INSPIRIEN

505 Cloverdale Road, Suite 104
Montgomery, AL 36106
Return to: notifications@inspirien.net

Important Notice to Applicants

Important Information Concerning Claims Made Policies

With a claims-made policy, two dates matter most, the **effective date** (policy start date) and the **retroactive date** (the first date you had uninterrupted claims made coverage, unless otherwise stated).

Coverage applies only to incidents occurring **on or after the retroactive date** if the claim is **first made and reported in writing to Inspirien during the policy period**. No coverage applies to:

- Incidents before the retroactive date.
- Claims, suits, or proceedings first brought before the effective date.
- Incidents known (or that should have been known) prior to the effective date that could reasonably lead to a claim.
- Incidents or claims reported to another insurer before the effective date.

To avoid gaps, applicants should report all potential claims to their current carrier before their policy ends (or within the reporting period allowed). Another option is to purchase a **"tail" (reporting endorsement)** to extend reporting time. For details, contact your agent or Inspirien.

Important Information Regarding Extended Reporting Periods (Tail)

Upon termination of your policy, either by you or by us you will have the right to purchase an endorsement providing an Extended Reporting Period, during which claims otherwise covered by this policy may be first made against you and reported to us.

Without this endorsement, you will not have coverage for any claim reported to us after your policy terminates. The endorsement would reinstate your policy limit once for all claims reported after the termination date.

To exercise your option to purchase this endorsement, you will need to contact your insurance agent within the number of days indicated in your policy after the policy terminates. You must also pay any outstanding premium balance that remains on your terminated Claims Made policy.

Important Information Concerning Electronic Delivery of Policies

To receive electronic delivery of policy information you must have a valid email on file with us and have a device capable of receiving emails, viewing and downloading files, and a PDF reader. If a document requires proof of receipt, we will utilize an electronic method that provides such verification like a read receipt confirmation. If we receive a non-deliverable notification we will attempt to deliver via an alternative electronic method or revert to paper delivery.

Please acknowledge your desire of policy information delivery by checking the appropriate box:

___ I agree to receive all mailings and communication electronically; such electronic mailings or communications may even include cancellation or nonrenewal notices.
___ I do not consent to electronic delivery.

Signature _____ Date _____
Printed Name _____

Email address for electronic delivery _____

Alabama Applicants Only Arbitration Acknowledgement: Important Information Concerning Your Legal Rights

This Document Affects Your Legal Rights. Read the Following Information Carefully.

1. **The policy for which you have applied includes a binding arbitration agreement.**

2. **The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.**

3. **The results of the arbitration are final and binding on you and the insurance company.**

4. **In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.**

5. **When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.**

6. **Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.**

Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause - contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disagreements be resolved by binding arbitration.

Signature _____ Date _____
Printed Name _____

This notice provides no coverage and should not be construed to replace any provisions of your policy. You should read your policy and your Declarations page for complete information about your coverage. If there is any conflict between the policy and this notice, the provisions of the policy will govern.

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Application for Healthcare Facility Professional and General Liability

Section 1 – Applicant Information

Name of Facility	**Name of Facility D/B/A**
Contact Person	**Telephone**
Fax	**Business Address**
Mailing Address	**Billing Address, if different**
Email Address	**Website**
Federal Tax ID	**Telephone**

Coverage Effective Date

From:_____ To:_____

Section 2 - Limits of Liability
(Indicate Limits Desired)

Professional Liability (Claims Made)

$_____ Each Claim $ _____ Annual Aggregate

Deductible/Annual Aggregate (select one)
___ No Deductible ___ $25,000 ___ $50,000 ___ $100, 000 ___ $250,000
___ other _____

Enter retroactive date desired _____

Commercial General Liability

Do you wish to purchase Commercial General Liability Coverage? ___ Yes ___ No
If yes, what coverage type? ___ Claims Made ___ Occurrence
If claims made, retroactive date desired _____
If yes, please complete General Liability Application section below.

Excess Liability

Do you wish to purchase Excess/Umbrella Liability Coverage? ___ Yes ___ No
If yes, please complete the ***Excess Medical Professional and Umbrella Liability Application***.

