Lancet Indemnity RRG Application Checklist

- ☐ Complete Application
- ☐ Completed claim form for every previous medical malpractice claim
- ☐ Curriculum Vitae
- ☐ Declaration sheet from your current carrier
- ☐ Copy of your license(s)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions; if a question is not applicable, state “NOT APPLICABLE”.
2. If Space is insufficient to answer any questions fully, attach a separate sheet.
3. The Application must be signed and dated by the applicant.
4. It the answer to any question is none, state “NONE”.
5. Please do not complete the application earlier than 60 days before proposed effective date of coverage.

Preparers Signature x_____ Date _____

LANCET INDEMNITY RRG

Submitted by:_____Agent/Agency_____
Address:_____ City:_____State_____Zip_____
Email:_____

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS

THIS IS FOR A CLAIMS MADE AND ASSERTED POLICY

(PLEASE TYPE OR PRINT IN INK)

1. A. Full Name of Applicant: _____ MD___ DO___

   B. Date of Birth _____ Place of Birth _____ SS# _____
   C. Federal DEA # _____Email Address_____

   D. Are you a U. S. Citizen? ____ If "no" please indicate your status and entry into USA on separate sheet. Include a copy of your current Permanent Visa

2. A. Principal Office Address

   Street: _____

   City: _____ State _____Zip_____

   County: _____Phone # _____ Fax # _____

   B. Mailing Address: (All correspondence from Lancet Indemnity RRG will be sent to the principal address unless otherwise noted)

   Street: _____

   City: _____State_____ Zip_____

   County: _____ Phone # _____ Fax # _____

   C. Residence Address:

   Street: _____

   City: _____State_____ Zip_____

   County: _____ Phone # _____

   D. Other Offices (Please attach a separate sheet for additional office locations)

   Street: _____

   City: _____ State_____ Zip_____

   County: _____Phone # _____

3. Limits of Liability desired: __ $ 100,000 / $ 300,000 __ $ 200,000 / $ 600,000 __ $ 250,000 / $ 750,000 __ $ 500,000 / $ 1 Mil. __ $ 1 Mil / $ 3 Mil __ Other (Limits in policy will govern coverage)

4. Desired Effective Date (12:01 a.m.): _____

5. I practice as: _____ Solo Practitioner (unincorporated) _____ Professional _____ Corporation
_____ Solo Practitioner (incorporated) _____ Partnership
_____ Professional Corporation
_____ Employee of (name): _____
_____ Other (Describe) _____

6. If you practice other than as an employee or an unincorporated solo practitioner:

A. List the names of ALL your partners, your employees or members of your professional association or corporation who practice medicine and their current insurance carriers:

_____
_____
_____
_____
_____

B. Provide the formal corporate, association, partnership or business name and Tax ID #:

_____

C. Would you like coverage for the above entity? ____Yes _____ No

7. List all states where you are licensed to practice:

State _____ License #_____ Permanent or Temporary? _____

State _____ License #_____ Permanent or Temporary? _____

State _____ License #_____ Permanent or Temporary? _____

If licensed in additional states please attach a separate sheet of paper.

8. A. List hospitals at which you are currently a staff member and show % of work at each hospital.

_____ % _____

_____ % _____

_____ % _____

_____ % _____

B. Briefly describe type and extent of your hospital privileges:

_____
_____
_____

_____ Temporary _____ Permanent

C. Are you Chief or Head of a hospital department? _____ Yes _____ No
If yes, please explain in detail. _____

9. Do you or the firm listed in Question 6.B. above own (wholly or in part), operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? _____

   If "yes" provide details, including name, location, size and number of beds.

CURRENT PRACTICE

10. Medical Specialty: _____ % of Practice: _____

    Sub-Specialty: _____ % of Practice: _____

    Average weekly patient load: _____ Number of weekly practice hours: _____

    % of Practice outside of office location: Nursing Home_____; Rehab_____; Other (explain) _____

    A. Number of years at current office location: _____

    B. Have there been any significant changes in your practice during the past 5 years, i.e. changes in specialty, changes in location, addition or deletion of procedures, etc. ☐ Yes ☐ No If "Yes", please explain:

    _____

MEDICAL PROCEDURES

11. Check the appropriate box, indicating the extent of surgery you perform:

    ☐ No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing of minor lacerations

    ☐ Minor Surgery – includes circumcisions other than on newborns and vasectomies # Annually _____

    ☐ Major Surgery – includes all procedures done under general, spinal or caudal anesthesia # Annually _____

