GenStar

# NEW BUSINESS APPLICATION

## PROFESSIONAL LIABILITY

### Physicians & Surgeons
### Claims-Made and Reported Coverage

*Please complete this application and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.*

**INSTRUCTIONS TO THE APPLICANT:**

- You must provide a fully completed application, signed and dated by you within 45 days of the desired effective date of coverage.
- Appropriate Supplementary Applications, Claim Information Supplement(s) and additional documentation must also be completed as needed.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The following additional information must be provided:
  - Copy of your current professional liability insurance Declarations page.
  - Copy of your Curriculum Vitae.
  - Copies of all advertising that you use.
  - Copy of your business letterhead.

Company loss runs, valued within the last 90 days.

## I. GENERAL INFORMATION

| | | |
|---|---|---|
| 1 | Applicant Name: | Date of Birth: |
| | Professional Designation: ☐ M.D. ☐ D.O. ☐ D.P.M. ☐ Other (describe): | |
| 2 | Applicant Type: ☐ Individual ☐ Corporation ☐ Partnership ☐ LLC Employed Physician - by whom: ☐ Other (describe): | |
| | Practice Type: ☐ Solo Practice ☐ Group Practice | |
| | Entity Name: | |
| | How many other physicians practice at this entity? | Applicant's percentage of ownership: % |
| | "Doing business as" (d/b/a) names used? If **YES**, specify: | ☐ Yes ☐ No |
| | Do you want this entity covered? | ☐ Yes ☐ No |
| 3 | Mailing Address: | |
| | City: | County: |
| | State: | ZIP: |
| 4 | Primary Practice Location: | Number years at location: |
| | City: | County: |
| | State: | ZIP: |
| | Do you have more than one practice location? If **YES**, please provide the following for each location: location address, hours of operation, procedures performed, number of years at location: | ☐ Yes ☐ No |
| 5 | E-mail: | Office Phone: |
| | Web Site: | Office Fax: |
| 6 | Residence Address: | Residence Phone: |
| | City: | County: |
| | State: | ZIP: |

## II. MEDICAL TRAINING and EDUCATION

| | | | | | |
|---|---|---|---|---|---|
| 1 | Medical Specialty: | | Percentage of Practice: % | | |
| | Sub-Specialty: | | Percentage of Practice: % | | |
| 2 | Date you began practicing medicine: | | | | |
| 3 | | Hospital / College | City and State | Completed | Dates From / To |
| | Medical School | | | ☐ Yes ☐ No | |
| | Internship | | | ☐ Yes ☐ No | |
| | Residency | | | ☐ Yes ☐ No | |
| | Additional Residency | | | ☐ Yes ☐ No | |
| | Fellowship | | | ☐ Yes ☐ No | |
| 4 | Are you a U.S. citizen? If **NO**, please provide a copy of documents confirming your status. | | | | ☐ Yes ☐ No |

| | | |
|---|---|---|
| 5 | Are you a Foreign Medical School Graduate? If **YES**, please provide the date of ECFMG certification: | ☐ Yes ☐ No |
| 6 | Are you currently Certified by any board recognized by the **American Board of Medical Specialties**? If **YES**, please provide: Name of Board: Certificate Expiration: | ☐ Yes ☐ No |
| 7 | Are you a member of any medical association? If **YES**, please list memberships: | ☐ Yes ☐ No |
| 8 | Please indicate the number of CME hours you have completed in the past two years: | |

## III. MEDICAL PRACTICE HISTORY

| | | |
|---|---|---|
| 1 | Within the last five (5) years, have your practice characteristics, procedures performed, or business association(s) changed? If **YES**, please describe: | ☐ Yes ☐ No |

2 List all primary office locations where you have practiced in the last ten (10) years. (Use separate sheet if more space is needed)

| Street Address & City | County | State | Dates – From / To |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

3 List all hospitals where you have staff privileges: (*If no hospital privileges, attach protocol for patient hospital admission)*

| Hospital | City / State | County | % of Practice | Type of Privileges |
|---|---|---|---|---|
| | | | % | |
| | | | % | |
| | | | % | |