Section 3 – Facility Information

Type of Facility

___ Hospital-General ___ Clinic-MD Owned ___ Laboratory ___ Long Term Care
___ Hospital-Children ___ Community Health Center ___ Surgical Center
___ Other _____

___ Hospital-Specialized (please indicate which below)
___ Psychiatric ___ Teaching ___ Detox ___ Geriatric ___ Rehabilitation ___ Women's
___ Other _____

Services

Does the facility own, operate, or anticipate acquiring any of the following?
___ Abortion Clinic ___ Dietary ___ Obstetrical ___ Robotic Surgery
___ Ambulance ___ Emergency Center, ___ Open Heart ___ Self-Care/Wellness
___ Blood Bank Freestanding ___ Pathology ___ Shock Trauma
___ Burn Unit ___ Gift Shop

____ Coronary Rescue
____ Day Care
____ Dialysis
____ Heliport # of Landings _____
____ Inhalation Therapy
____ Morgue
____ Nursery
____ Pharmacy
____ Physical Fitness Center
____ Radiation Therapy
____ Radiology
____ Substance Abuse Center, Freestanding
____ Surgical Center

Which of the following are performed at your facility?
____ Experimental Surgery ____ Neurosurgery ____ Open-heart Surgery
____ Weight Reduction/Bariatric Surgery

Will any new services be provided in the next 12 months? ____ Yes ____ No
Will any services be discontinued in the next 12 months? ____ Yes ____ No
Have any services been discontinued in the last 24 months? ____ Yes ____ No
If yes to any of the above, please provide details.

_____
_____
_____

Operations/Ownership

____ Individually Owned ____ Partnership ____ Corporate ____ Municipal ____ Non-Profit ____ For Profit
____ Other _____

Do you have any revenue affiliations (e.g., Joint Ventures, PPSs, HIMOs, Etc.)? ____ Yes ____ No
If yes, please provide details:

Name of Entity	Relationship (e.g., Joint Venture, Owner, etc.)

Does your facility have a management contract to provide management services to other facilities? ____ Yes ____ No
If yes, please provide the name and address of the entity and a copy of contract _____
Does another organization provide management services to your facility? ____ Yes ____ No
If yes, please provide the name and address of the entity and a copy of contract.

_____

Affiliations/Accreditations

____ Joint Commission Accredited Date _____ ____ Medicare Approved ____ Member AHA
____ AAAHC Accredited Date _____
____ AAASF Accredited Date _____

Please list any medical school affiliation or allied healthcare school affiliations.

_____
_____
_____

Type of Patients (Indicate % of each)

_____ Medical _____ Substance Abuse _____ Surgical _____ Psychiatric
_____ Obstetrical _____ Rehabilitation _____ Long Term _____ Other

Owned Long Term Care Facilities (Nursing Home/Assisted Living/Hospice/Home Health)

Do you own a Nursing Home/Assisted Living/Hospice/Home Health? ____ Yes ____ No
If coverage is desired for any long term care services, please complete questions in Section 6 below.

Telemedicine

Explain any telemedicine activities in which your entity takes part.

_____
_____
_____

Clinical Research

Describe the aims and specific objectives of any human clinical trials to be performed and by whom.

_____
_____
_____

Is this research clinical or academic in nature? ____ Clinical ____ Academic

What are the risks and potential benefits of the research to the subjects?

_____
_____
_____

What primary coverage is in place for clinical research exposure?

_____
_____
_____

Please provide a copy of the following:

___ Study Protocols ___ Conflict of interest Policy ___ Patient Selection
___ Informed Consent Policy ___ Institutional Review Board Rules and Regulations as they relate to your entity

Section 4 – Facility Exposure Information

Class	Projected Inpatient Days this Year
Acute Care Beds	
Swing Beds	
Hospital Bassinets	
Deliveries including C Section (Actual Number)	
Psychiatric/Substance Abuse Beds	
Physical Rehabilitation Beds	
Nursing Home Beds	
Assisted Living Beds	
Hospice Beds	
Independent Living Beds	

Class	Projected # of Visits/Surgeries this Year
Hospital Inpatient Surgeries	
Hospital Outpatient Surgeries	
Hospital Emergency Department Visits	
Clinics, Dispensaries, Infirmaries Visits	
Other Hospital Outpatient Visits (visits not otherwise classified)	
Psychiatric/Substance Abuse Visits	
Physical Rehabilitation Visits	
Home Health Visits	
Hospice Visits	

Class	Units	Exposure Units Current Year
Wellness Center	*Receipts	
Medical/X-ray	*Receipts	
Laboratory	*Receipts	
Pharmacy	*Receipts	

*Receipts for outpatient services only – do not include receipts from inpatient services.