    ☐ Perform obstetrical procedures

    ☐ Assisting in surgery on your own patients # Annually _____

    ☐ Assisting in surgery on patients other than your own # Annually _____

    ☐ Hospitalist

12. Check the following procedures which you perform. **If none, check here:** ⇨

Primary	Assisting	
☐	☐	Abortions - # per year: _____ **Please also complete Obstetrics & Gynecology supplement to this application**
☐	☐	Acupuncture or acupressure
☐	☐	Adenoidectomies
☐	☐	Anesthesia, general **Please also complete Anesthesiology supplement to this application**.
☐	☐	Angiography, angioplasty, Arteriography, cardiac catheterization
☐	☐	Appendectomies

Primary/Assisting

☐	☐	Banding Hemorrhoids
☐	☐	Blepharoplasty
☐	☐	Bronchoscopy
☐	☐	Cesarean sections - # per year: _____ **Please also complete Obstetrics & Gynecology supplement to this application**
☐	☐	Chemabrasion
☐	☐	Circumcision – Other than newborn
☐	☐	Colonoscopy
☐	☐	Cosmetic injection or implants of any kind, including botox, collagens, free fat, silicone
☐	☐	Cosmetic plastic surgery or procedures (elective)
☐	☐	Cosmetic plastic surgery (reconstructive) **Please also complete Plastic Surgery supplement to this application.**
☐	☐	Cryosurgery
☐	☐	D & C's
☐	☐	Dermabrasion or laser skin resurfacing
☐	☐	Electro Convulsive Therapy
☐	☐	Endoscopic procedures
☐	☐	Endoscopic Retrograde Cholangiopancreatography
☐	☐	Esophageal Gastro Dilation
☐	☐	Facelift
☐	☐	Fertility / Infertility treatment
☐	☐	Gastric by-pass / stapling or other weight control surgery or procedures
☐	☐	Hair growing, transplants or scalp reduction surgery
☐	☐	Hemorrhoidectomy
☐	☐	Hernias
☐	☐	Hyperbaric Chamber treatment
☐	☐	Hysterectomies **Please also complete Obstetrics & Gynecology supplement to this application**
☐	☐	Hypnosis
☐	☐	Insertion of intrauterine or subcutaneous contraceptive devices
☐	☐	Laparoscopy
☐	☐	Lasers – used in therapy or surgery
☐	☐	Liposuction

Primary/Assisting

☐	☐	Lumbar puncture - # per year _____
☐	☐	Needle biopsy
☐	☐	MOHS microscopic surgery
☐	☐	Obstetrical deliveries - # per year: _____ **Please also complete Obstetrics & Gynecology supplement to this application**
☐	☐	OB deliveries at other than a licensed acute care hospital **Please also complete Obstetrics & Gynecology supplement to this application**
☐	☐	Office x-rays – Over read: ☐ Yes ☐ No By whom: _____
☐	☐	Open reductions of fractures
☐	☐	Pain Management **Please also complete Pain Management supplement to this application**
☐	☐	Prenatal care
☐	☐	Radial keratotomy, LASIX, PRK, AKL, or PTK
☐	☐	Radiation therapy
☐	☐	Spinal anesthesia
☐	☐	Spinal surgery
☐	☐	Telemedicine
☐	☐	Tonsillectomies
☐	☐	Thoracic Surgery _____%
☐	☐	Tubal Ligation **Please also complete Obstetrics & Gynecology supplement to this application**
☐	☐	Transplant Surgery
☐	☐	Trigger point injections
☐	☐	Urological Surgery **Please also complete Urology supplement to this application**
☐	☐	Vascular Surgery _____%
☐	☐	Vasectomies
☐	☐	V.B.A.C.'s - # per year _____ **Please also complete Obstetrics & Gynecology supplement to this application**
☐	☐	Any procedures not customary to specialty: _____ _____

13. A1. Indicate number of hours per month devoted to hospital emergency room care: _____

A2. Is this emergency room care:
1. On your own patients only? _____
2. Required for staff privileges? _____
3. Other (details) _____

A3. **Please complete Emergency Medicine supplement to this application.**

14. Do you perform or assist in surgery? _____

    If "yes", **please complete General Surgery supplement to this application.**

    A. Do you perform surgery in your office? _____ if "yes" list surgical procedures: _____

    _____

    _____

    B. Do you perform surgery in other non-hospital facilities? _____ If "yes" list facilities and surgical procedures._____

    _____

    _____

    C. In the course of surgery, is general anesthesia administered? _____
       1. By you? _____
       2. By others? _____

15. Do you practice weight reduction or control (other than by diet-exercise)? _____

    If "yes", **please complete Bariatric supplement to this application.**

16. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? _____ If "yes" please attach detailed explanation of this activity.

