Russell Bond
Insurance Wholesalers

ESOP™

NOTICE:

FOR URGENT CARE, SLEEP CENTERS, CLINICAL RESEARCH, INTRAOPERATIVE NEUROMONITORING, AND SURGICAL CENTERS, PLEASE UTILIZE THE APPLICATIONS SPECIFIC TO THOSE TYPES OF FACILITIES.

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON CLAIMS MADE BASIS AND COMMERCIAL GENERAL LIABILITY COVERAGE WRITTEN ON EITHER A CLAIMS MADE OR AN OCCURRENCE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THE APPLICATION AND ANY SUPPLEMENTAL APPLICATIONS WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED ACCURATELY AND COMPLETELY.

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.**
- **If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.**
- **This form must be completed, dated and signed by the CEO, CFO, Administrator, Executive Director or Risk Manager of the Applicant.**
- **We treat all applications as confidential.**

Please include the following:

1. Loss History (supply the following):
   a. Claims listing of ten years currently valued, including current year, and detailed loss information (preferably in electronic form). Please see ADDENDUM A for the format.
   b. Carrier Loss Runs to support information in 1.a. above.
   c. Full details of all allegations for Claims on which there were losses paid in excess of $25,000, even if currently open or pending.

2. Most recent accrediting agency (JCAHO, CAP, CARF, etc.) and state licensure report, with recommendations and the institution's response to any contingencies, for each and every licensed and/or accredited facility. Please provide copy of original report from the agency (not the internet summary).

The information and documentation requested above is required before a firm quotation can be provided.

I. PRODUCER INFORMATION

CompanyName:_____
Business Address:
Street:_____City,State:_____Zip: _____
Telephone#: _____Fax#: _____
Agent Name:_____ Surplus Lines Tax Filing State: _____
Surplus Line Agent Business Address:
Street:_____City,State:_____Zip: _____
Telephone#:_____Surplus Lines License#: _____

II. APPLICANT INFORMATION

Applicant Name: _____
DBA Name (if applicable): _____
Date of Incorporation or Formation: _____
Mailing Address:
Street: _____ City, State: _____ Zip: _____
County: _____ Federal Tax ID#: _____
Telephone #: _____ Fax #: _____
Website (if applicable): _____
Annual Revenues: _____

APPLICANT IS: (Check all that apply.)	☐ Individual	☐ Partnership	☐ Corporation	☐ Joint Venture	☐ LLC	
TAX STATUS:	☐ Profit	☐ Non-Profit	☐ Charitable	☐ Government		
LICENSES/ ACCREDITATIONS: (Attach most recent report.)	☐ Licensed by the state	☐ Accredited by CAP	☐ Accredited by JCAHO	☐ Member of ACHC	☐ Medicare Approved	☐ Other (please specify): _____ _____ _____

Does the Applicant conduct or provide any services via the Internet?
☐ Yes ☐ No If "Yes," describe services: _____

Please provide the Name(s), Location(s) and Description(s) of all legal entities for which coverage is being sought (including subsidiaries) below:

Location	Name of Entity	Business Address	Business Description	Date of Formation or Acquisition	% of Ownership by Applicant	Retroactive Date

In the past five years, has the Applicant sold or divested itself of any facilities, subsidiaries or assets, or discontinued any of its operations?

☐ Yes ☐ No If "Yes," describe: _____

Provide number of years this facility has been:
Operating: _____
Under present ownership: _____
Under present management: _____

Are there expectations to add any new facilities, operations, products, services, or procedures in the next twelve months?
☐ Yes ☐ No If "Yes," describe: _____

III. REQUESTED COVERAGE

Professional Liability (Claims Made Only):

Effective Date: _____ Retroactive Date: _____

Per claim/Aggregate Limit: ☐ $500K/1.5M ☐ $1M/3M ☐ $2M/4M ☐ Other $ _____

Deductible: ☐ $5K ☐ $10K ☐ $25K ☐ Other $ _____

General Liability: ☐ Occurrence ☐ Claims-Made

Effective Date: _____ Retroactive Date: _____

Per claim/Aggregate Limit: ☐ $500K/1.5M ☐ $1M/3M ☐ $2M/4M ☐ Other $ _____

Deductible: ☐ $5K ☐ $10K ☐ $25K ☐ Other $ _____

Employee Benefits Liability (Claims Made):