Section 5 – Staff

Employees: Non-Physician, Non-Dentist (indicate the number of the following types of employees in your facility)

___ Lab Technicians	___ Perfusionists	___ Registered Nurses	___ Pharmacists	___ CRNAs
___ Paramedics/EMTs	___ X-ray Technicians	___ Volunteer Workers	___ Heart-Lung Technicians	___ LPNs
___ Nurse Practitioners	___ Physician Assistants	___ Students	___ Traveling Nurses	___ Midwives

Do you wish to include the individuals listed above as additional insureds sharing in the facility's limits? ____Yes ____No
If yes, please include the Full Time Equivalent (FTE) for the following:
Nurse Practitioners _____ Physician Assistants _____ CRNAs _____ Midwives _____

Contracted Physicians/Services

Are your physicians/dentists or any other services contracted? ____Yes ____No
If contracted, name of group/physicians? _____
How often does that staff work at the entity? _____
Is the staff obligated to follow entity rules and procedures? ____Yes ____No
Does the staff have the right to refuse patients? ____Yes ____No

Employed Physicians/Dentists

Indicate the number of employed physicians/dentists in your facility:
Surgeons _____ Physicians _____ Dentists _____ Intern/Externs _____ Residents/Fellows _____

Is coverage to be provided to the individuals listed? ____Yes ____No
If yes, please complete and submit ***Application for Professional Liability Insurance for Physicians and Dentists.***
Do the individuals share the limits? ____Yes ____No
Do excess limits apply? ____Yes ____No

Professional Liability Requirements for Physicians/Dentist

Do the medical staff by-laws require each employed or contracted physician or dentist to maintain Professional Liability Insurance? ____Yes ____No
If yes, what are the minimum limits of liability required? _____
How many physicians are credentialed and on staff? _____
How is coverage verified (e.g. Certificate of Insurance required)? _____
Please describe the monitoring system to ensure malpractice policies of physicians are kept current .
_____
_____
_____
Has the license of any physician been restricted or suspended in the last two years? ____Yes ____No
If yes, was the employee employed or contracted? ____Employed ____Contracted Name: _____
Have the privileges of any physician been restricted or suspended in the last year? ____Yes ____No
If yes, was the employee employed or contracted? ____Employed ____Contracted Name: _____

Risk Management

Is there a designated Risk Manager? ____Yes ____No
If yes, please provide a copy of the Risk Manager's C.V. and answer the following:
Does the Risk Manager have support from the board of directors? ____Yes ____No
Does the Risk Manager have the authority to implement change? ____Yes ____No

Does the entity have a written Risk Management Program? ____Yes ____No
If yes, please provide.

What percent of your internal Quality Assurance/Performance Improvement (QAPI) reports in the current year are:
Incidents _____ Near Misses _____ Unsafe Conditions _____ (totals should equal 100%)

Section 6 – Specific Departments

Nursing Home/ Assisted Living/Hospice

Do you employ or contract the medical director? ? ____Employed ____Contracted

Briefly describe the director's medical qualifications.
_____
_____
_____
_____

If there is not a medical director, who is responsible for overseeing the professional services and care provided?
_____
_____
_____
_____

Does the medical director also act as the attending physician for any residents? ____Yes ____No
If yes, indicate the medical professional liability limits required: $_____ each claim/$_____ annual aggregate

Are employees/contractors' references contacted before hiring/placement ? ____Yes ____No

How are references checked?

_____
_____
_____

Do you question prospective employees as to any criminal record and are background checks performed?
____Yes ____No

How are patient transfer decisions made?

_____
_____
_____

Do you require written orders from an attending physician for:
All Medications and Drugs ____Yes ____No
Special Dietary requirements ____Yes ____No
Any other special treatment/therapy ____Yes ____No

How often are attending physicians required to update their patient charts? _____

Are nursing assessments made on all new patients? ____Yes ____No

Do you contract for medical professional services? ____Yes ____No
If yes, check the appropriate boxes:
____Physical Therapy ____Nursing Service ____Pharmacy ____Respiratory Therapy
____Speech Therapy ____Nutrition ____Other _____

Anesthesia

____Employed ____Contracted If contracted, name of group/physician(s) _____

_____ Number of Anesthesiologists _____ Number of CRNAs

Is there an anesthesiologists or CRNA on the premises 24 hours a day? ____Yes ____No
Are CRNA always supervised by an anesthesiologist? ____Yes ____No
Are Family Practitioners administering anesthesia? ____Yes ____No
If yes, indicate the number of administering anesthesia _____
Does an informed consent discussion take place between the patient and the anesthesiologist or CRNA that includes anesthesia contemplated benefits, risks, alternatives, and complications and documented in the medical records?
____Yes ____No

Emergency

____Employed ____Contracted If contracted, name of group/physician(s) _____

If your facility does not operate an Emergency Room, check here: _____
If there is no Emergency Department, how does the facility arrange for treatment of trauma patients?