17. A. List number and type of professional employees: **If none, check here:** ☐

    _____ Physicians (other than yourself) _____ Surgeons Assistants
    _____Nurse Practitioners _____ Physicians Assistants
    _____Nurse Midwives _____ Nurse Anesthetists
    _____Other (describe with duties in detail, including extent supervised on a separate sheet and attach)

    B. Are all of the above individuals licensed in accordance with applicable state and federal regulations? _____ If "no", attach explanation.

18. ATTACH DETAILED EXPLANATION FOR ANY 'YES'. ANSWERS:

    Have you or any of the above employees:

    A. Ever been the subject of investigation or disciplinary proceedings or reprimand by a governmental or administrative agency hospital or professional association? _____

    B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? _____

    C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment? _____

    D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? _____

    E. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? _____

    F. Ever failed any medical licensing or specialty organization examination? _____

    G. Have any chronic physical illness or defect? _____

19. Do you supervise any individuals other than your own employees? _____ If “yes” provide a detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also indicate, by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

20. Are you in the employ of any individual, firm or corporation other than your own? _____
    If yes, attach explanation, including details of any responsibilities.

21. Are you under contract to any individual, firm or corporation other than your own? _____
    If yes, attach explanation including details of your responsibilities. If this contract contains a hold-harmless agreement, a copy of the contract must be attached to the application.

22. Are you in the employ of any governmental entity? _____
    If yes, attach explanation, including details of your responsibilities.

23. Are you under contract to any government entity? _____
    If yes, attach explanation, including details of your responsibilities.

24. A. Do you advertise your professional services in any manner (other than a simple listing in the telephone directory)? _____

    B. Are you associated with any agency or organization that engages in any kind of advertising for solicitation of patients? _____ If 'yes' submit copy of ALL the advertisements.

25. A. From what medical school did you graduate? _____
    Degree: _____ Year: _____
    Location of Medical School (City, State, Country) _____

    B. If foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates? _____ If "yes". state year and describe _____
    _____

    C. Residency? _____ If "yes” complete the following for each residency served:

    Location _____ From _____ To _____
    Type_____ Did you complete?_____

    Location _____ From _____ To _____
    Type_____ Did you complete?_____

    Location _____ From _____ To _____
    Type_____ Did you complete?_____

    D. Additional Medical Training? _____ If "yes" complete the following:

    Location _____ From _____ To _____ Type _____

    E. Are you American Board certified? ____ If so, what Specialty_____

    Date certified: _____ Date Recertified: _____

26. Do you practice in a surgi-center, abortion clinic, drug control clinic, emergi-center, extended hours walk-in clinic or birthing center? _____ If "yes.", state location and describe:_____

_____

_____

27. Did you practice with other physicians in an employer-employee relationship, ostensible or formal partnership, medical association or medical corporation during the period for which you are requesting Prior Acts Coverage? ☐ Yes ☐ No

If "yes", list the full name(s) of the entity(ies) and physician(s) with whom you practiced and the period of each such association. Attach additional pages as needed.

NAME OF ENTITY(IES)	NAME OF PHYSICIAN(S)	FROM TO

CHANGES IN PRACTICE:

Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in this application for Medical Professional Liability Claims-Made Coverage? For instance, did your practice formerly include obstetrical care or emergency room services that you are no longer providing or did you ever perform silicone implants of any kind? ☐Yes ☐ No

Did any of your policies contain any coverage restrictions? ☐ Yes ☐ No

If "yes", please describe, including all applicable dates. Attach additional pages as needed.

_____

_____

28. Indicate membership in professional societies:

A. American Board in Medical Specialties: _____
B. Special Medical Societies: _____
C. Specialty Colleges: _____
D. County Medical and Others: _____

29. Have you participated in any continuing medical education program within the past five years? _____

If yes, describe (include photocopies of CME certificates)_____

_____

_____

30. Do you or the firm named in Question 6. B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? _____

If yes, describe_____

_____

_____

31. Has any claim* or suit for alleged malpractice **ever** been brought against you or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No **If "yes", please complete a claim/incident report for <u>each</u> claim.**

*Claims include intent to sue, written demand from patient or lawyer, incidents, withdrawn, settled, etc.