4 List all States where you practice or have a medical license:

| State | Medical License Number(s): | DEA License Number(s): | % of practice in each state: |
|---|---|---|---|
| | | | % |
| | | | % |
| | | | % |

5 Legal / Professional / Administrative Actions against you:

| | | |
|---|---|---|
| a | Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? If **YES,** please explain: | ☐ Yes ☐ No |
| b | Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? If **YES,** please explain: | ☐ Yes ☐ No |
| c | Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? If **YES,** please explain: | ☐ Yes ☐ No |
| d | Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? If **YES,** please complete the **Substance Impairment Supplemental Application**. | ☐ Yes ☐ No |
| e | Have you ever been charged with, or convicted of a crime other than minor traffic violations? If **YES,** please explain: | ☐ Yes ☐ No |
| f | Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s), or a state licensing authority? If **YES,** please explain: | ☐ Yes ☐ No |

## IV. OFFICE STAFF

1 Do you employ, contract with, or supervise any **physician(s) or surgeons(s)**? If **YES,** enter information below and attach current certificate(s) of insurance. ☐ Yes ☐ No

| Physician/Surgeon Name | Medical Specialty | Limits of Liability | Employ (E) Contract (C) Supervise (S) | Insurer |
|---|---|---|---|---|
| | | | ☐ E ☐ C ☐ S | |
| | | | ☐ E ☐ C ☐ S | |
| | | | ☐ E ☐ C ☐ S | |
| | | | ☐ E ☐ C ☐ S | |

2 Do you employ, contract with, or supervise any non-physician health care extenders? If **YES,** enter information below: ☐ Yes ☐ No

| Type | Number Employed | Number Supervised Only | Type | Number Employed | Number Supervised Only |
|---|---|---|---|---|---|
| Midwife | | | Medical Assistant | | |
| CRNA | | | Medical Lab Technician | | |
| Nurse Practitioner | | | Pharmacist | | |
| Physician Assistant | | | Nurse (RN/LPN) | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Surgeon Assistant | | | X-Ray Technician | | |
| | Optometrists | | | Physical Therapist | | |
| | Other (Please provide detail): | | | | | |

## V. PROCEDURES/PRACTICE SPECIFICS

| | | |
|---|---|---|
| 1 | a | Average Weekly Patient Encounters: |
| | b | Average Weekly Practice Hours: |
| | c | Percentage of Locum Tenens Work: % |

| | | |
|---|---|---|
| 2 | Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center? If **YES**, please describe: | ☐ Yes ☐ No |

3 Does your practice include the following? Check all that apply.

☐ **No Surgery -** No surgery with the exception of: suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.

☐ **Minor Surgery -** Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures:

- Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP),
- Pneumatic or mechanical esophageal dilation (not with bougie or olive),
- Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic,
- Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue,
- Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae

**Any procedure performed on a patient while under general anesthesia is not considered Minor Surgery.**

☐ **Major Surgery -** Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of an operation. It also includes removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.

☐ **Gynecology / Obstetrics** If checked, please indicate which procedures:

| | |
|---|---|
| ☐ Office Gynecology only | ☐ Elective Abortions |
| ☐ Pre-natal care through 1st trimester only | Number each month: |
| ☐ Pre-natal care through 2nd trimester only | Maximum Gestation Age: |
| ☐ Pre-natal care full term | Where performed: |
| ☐ Amniocentesis | ☐ Therapeutic Abortions |
| ☐ High Risk Pregnancies | Number each month: |
| ☐ Toxemia Management | Maximum Gestation Age: |
| ☐ Dilation and Curettage | Where performed: |
| ☐ Cryosurgery | |

☐ **Obstetrics**

| | | | |
|---|---|---|---|
| **Indicate annual number of:** | Vaginal Deliveries: | **Indicate percentage of:** | Low forceps deliveries: % |
| | Cesarean Sections: | | Mid forceps deliveries: % |
| | VBAC Deliveries: | | Breech Deliveries: % |
| | Non-Hospital Deliveries: Describe circumstances: | | |

| | |
|---|---|
| Does a Midwife perform any actual deliveries/births? If **YES**, annual number performed by Midwife: | ☐ Yes ☐ No |