_____
_____
_____

If there is a Joint Commission accredited Emergency Department, select the level of services provided:
_____ Level I (Tertiary)
_____ Level II (Comprehensive)
_____ Level III (Basic)
_____ N/A
_____ Other _____

If the Emergency Department is not Joint Commission accredited, what is the designated level of service provided?

_____
_____
_____

Does the Emergency Department have a trauma center designation? ____Yes ____No If yes, attach protocol.
Does the Emergency Department have a fast-track service? ____Yes ____No
If yes, who provides care? _____
Does the Emergency Department have 24-hour in-house physician coverage? ____Yes ____No
Are all emergency room patients seen by a physician before discharge? ____Yes ____No
If no, do board and bylaws approve use of mid-level providers? ____Yes ____No

Obstetrics

____Employed ____Contracted If contracted, name of group/physician(s) _____

Total number of OB of staff? _____

Level of OB Unit:

____Level I is usually categorized as basic or well-newborn unit. It provides the care for low-risk infants born in the hospital and for stable, growing, or recovering infants who are returned to their birth hospital from a Level II or Level III facility. The service must have a professional staff member skilled in neonatal resuscitation on site, and pediatrician on call 24-hours a day.

____Level II is usually categorized as a specialty unit. It provides all Level I services and offers specialized services to moderately ill infants either born in the hospital or transferred from Level I facilities. They must provide certain medical specialty and support services including on-site 24-hour coverage by a pediatrician, and specially trained laboratory and radiology staff.

____Level III is usually categorized as a Perinatal Center and/or Neonatal Intensive Care Unit. It provides services to newborns of all risk levels, including babies with unusual or severe complications and anomalies, in addition to Level I and II services. They offer a comprehensive range of specialty and subspecialty services to maternal and newborn patients at the center, and to others referred to it from Level I or II facilities.

Do family/general practice physician have OB privileges? ____Yes ____No If yes, how many? _____
What is the number of deliveries per individual practitioners? _____
Do midwives practice in labor and delivery? ____Yes ____No
If yes, are there written protocols for privileges? ____Yes ____No
Do you follow ACOG guidelines concerning VBACs? ____Yes ____No
Who provides anesthesia during labor and delivery? _____

Section 7 – Commercial General Liability Application

Desired Limits

General Aggregate	$ _____
Products – Completed Operations Aggregate	$ _____
Each Occurrence	$ _____
Personal and Advertising Injury Limit	$ _____
Damages to Premises Rented to You Limit	$50,000 or ____Excluded Coverage
Medical Expenses Limit	$5,000 or ____Excluded Coverage

Deductibles

$_____ Per Claim/Person $_____ Annual Aggregate

Location							
	Address	Function	No. Stories	Year Built	Construction	*Fire Protection	Sq. Ftg.
Owned							
Leased							

If necessary, please attach separate sheets

*Fire Protection Key: CS = Complete Sprinkler PS = Partial Sprinkler HD = Heat Detector SD = Smoke Detector AA = Automatic Alarm MA = Manual Alarm

		Yes	No
a.	Is a formal, written, safety and security program in operation?	____	____
b.	Any exposure to flammables, explosives, chemicals?	____	____
c.	Any exposure to radioactive/nuclear materials other than in the ordinary operation of a medical premise?	____	____
d.	Have your operations or have past operations ever involved storing, treating, discharging, applying, disposing or transporting of hazardous materials other than those in ordinary operation?	____	____
e.	Machinery or equipment loaned or rented to others?	____	____
f.	Any watercraft, docks, or floats owned, hired, or leased?	____	____
g.	Any parking facilities owned/rented?	____	____
	If yes, is a fee charged for parking?	____	____