Total Number of Claims_____ # of Open / Reserved_____ # of Closed_____

Have you reported all claims and circumstances that might reasonably lead to a claim or suit to your current carrier? ☐ Yes ☐ No

32. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? _____
IF "YES" A SUPPLEMENTAL CLAIM INFORMATION FORM MUST BE COMPLETED FOR EACH INCIDENT.

33. List prior professional liability insurance carried for each of the past ten years. <u>IF NONE</u>, STATE NONE.

Insurer	Policy #	Policy Limit	Deductible	Premium	Inception	Expiration	Claims Made or Occurrence

34. What is the retroactive exclusion date on your current policy? _____

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 1 of this application to (present date) have been reported to my current insurance carrier.

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to the Company prior to the effective date of such coverage and are listed previously or by supplemental form attached below.

WARRANTY

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy coverage excess of this policy.

Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains to my background, competence and qualifications.

ACKNOWLEDGED AND AGREED: _____

APPLICANT (Signature Required) _____ Date: _____

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force. Furthermore the policy includes the cost of defense of claims within the policy limit which means that the Policy limit available to pay a claimant WILL be reduced by the cost of investigation, defense and other expenses involved in the defense. The applicant, by signing this application below confirms (his/her) understanding of all provisions represented by the Insurer.

Signature of Applicant_____Date_____

Lancet Indemnity
Risk Retention Group

2810 W. St. Isabel St.
Suite 201 B
Tampa, Florida 33607
Tel: (877) 370-2262
Fax: (813) 290 - 7070

APPLICATION FOR PRIOR ACTS COVERAGE

(Must Be Returned With The Professional Liability Application)

PLEAS PRINT OR TYPE

Item 1

Name of Applicant: _____

Item 2

Earliest Date of Prior Acts Coverage Requested: _____

At all time, from the date above, have you been continually covered by a claim-made policy?

Yes No

If No, please explain: _____

_____

Item 3

In the last 24 months, (or if retroactive date is more than 24 months) do you have knowledge of any unsatisfactory outcome or event?

If so, please complete one form for EACH unsatisfactory outcome or event

Patient's Name: _____

Date(s) of Treatment is question: _____

Outcome / Result: _____

_____

I. Medical Care (Please Circle)

A. Any patient(s) who had a significant injury resulting from your treatment? Yes No

B. Any patient(s) who had any unexpected compromise to airway or neurovascular bundle that led to injury? Yes No

C. Any patient(s) who had a poor result that was not expected and became angry at you? Yes No

D. Any patient(s) who died unexpectedly while under your care? Yes No

E. Any patient(s) who died unexpected respiratory or cardiac arrest? Yes No

F. Any patient(s) who sustain a major organ failure (heart, lung, or kidney) not present at time of treatment was rendered? Yes No

G. Any case(s) where a foreign body was retained? Yes No

H. Any written or verbal contact from patient, family, attorney or other representative with a demand for money or service or other indication of an intent to file a claim, lawsuit or other complaint against you? Yes No

II. Surgical Care (Please Circle)

A. Unexpectedly returned to the operating room during the same admission? Yes No

B. Sustained an acute MI or CVA during or within 72 hours of elective surgery or other major diagnostic or therapeutic procedure? Yes No

C. Patient with post operative curse that led to permanent injury? Yes No

III. Obstetrical Care

A. Any result that led to injury of the mother? Yes No

B. Any result that led to injury of the infant? Yes No

C. Specially:

Cerebral palsy? Yes No

Mental Retardation? Yes No

Fracture? Yes No

Brachial Plexus? Yes No

DEATH(s)? Yes No

IV. Other, please explain: _____

_____

_____

Item 4

Has your practice changed in any way since the date noted in Item 2 (classification or procedure changed?)

_____

_____

_____

Item 5

ATTACH A COPY OF THE MOST RECENT CLAIMS-MADE POLICY ISSUED TO YOU. This must contain the retroactive date noted in Item 2 above. If it does not, attach all policies pertaining to the continuous claims-made coverage which you have had back to the date stated in Item 2.

Item 6

If you require coverage for “additional Insured” that were on prior policies, you must include any endorsements showing the type and name of those Additional Insured. This includes group coverage. Each proposed Additional Insured is subject to a separate underwriting decision.

If the limits of liability under your prior claims-made policy were less than that for which you are applying for hereunder, the lower limits apply.

Please understand that there may be differences in coverage between that provided by your previous carrier(s) and the coverage applied for hereunder. Only those items covered under the Policy will be covered under a prior acts endorsement.