☐ **Radiology -** ☐ Diagnostic ☐ Therapeutic ☐ Interventional

| | |
|---|---|
| Annual number of readings performed: | Type of readings performed: |
| Do you perform any non-physician-referred screening mammographies? If **YES**, please describe your procedures for assuring continuity of care/follow up: | ☐ Yes ☐ No |
| Do you read, interpret, and/or diagnose files, electronic images, or slides of patients residing in any State(s) other than your primary practice State address? If **YES,** complete the **Teleradiology Supplemental Application.** | ☐ Yes ☐ No |

☐ **Anesthesia / Office Surgery -** Performance or assistance in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis. Indicate annual number and description of procedures:

| Procedure | Number | Description of Procedures |
|---|---|---|
| ☐ General Anesthesia | | |
| ☐ Spinal or Caudal Anesthesia | | |

| | | | | |
|---|---|---|---|---|
| | | ☐ Other | | |
| | | Anesthesia administered by: | | |
| | | Distance to nearest hospital: | | |
| | | Description of life saving equipment/supplies: | | |
| | ☐ | **Pain Management -** Check the procedures that you perform: | | |
| | | ☐ Blocks ☐ Epidurals ☐ Trigger Point Injections ☐ Surgically Implanted Devices | | |
| | | Do you prescribe synthetic opiates? If **YES**, | | ☐ Yes ☐ No |
| | | a Number of prescriptions written: | | |
| | | b Describe controls in place to reduce or eliminate drug-seeking behavior: | | |
| | ☐ | **Elective Plastic Surgery -** Describe procedures and annual number performed: | | |
| | ☐ | **Alternative Medicine -** Describe procedures and annual number performed: | | |
| | ☐ | **Weight Control / Bariatrics -** Complete the **Bariatric Surgery Supplemental Application**. | | |
| | | Describe procedures for weight reduction/control by other than diet and exercise: | | |
| | | Percentage of patients treated exclusively for weight control % | | |
| | | List injections used for weight control: | | |
| | | If you prescribe or dispense drugs for weight control, please list drugs and describe protocols: | | |
| | ☐ | **Podiatry -** Check the procedures that you perform: | | |
| | | ☐ Reduction of simple fractures of the heel or ankle | | |
| | | ☐ Reduction of compound factures of the heel or ankle | | |
| | | ☐ Use of lasers | | |
| | | ☐ Cutting or penetration of tissue other than that as defined as “No Surgery” above | | |
| | | ☐ Arthrodesis | | |
| | | ☐ Permanent removal of nail plate except by the use of electrical or chemical cautery | | |
| | | ☐ Surgical procedures of the ankle joint which includes any of the following:<br>▪ Tibia and/or fibula and their related structures<br>▪ Arthroplasty<br>▪ Grafts and/or implants | | |
| | | ☐ Surgical treatment of the muscles and tendons at the level of the ankle joint | | |
| | | ☐ Any other surgical procedures performed on the foot and/or ankle. Please describe: | | |