Effective Date: _____ Retroactive Date: _____

Per claim/Aggregate Limit: ☐ $500K/1.5M ☐ $1M/3M ☐ $2M/4M ☐ Other $ _____

Employment Practices Liability (Claims Made):

Effective Date: _____ Retroactive Date: _____

Per claim/Aggregate Limit: $100K/300K Deductible $25K

Excess Coverage (Claims Made Only):

Effective Date: _____ Retroactive Date: _____

Limit Per Claim: ☐ $1M/1M ☐ $5M/5M ☐ $10M/10M ☐ Other $ _____

Umbrella:

Effective Date: _____ Retroactive Date: _____

Per claim/Aggregate Limit: ☐ $1M/1M ☐ $5M/5M ☐ $10M/10M ☐ Other $ _____

IV. PROFESSIONAL LIABILITY EXPOSURES

* AN ASTERISK NEXT TO A GENERAL FACILITY TYPE INDICATES THAT A SUPPLEMENTAL APPLICATION MUST BE COMPLETED FOR THAT GENERAL FACILITY TYPE. AN ASKERISK NEXT TO A SUB-CATEGORY INDICATES THAT THERE IS A SUPPLEMENTAL APPLICATION SPECIFIC TO THAT SUB-CATEGORY, WHICH NEEDS TO BE COMPLETED, INSTEAD OF THE GENERAL CATEGORY SUPPLEMENT.

Facility Type	Visits [1]	Beds or Other [2]	Facility Type	Receipts $ [3]	Other
Residential Care/Group Homes*			**Treatment Centers**		
☐ Adolescent/ Child Residential Care			☐ Student/Community Health Center*		# Reads
☐ Adult Group Home			☐ Cancer Treatment – Outpatient Center*		
☐ Developmental Disability /Residential Care			☐ Dialysis*		
☐ Substance Abuse Facility			☐ Medi Spa*		
			☐ Other Treatment		
Outpatient/Behavioral Care*			**Laboratory***		
☐ Behavioral/ Mental Health/ Counseling Center			☐ Organ/Tissue Bank		
☐ Substance Abuse Facility			☐ Pathology Lab		
☐ Counseling Center			☐ Blood/Plasma Banks*		
			☐ Other Lab		
Outpatient Rehabilitation*			**Other Services:**		
☐ Cardiac Rehabilitation			☐ DME*		
☐ Trauma Rehabilitation			☐ Medical Registry Services/Staffing*		FTE's
☐ Physical/ Occupational Rehabilitation / Outpatient Center			☐ Pharmacy*		
☐ Other Counseling/ Rehabilitation			☐ Other Services		
Home Health/Hospice*			**Transport***		
☐ Home Health Care			☐ Air Ambulance Service		
☐ Hospice Care - Outpatient		FTE's	☐ Ground Ambulance Service:		
☐ Hospice Care - Inpatient		Beds	☐ Non-Emergency		
☐ Respite Care		FTE's	☐ Emergency		
☐ Other Hospice		FTE's	☐ Other Transport		
Describe:		FTE's			
Imaging/Radiation					
☐ Imaging Center*		# Reads			

[1]**Visits:** Count each patient each time they enter your facility, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.

[2]**Beds:** Use the total number of occupied beds.

[3]**Annual Receipts**: Use gross annual receipts.

V. GENERAL LIABILITY EXPOSURE

1. Physical Exposures:

Please complete the following table for each building or facility. Attach a separate sheet, if necessary.

Location	Area	Age	Type of Construction	# of Floors	Type of Fire Protection (City, State)
Patient Care Buildings					
Other Buildings					

2. Motor Vehicle Exposures*:

Type of Vehicle	# Owned/Operated by Applicant
Private Passenger	
Service	
Patient Transport Emergent	
Non Emergent	
Other (please describe)	

If there is hire non-owner auto exposure a supplemental application must be completed.

