Pharmacist (Non-Mail Order – Non-Nuclear) | | | | | | |
| Pharmacy Assistant | | | | | | |
| Pharmacy Technician (Dispensing) | | | | | | |
| Phlebotomist | | | | | | |
| Physical Therapist | | | | | | |
| Physician's Assistant | | | | | | |
| Psychological Assistant (Masters Degree) | | | | | | |
| Psychologist (Bachelors or Masters Degree) | | | | | | |
| Psychologist (Doctorate Degree) | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Radiological Technologist | | | | | | |
| Rehabilitation Counselor/Therapist | | | | | | |
| Rehabilitation Counselor/Therapist Assistant | | | | | | |
| Respiratory Assistant | | | | | | |
| Respiratory Therapist | | | | | | |
| Social Worker | | | | | | |
| Speech Therapist | | | | | | |
| Surgical Assistant | | | | | | |
| Surgical Technologist | | | | | | |
| Surgical Technologist/First Assistant | | | | | | |
| Ultrasound Technician | | | | | | |
| Utilization Review Technician | | | | | | |
| Volunteer | | | | | | |
| Wellness Counselor | | | | | | |
| X-Ray Machine Operator/Technician | | | | | | |
| Other: | | | | | | |

**V. License/Certification Information**

| | | |
|---|---|---|
| 1. Licensed Specialty: | | |
| 2. Licensing Agency: | | |
| 3. Applicant Accreditation: | Date Surveyed: | Score: |
| 4. List any other professional degrees, licenses or certifications obtained by Applicant? | | |
| 5. Has a professional licensing board, certification board or professional ethics board taken disciplinary action against the Applicant?<br>Are any disciplinary actions pending? | ☐ Yes<br>☐ Yes | ☐ No<br>☐ No |
| 6. Has the Applicant ever surrendered their license for any reason? | ☐ Yes | ☐ No |
| 7. Has the Applicant's License or Certification ever been revoked, suspended, refused, canceled or voluntarily surrendered?<br>Are any such charges pending against the Applicant? | ☐ Yes<br>☐ Yes | ☐ No<br>☐ No |
| 8. Is the Applicant licensed in all states in which it is operating? | ☐ Yes | ☐ No |

**VI. Risk Management**

| | | |
|---|---|---|
| 1. Has the Applicant ever been convicted of a misdemeanor or felony or is any such charge pending? | ☐ Yes | ☐ No |
| 2. Has any hospital or other healthcare entity ever denied, suspended, non-renewed, revoked, declined or in any way restricted the Applicant's privileges?<br>Has any hospital or other healthcare entity invoked probation against the Applicant? | ☐ Yes<br>☐ Yes | ☐ No<br>☐ No |
| 3. Are complete records kept on all patients? | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| If so, are they stored in locked cabinets/rooms?<br>Does the Applicant require signed release forms for the release of records? | ☐ Yes<br>☐ Yes | ☐ No<br>☐ No |
| 4. Has the Applicant ever had an incident that resulted in an allegation of sexual abuse? | ☐ Yes | ☐ No |
| 5. Does the Applicant have a drug or alcohol addiction or dependency now or in their history? | ☐ Yes | ☐ No |
| 6. Is an informed consent process in place? | ☐ Yes | ☐ No |
| 7. Has the Applicant ever been investigated by a State Health Department, State Licensing Board, or other Governmental Body? | ☐ Yes | ☐ No |
| 8. Does the Applicant conduct patient/client surveys? | ☐ Yes | ☐ No |
| 9. Are written policies and procedures in place regarding the following: | | |
| Advance Directives/Living Wills | ☐ Yes | ☐ No |
| Patient Acceptance | ☐ Yes | ☐ No |
| Incident Reporting | ☐ Yes | ☐ No |
| Medical Record Documentation | ☐ Yes | ☐ No |
| Acceptance of verbal physician orders | ☐ Yes | ☐ No |
| Drug Administration Procedures | ☐ Yes | ☐ No |
| Patient Rights | ☐ Yes | ☐ No |
| Patient Discharge Procedures | ☐ Yes | ☐ No |
| Handling of Complaints | ☐ Yes | ☐ No |
| Employee Training | ☐ Yes | ☐ No |
| Lifting Requirements | ☐ Yes | ☐ No |
| Food Preparation | ☐ Yes | ☐ No |
| Medical Equipment Training | ☐ Yes | ☐ No |
| Chain of Command | ☐ Yes | ☐ No |
| Reporting of Suspected Abuse | ☐ Yes | ☐ No |
| Is compliance with these policies enforced and monitored? | ☐ Yes | ☐ No |