| | | |
|---|---|---|
| 4 | Please check any procedures that you perform: | |
| | ☐ Adenoidectomy | ☐ Hysterectomies |
| | ☐ Amputations | ☐ Hyperbaric Chamber Treatments |
| | ☐ Anal Fissure | ☐ Joint Replacement Surgery |
| | ☐ Angiography | ☐ Kidney, Ureter and Bladder Surgery |
| | ☐ Arterial Catheterization | ☐ Laparoscopies |
| | ☐ Arteriography | ☐ Liposuction Procedures |
| | ☐ Assisting in surgery on patients other than your own | ☐ Malignant Lesion Surgery |
| | ☐ Assisting in surgery on your own patients | ☐ Mastoidectomy |
| | ☐ Bariatric Surgeries | ☐ MOHS Micrographic Surgery |
| | ☐ Bio-Identical Hormone Replacement Therapy | ☐ Myelography |
| | ☐ Blepharoplasty | ☐ Needle Biopsies |
| | ☐ Breast Implants, Augmentation or Reduction | ☐ Oophorectomy |
| | ☐ Cardiac Catheterizations | ☐ Open Reduction of Fractures (Plating and Pinning) |
| | ☐ Cervical Biopsy | ☐ Orchidectomy |
| | ☐ Cervical Cautery | ☐ Organ Transplants |
| | ☐ Chelation Therapy | ☐ Orthopedic Surgery (Including Spinal Surgery) |
| | ☐ Chemical Peels | ☐ Orthopedic Surgery (No Spinal Surgery) |
| | ☐ Cleft Lip or Palate Surgery | ☐ Otoplasty |
| | ☐ Clinical Trials | ☐ Pedicle Screw Insertion |
| | ☐ Closed Reduction of Fractures | ☐ Penile Augmentation/Implants |
| | ☐ Cholecystectomies | ☐ Pericardiocentesis |
| | ☐ Collagen Lip Injection | ☐ Pregnancy Care into Second Trimester |
| | ☐ Colonoscopy | ☐ Pregnancy Care into Third Trimester |
| | ☐ Electroshock Therapy | ☐ Prostatectomy |
| | ☐ Endometrial Biopsy | ☐ Reconstructive Plastic Surgery |
| | ☐ Endoscopic Laser Therapy | ☐ Salpingectomy |
| | ☐ Hair Transplant Procedures | ☐ Gender Reassignment Procedures |
| | ☐ Hand Surgery | ☐ Sterilization Procedures |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | ☐ Hemorrhoidectomies | | | ☐ Thrombectomy of Arteries and Veins | | | |
| | ☐ Hernioplasty | | | ☐ Other, list: | | | |
| | ☐ Human Chorionic Gonadotropin (HCG) | | | | | | |
| 5 | Do you own or operate a Laboratory? If **YES**, | | | | | | ☐ Yes ☐ No |
| | a | Does the laboratory provide services solely for your patients? | | | | | ☐ Yes ☐ No |
| | b | If not limited to your patients, please explain: | | | | | ☐ Yes ☐ No |
| 6 | a | Are you now performing experimental or investigational procedures or prescribing/dispensing experimental drugs? If **YES**, please explain: | | | | | ☐ Yes ☐ No |
| | b | Have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? If **YES**, please explain: | | | | | ☐ Yes ☐ No |
| 7 | a | Do you now treat prisoners in a State, Federal or any correctional institution? | | | | | ☐ Yes ☐ No |
| | b | Have you ever treated prisoners in a State, Federal or any correctional institution? If **YES**, please provide last date of treatment: | | | | | ☐ Yes ☐ No |
| 8 | a | Do you work in an Emergency Department? If **YES**, | | | | | ☐ Yes ☐ No |
| | b | Is this solely to satisfy requirements for hospital privileges? | | | | | ☐ Yes ☐ No |
| | c | Indicate the average number of hours you work in the Emergency Department each month: | | | | | |
| 9 | a | Are you a sports team physician or health care provider? | | | | | ☐ Yes ☐ No |
| | b | If **YES,** check all that apply: ☐ High School ☐ College ☐ Professional ☐ Other: Name and location of team(s): | | | | | |
| 10 | a | Do you treat patients in a Nursing Home or a similar care facility? If **YES**, | | | | | ☐ Yes ☐ No |
| | b | How many patients currently reside in a Nursing Home or similar care facility? | | | | | |
| | c | Is the Nursing Home or a similar care facility a contractual relationship or are new patients being seen? | | | | | ☐ Yes ☐ No |

11 Indicate if you are now, or have ever been, any of the following at any Nursing Home, Hospital, Hospital Department, Sanitarium, HMO, PPO, Ambulatory Care Clinic with bed and board facilities, or any other business enterprise:

| | Now | % of Practice | In the Past | % of Practice | Type of Facility (identify from list above) |
|---|---|---|---|---|---|
| Proprietor | ☐ | % | ☐ | % | |
| Partner | ☐ | % | ☐ | % | |
| Officer | ☐ | % | ☐ | % | |
| Director | ☐ | % | ☐ | % | |
| Administrator | ☐ | % | ☐ | % | |
| Executive Director | ☐ | % | ☐ | % | |
| Medical Director | ☐ | % | ☐ | % | |
| Contractor | ☐ | % | ☐ | % | |
| Provider of Services | ☐ | % | ☐ | % | |
| Employee | ☐ | % | ☐ | % | |