3. Employee Benefits Liability Exposures:

a. Number of Employees? _____

b. Are all Employee Benefits Self-Administered by the Applicant? ☐ Yes ☐ No

VI. EMPLOYMENT PRACTICES LIABILITY INSURANCE

a. Is the Applicant requesting Employment Practices Liability Coverage (EPLI)?
☐ Yes ☐ No If "Yes," number of employees? FT _____ PT _____

b. Does the Applicant or any other entity proposed for coverage have EPLI coverage under any other policy* (i.e. D&O – if so EPLI is not available on this policy)?
☐ Yes ☐ No If "Yes," describe: _____

c. Does the Applicant and every other entity proposed for coverage have an employee handbook?
☐ Yes ☐ No

d. Has the Applicant or any proposed insured had any EPL Claims brought against them in the past five years? (Including those closed with no payment.)
☐ Yes ☐ No If "Yes," please describe in an attachment hereto.

e. Has the Applicant or any proposed insured had any EEOC proceedings brought against them?
☐ Yes ☐ No If "Yes," please describe in an attachment hereto.

VII. ADMINISTRATION AND STAFF

MEDICAL DIRECTORS:

a. Does the Medical Director of any facility provide direct patient care?
☐ Yes ☐ No ☐ N/A

b. Does each Medical Director have Medical Malpractice Insurance?
☐ Yes ☐ No ☐ N/A

If "Yes," what are the required Limits of Liability? _____

PHYSICIANS AND SURGEONS:

(COMPLETE TABLE BELOW OR PROVIDE A ROSTER SHEET):

Names	Specialty	Insurance Carrier/Policy Number/Policy Period	Check One:	Hours per month:	Financial Interest:
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		

HEALTH CARE PROFESSIONALS:

(INDICATE NUMBER OF PERSONNEL IN EACH APPLICABLE CATEGORY)

	Employees		Contractors	
	Full-Time	Part-Time	Full-Time	Part-Time
Aides				
Podiatrists				
Counselors				
Dentists/Oral Surgeons				
Dieticians				
EMT's/Paramedics				
Nurse Anesthetists				
Nurse Midwives				
Nurse Practitioners/Physician Assistant				
Occupational Therapists				
Pharmacists				
Physical Therapists				
Psychologists/Mental Health Counselor				
RNs/LPNs/LVNs				
Social Workers				
Speech/Hearing Therapists				
Technicians (X-ray, Lab, etc)				
Physicians/Surgeons				
Other (Describe):				
Total:				
Provide Total Number of: Students: _____ Volunteers: _____				

VIII. INSURANCE REQUIREMENTS

a. Indicate if employed or contracted healthcare professionals carry Professional Liability Insurance:
(If "No," please explain why not.)

i. Physicians or surgeons?
☐ Yes ☐ No Explain: _____

ii. Dentists, nurse anesthetists, nurse practitioners, physician's assistants, and nurse midwives?
☐ Yes ☐ No Explain: _____

iii. Allied health care professionals?
☐ Yes ☐ No Explain: _____

b. Will any of the above be included as Additional Insureds on this policy?
(If "Yes," attach schedule or list.)

☐ Yes ☐ No Explain: _____

i. Indicate the minimum Professional Liability Insurance Limits required for employed or contracted:

Physicians or surgeons?
$ _____ Each Occurrence/ $ _____ Aggregate

Dentist, nurse anesthetist, nurse practitioners, physician's assistants, and nurse midwives?
$ _____ Each Occurrence/ $ _____ Aggregate

Allied health care professionals?
$ _____ Each Occurrence/ $ _____ Aggregate

c. How often does the Applicant verify Professional Liability Insurance limits?

_____

_____

IX. HIRING, SCREENING AND TRAINING PROCEDURES FOR EMPLOYEES AND CONTRACTORS, AND PROVIDER CREDENTIALS

a. Do screening/hiring procedures include the following?

i.	Educational background	☐ Yes	☐ No
ii.	Previous employers/employment history	☐ Yes	☐ No
iii.	Personal references	☐ Yes	☐ No
iv.	Hospital privileges for physicians and dentists	☐ Yes	☐ No
v.	Criminal background check:	☐ Yes	☐ No
	☐ County ☐ State ☐ Federal		
vi.	Medical professional claims history	☐ Yes	☐ No
vii.	Drug/alcohol abuse screening	☐ Yes	☐ No

b. Are each of the above procedures followed and documented?
☐ Yes ☐ No If "No," explain: _____

c. How often does the Applicant perform recredentialing and update its list of specific privileges?
_____

d. Does **any** proposed Insured have a pending license suspension or revocation, or any pending disciplinary action?
☐ Yes ☐ No If "Yes," explain: _____

e. Has any facility proposed for coverage been required to notify the National Practitioner Data Bank of any license suspension, peer review action or professional liability payment involving any member of the medical or dental staff? ☐ Yes ☐ No

f. Are written job descriptions established for all employees? ☐ Yes ☐ No

g. Is a competency-based checklist used to assess and document staff skills?
☐ Yes ☐ No If "No," explain: _____