I declare that I know of no potential or actual claims, suits or incidents presently pending which have not been reported to my previous carrier(s). I understand that "Carrier" also means "Insurer".

I understand that this is only an application for Prior Acts Coverage and not a guarantee of coverage. **UNDER NOCONDITION WILL PRIOR ACTS BE COVERED WITHOUT THE RETURN OF THIS APPLICATION AND APROPERLY EXECUTED ENDORSEMENT.**

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT IF PRIOR ACTS COVERAGE IS OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION, IT IS VOID.

I FURTHER WARRANT THAT I HAVE LISTED ALL INCIDENTS, AND UNFAVORABLE OR ADVERSE RESULTS KNOWN TO ME, OR OF WHICH I SHOULD HAVE BEEN AWARE, WHICH WOULD ARISE FROM MY ACTS OR OMISSIONS WHICH HAVE OCCURRED WITHIN THE LAST TWENTY-FOUR (24) MONTHS, OR SINCE THE REQUESTED RETROACTIVE DATE, IF MORE THAN TWENTY-FOUR MONTHS. I FURTHER WARRANT THAT I HAVE NOT WITHHELD ANY INFORMATION THAT IS REASONABLY LIKELY TO INFLUENCE THE JUDGMENT OF THE COMPANY IN CONSIDERING MY REQUEST FOR PRIOR ACTS COVERAGE. I FULLY UNDERSTAND THAT ANY INCIDENTS, OR UNFAVORABLE OR ADVERSE RESULTS WHICH ARE OR SHOULD BE KNOWN TO ME AND WHICH CAN REASONABLY BE EXPECTED TO RESULT IN A CLAIM WILL NOT BE COVERED, WHETHER LISTED ON THIS FORM OR NOT.

Date: _____ Signature: _____

Lancet Indemnity

This form must be completed ONLY of you are requesting 1st year/ no prior acts coverage

WAIVER OF PRIOR ACTS COVERAGE
Lancet Indemnity, RRG

I acknowledge the need to purchase tail coverage (reporting endorsement) from my previous carrier where I was insured under a claims-made policy. I realize that my failure to purchase such coverage from my previous carrier will result in an uninsured exposure while insured by my previous carrier's policy. I understand that the policy which I am purchasing from Lancet Indemnity, RRG will not provide prior acts coverage.

_____

Signature

_____

Printed Name

_____

Date

LI (11/09)

Lancet Indemnity
Risk Retention Group

2810 W. St. Isabel St.
Suite 201 B
Tampa, Florida 33607
Tel: (877) 370-2262
Fax: (813) 290 - 7070

STATEMENT OF NO KNOWN CLAIMS / LOSSES

(This statement must be completed, signed and returned with the completed application)

My signature below confirms that:

1. I have no known losses or claims that have not been reported to my prior insurance carrier.

2. I have no knowledge or information relating to a MEDICAL INCIDENT which could reasonably result in a claims, that has NOT been reported to a prior insurance carrier.

3. I have no knowledge of ANY REQUEST FOR MEDICAL RECORDS which might result in a claim.

4. I have no knowledge or information relating to service or service on a Board which might result in claim.

5. I have no known “potential” or “anticipated” losses.

6. No prior professional liability carrier has REFUSED coverage for, or DECLINED to accept a report of a medical incident, threat of a claim, letter of intent, and adverse result notice or attorney contract.

Signature _____ Date _____

Printed _____

Lancet Indemnity, RRG
Physician Owned and Directed
2810 W. St. Isabel Suite 201 B
Tampa, FL 33607

IMPORTANT – YOU MUST READ CAREFULLY

GENERAL FRAUD WARNING

Any person who knowingly includes false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.

Arkansas: 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.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime may be subject to fines and confinement in state prison.

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.

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.

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.

Kentucky: 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.

Louisiana: 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.

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 denial of insurance benefits.

Missouri: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

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.

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 fines civil and criminal penalties.

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.

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 false or deceptive statement is guilty of insurance fraud.

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.

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.

Tennessee: 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.

Virginia: 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 and civil damages.

West Virginia: 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.

Consent, Warranty, Representations and Acknowledgement of Understanding

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance that may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, Its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communication, reports, records, statement, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and is not evidence of coverage.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant and that my application will be evaluated by authorized personnel. Submission of a payment or a deposit with this application and provisional receipt thereof by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment will be returned to the applicant. I further acknowledge that incomplete or incorrect information could result in retroactive premium adjustment, denial of coverage or voidance of any policy issued in reliance on such information.

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Applicant's Signature **Date**