For items checked above**,** provide name(s) of facilities and explain details:

| | | | |
|---|---|---|---|
| 12 | Do you engage in tele-medicine activity? If **YES,** please describe the activity: | | ☐ Yes ☐ No |
| 13 | Do you prescribe drugs or provide diagnosis via the Internet? If **YES,** please describe: | | ☐ Yes ☐ No |
| 14 | Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)? If **YES,** please describe: | | ☐ Yes ☐ No |

## VI. PRIOR POLICY and LOSS INFORMATION

1 Please provide the following information pertaining to your past 5 years of professional liability coverage:

| Policy Period | Insurance Carrier | Policy Limits | Deductible | Type of Policy | Premium | ✳Total # of Claims |
|---|---|---|---|---|---|---|
| | | | | ☐ CM ☐ Occ | $ | |
| | | | | ☐ CM ☐ Occ | $ | |
| | | | | ☐ CM ☐ Occ | $ | |
| | | | | ☐ CM ☐ Occ | $ | |
| | | | | ☐ CM ☐ Occ | $ | |

✳Total # of claims, by carrier, regardless of payment, no-payment, dismissal or status.

| | | | |
|---|---|---|---|
| 2 | Have you ever practiced without professional liability insurance? If **YES**, specify dates from and until: | | ☐ Yes ☐ No |
| 3 | Have you ever had any insurance company decline, cancel, rescind or non-renew any Professional Liability Insurance Policy? *(Response not required in the State of Missouri.)* If **YES**, please provide details: | | ☐ Yes ☐ No |
| 4 | Are you aware of any of the following: | | |
| | a | Known losses or claims that have not been reported to a prior insurance carrier or any other source | ☐ Yes ☐ No |

| | | | |
|---|---|---|---|
| | | from which payment might be made? | |
| | b | A specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, that has not been reported to a prior insurance carrier? | ☐ Yes ☐ No |
| | c | Any request for medical records by a patient or his/her attorney which might result in a claim? | ☐ Yes ☐ No |
| | d | Information relating to service(s) on a Board which might result in a claim? | ☐ Yes ☐ No |
| | e | Any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, threat of claim, letter of intent, adverse result notice or attorney contact? | ☐ Yes ☐ No |
| | f | Any involvement, now or ever, in any Professional Liability claim or suit? If **YES,** a **Claim Information Supplemental Application** *must* be completed for each claim. | ☐ Yes ☐ No |
| | If **YES** to any of the above, please provide details: | | |

## VII. COVERAGE REQUESTED

***NOTE: The Company may not offer or quote requested coverage.***

Effective Date: Retroactive Date:

*Important: Declarations Page of your current policy must be attached if a retroactive date is requested.*

| | | | |
|---|---|---|---|
| **Limits of Liability**: | ☐ $ 100,000 / $300,000 | **Deductible:** | ☐ None |
| | ☐ $ 200,000 / $600,000 | | ☐ $ 5,000 |
| | ☐ $ 250,000 / $750,000 | | ☐ $ 7,500 |
| | ☐ $1,000,000 / $3,000,000 | | ☐ $10,000 |
| | Other: $ | | Other: $ |

## VIII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

**PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.**
**By signing this Application, you represent and agree to each of the following five (5) items:**

| | | |
|---|---|---|
| 1 | You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and | |
| 2 | This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply) | |
| | ☐ Part-time Supplemental Application | ☐ Statement of No Known Claims Letter |
| | ☐ Claim Information Supplemental Application | ☐ Other (specify): |
| 3 | Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are: | |
| | a | Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated; |
| | b | Representations you are making on behalf of all persons and entities proposed to be insured; |
| | c | A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations. |
| 4 | This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated. | |
| 5 | You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance. | |

**FRAUD WARNING**

**Notice to Applicants of all states except New Jersey, New York, Pennsylvania, and Washington D.C.:**

**Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 the person to criminal and civil penalties 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 New York Applicants:**

**Any person who knowingly and with the 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 provision.**

**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 a 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 Washington D.C. 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.**

**IMPORTANT NOTICE:** Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

The applicant must sign this Application within 45 days prior to the policy inception date.

| Signature of Applicant: | Date: |
|---|---|
| Print or Type Name and Title: | |