X. CONTRACTUAL AGREEMENTS

a. Does Legal Counsel review all contractual agreements for the proposed Insureds?
☐ Yes ☐ No

b. Has any proposed Insured agreed to hold harmless and indemnify a third party under contract?
☐ Yes ☐ No
If "Yes," please attach a copy of such contract.

c. Please describe any services provided by the proposed Insureds to other entities pursuant to contract:
_____
_____

Indicate the Limits of Liability the Insured is required to carry pursuant to any such service contract:
_____

d. Does the proposed Insured entity or facility lend or lease equipment from others?
☐ Yes ☐ No

e. If "Yes," to question d., are there hold harmless and indemnity agreements in place with these lessors? ☐ Yes ☐ No

Indicate the Limits of Liability the Insured is required to carry pursuant to any such lease agreement:
_____
_____

XI. RISK MANAGEMENT/QUALITY MANAGEMENT

a. Does the Applicant have a written Risk Management/Quality Management program? ☐ Yes ☐ No

b. If "Yes," does it include Peer Review? ☐ Yes ☐ No

c. If "Yes," does the governing body of the Applicant periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No

d. Who coordinates the Risk Management/Quality Program (i.e., Risk Manager)?

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

e. Is the Risk Manager responsible for reviewing incident reports? ☐ Yes ☐ No

XII. CLAIMS HISTORY

***** Losses – Please include Loss Runs and attach a detailed explanation to any "Yes" answers, or complete a Supplemental Claim Form.

a. Is any proposed Insured aware of any event, transaction, accident, circumstance or loss that has occurred that might give rise to a claim or suit in the future? ☐ Yes ☐ No

b. Have all such incidents been reported to the Applicant's current insurance carrier? ☐ Yes ☐ No

c. Has any proposed Insured had any professional liability claim or suit brought against them during the last five years? ☐ Yes ☐ No

d. Has any proposed Insured, including any individual, entity or facility, been the subject of a disciplinary investigation or proceeding, or reprimanded by any governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

e. Has any proposed Insured been the subject of any license suspension or revocation or been placed under probation? ☐ Yes ☐ No

PLEASE NOTE THAT, WITHOUT PREJUDICE TO ANY OTHER RIGHTS OF THE INSURER, IT IS AGREED THAT ANY CLAIM OR RELATED CLAIM, THAT ARISES OUT OF ANY CLAIM, INCIDENT, CIRCUMSTANCE OR LOSS THAT IS OR REASONABLY SHOULD HAVE BEEN DISCLOSED IS EXCLUDED FROM THE PROPOSED COVERAGE.

XIII. INSURANCE INFORMATION

Provide the following information for Professional Liability Insurance for the current policy year and previous four years:

Policy Period	Carrier	Limits	Deductible or SIR	Claims Made or Occurrence	Retro Date	Premium

Has any insurance company ever canceled, non-renewed, or declined to accept an application for, the Applicant's Professional or General Liability Insurance?

☐ Yes ☐ No

If "Yes," explain:

_____

If Applicant is requesting Umbrella or Excess coverage, please provide the following information:

Underlying Information:

Coverage	Carrier	Policy Dates	Limit	Policy Number
Automobile				
Employers Liability				
General Liability				

***Please provide loss information for the above, if these lines are being requested.**

XIV. NOTICES AND FRAUD WARNINGS

NOTICES TO APPLICANT:

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS APPLICATION DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE APPLICANT WILL IMMEDIATELY NOTIFY THE INSURER IN WRITING OF SUCH CHANGES. THE INSURER RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

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 LIABILTY EXPOSURES.

FRAUD WARNINGS:

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

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

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMING 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 MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA 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 INCLUDE IMPRISONMENT, FINES, AND 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 OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR

FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

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

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 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.

XV. APPLICANT'S SIGNATURE:

I hereby acknowledge that the above information is complete and accurate to the best of my knowledge and belief.

Print Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Title: _____

Date: _____

This Application must be completed, dated and signed by the CEO, CFO, Administrator, Executive Director or Risk Manager of the Applicant, who is authorized to sign on behalf of all proposed Insureds.