**VII. Employment Practices**

| | | |
|---|---|---|
| 1. Does the Applicant perform criminal background checks on prospective employees? | ☐ Yes | ☐ No |
| 2. Are job descriptions provided for all professional and nonprofessional employees? | ☐ Yes | ☐ No |
| 3. Do employees actively participate in continuing educational programs? | ☐ Yes | ☐ No |
| 4. Does the Applicant verify employment related references? | ☐ Yes | ☐ No |
| 5. Does the Applicant conduct personal interviews? | ☐ Yes | ☐ No |
| 6. Does the Applicant verify certification and/or professional licensure status of employees and independent contractors? | ☐ Yes | ☐ No |
| 7. Does the Applicant confirm in writing any of the following related to prospective employees:<br>Whether their medical professional liability insurance has been denied or cancelled? (Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)<br>Whether they have been involved in any professional liability claims or litigation?<br>Whether any action has ever been taken on their clinical privileges? | ☐ Yes<br>☐ Yes<br>☐ Yes | ☐ No<br>☐ No<br>☐ No |
| 8. Does the Applicant have a supervision plan to monitor staff? If yes, does the plan include surprise checks? | ☐ Yes | ☐ No |
| 9. Are employees screened to rule out drug, alcohol abuse? | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Are employees screened to rule out any allegations against them involving sexual abuse or molestation? | ☐ Yes | ☐ No |
| 10. Does the Applicant have a written crisis management plan for dealing with staff, victims, parents, authorities and media if you have an incident of abuse? | ☐ Yes | ☐ No |

**VIII. Professional Liability Insurance Coverage Information:** (Please list the last 3 years starting with the current.)

| Policy Period | Carrier | Limits | Retention | Premium | CM/Occ |
|---|---|---|---|---|---|
| | | | | | ☐ Claims Made<br>Retro date:_____<br>☐ Occurrence |
| | | | | | ☐ Claims Made<br>Retro date:_____<br>☐ Occurrence |
| | | | | | ☐ Claims Made<br>Retro date:_____<br>☐ Occurrence |

| | | |
|---|---|---|
| 1. Date of Applicant's first claims made Professional Liability Policy: | | |
| 2. Has the Applicant been continuously insured under a claims made professional liability policy since this date? | ☐ Yes | ☐ No |
| 3. Is the Applicant subject to a patient's compensation fund? | ☐ Yes | ☐ No |
| 4. Has the Applicant ever had professional liability insurance canceled or non-renewed?<br>(Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.<br>Nevada Applicants: If you have answered Yes, please provide an explanation.) | ☐ Yes | ☐ No |

**IX. Incident or Claim Information**

| | | |
|---|---|---|
| 1. Are you aware of any of the following events: | | |
| a. Any deaths of clients/patients reported while they were in your care or under your supervision? | ☐ Yes | ☐ No |
| b. Any incidents including slips, trips or falls of a client or patient reported? | ☐ Yes | ☐ No |
| c. Any mistaken procedures executed or incorrect diagnoses rendered? | ☐ Yes | ☐ No |
| d. Any severe drug reaction by a client or patient? | ☐ Yes | ☐ No |
| 2. Are you aware of any events where patients or their relatives have: | | |
| a. Directly accused you or your employees of malpractice? | ☐ Yes | ☐ No |
| b. Exhibited a total disregard of advice or irrational expectations of cure? | ☐ Yes | ☐ No |
| c. Abruptly discontinued care? | ☐ Yes | ☐ No |
| d. Repeated complaints about service or treatment? | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| 3. Has any patient requested release of their records to an attorney? | ☐ Yes | ☐ No |
| 4. Has any professional liability claim or suit ever been made against any Applicant/employee? | ☐ Yes | ☐ No |
| 5. Is the Applicant aware of any fact, circumstance or situation which may lead to any future claim? | ☐ Yes | ☐ No |

**X. Fraud Prevention and Signature**

**NOTICE TO ARKANSAS APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment for 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 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 HAWAII APPLICANTS:** For you protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**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 purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO MINNESOTA APPLICANTS:** A person who submits an application or 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 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 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 the 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.

**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 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 ALL OTHER APPLICANTS:**

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

**BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.**

**THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.**

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|---|---|
| Signature of Applicant | Signature of Broker/Agent |
| Title | Date |
| | Broker/Agent License Number: |
| Date | Signed by Licensed Resident Agent |
| | (Where Required By Law) |