h.	Recreational facilities provided?	____	____
i.	Is there a swimming pool on the premises?	____	____
j.	Sporting or social events sponsored?	____	____
k.	Any structural alterations or new construction planned?	____	____
l.	Any demolition exposure contemplated?	____	____
m.	Do you lease employees to or from other employers?	____	____
n.	Is there a labor interchange with any other business or subsidiaries?	____	____
o.	Are day care facilities operated or controlled?	____	____
p.	Do all patient care areas have:	____	____
	Self-closing fire doors in each floor?	____	____
	Automatic fire alarm systems connected to fire department?	____	____
	Smoke detectors?	____	____
	A written emergency evacuation plan?	____	____
	At least two clearly marked exits on each floor?	____	____
q.	Do you have a helipad or other landing area for helicopters?	____	____
	If yes, list location and number of landings per year: _____		
	Is the helipad licensed by the State Bureau of Aviation, Department of Transportation?	____	____
r.	Do you own, lease, or charter any aircraft?	____	____
	If yes, please provide a copy of your Aircraft and/or Aviation Liability Policy.		
s.	Do you own or lease any automobile?	____	____
	If yes, do you maintain a commercial Auto Policy?	____	____
	If no, do you wish to add hired and non-owned auto liability?	____	____
t.	Any mobile medical premises in operation?	____	____
	If yes, please provide details and a copy of your Commercial Automobile Policy.		
u.	If you have residential properties, are they certified as lead free (MA, NJ, and RI)?	____	____
	If yes, please provide documentation.		
v.	Does the property(ies) to be covered include units intended to rent or let as residential living quarters or dwellings (MA, MD)?	____	____
w.	Do you have medical students in a training program sponsored and controlled by you?	____	____
x.	Do you have any past losses or claims relating to sexual abuse or molestation allegations, discrimination or negligent hiring?	____	____
y.	Do you wish to add any additional insureds to your commercial general liability coverage? If yes, provide a list and relation to facility.	____	____

Explain any yes answers in the space provided below, if necessary, please attach separate sheets.

Section 8 – Prior Carrier Information

Professional Liability	**Years:**	**Years:**	**Years:**	**Years:**	**Years:**
Carrier					
Policy Number					
Policy Type	____Claims Made ____Occurrence	____Claims Made ____Occurrence	____Claims Made ____Occurrence	____Claims Made ____Occurrence	____Claims Made ____Occurrence
Limits					
Retro Date					
Premium Paid					

General Liability		**Years:**	**Years:**	**Years:**	**Years:**	**Years:**
Carrier						
Policy Number						
Policy Type		____Claims Made ____Occurrence	____Claims Made ____Occurrence	____Claims Made ____Occurrence	____Claims Made ____Occurrence	____Claims Made ____Occurrence
Retro Date						
Limits	General Aggregate					
	Products Comp OP Aggregate					
	Personal & ADV INJ					
	Each Occurrence					
	Premises Rented					
	Medical Payments					
Total Premium						

Has any insurance company ever:

a. Declined? ____Yes ____No
b. Failed to renew? ____Yes ____No
c. Cancelled your policy? ____Yes ____No
d. Conditionally renewed? ____Yes ____No

If yes to any of the above, please indicate the name of the company, date, and brief explanation below.
Company _____ Date _____
Explanation (if necessary, attach information for additional companies).
_____
_____
_____

Prior Acts

Have any claims ever been made against you? ____Yes ____No
Do you know of any pending claims, incidents, or activities, including any request for patient records that might give rise to a claim in the future? ____Yes ____No
Have you reported all claims or activities described above to your prior insurance carrier? ____Yes ____No
If no, identify each claim or incident that has not been reported on a separate sheet of paper and attach to your application.

Please attach a copy of the following to this application for all facilities:

____Most recent Audited Financial Statements
____Copy of brochures and marketing information
____Copy of sample contract for contracted physicians/dentists
____A complete copy of current policy and endorsements, unless already insured with Inspirien
____Minimum of 10 years lost history
____Organizational chart
____Most recent Medicare recertification survey, statement of deficiencies and plan of correction
____Written procedures for claims handling and risk management
____List of entities to be covered under the policy and relationship to the applicant

Section 9 – Optional Coverages

For New Jersey Applicants Only - Consent to Settle

This endorsement is automatically attached to all healthcare facility policies. It requires the Company to obtain your written consent before settling any claims brought against you. In accordance with New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for a 1% premium credit to your policy.

Would you like to remove this endorsement? ____Yes ____No

State Disclosure Addendum

Read Carefully Before Signing
The statements in this application, together with any supplemental applications, attachments and any other information submitted to the company in connection with this application will be referred to as the "policy application."

Representations as to accuracy of application, the authority of person signing, and applicant's obligation to supplement information
By signing below, I represent and certify: (I) that the information contained in the policy application is true and accurate; (ii) that I have made all reasonable efforts to investigate the accuracy of the information provided in the policy application and to obtain such information from all persons and entities to be insured by the requested policy as is necessary to provide true and accurate information in the policy application; and (iii) that I am duly authorized to sign this policy application on behalf of all persons and entities to be insured by the requested insurance and that I have carefully read this policy application.

I acknowledge that obtaining the requested insurance, including any renewals of the requested insurance, is conditioned upon providing true and accurate information in this policy application, and any such insurance that may be issued will be based upon the company's reliance on the information provided in the policy application. I also agree and understand that this policy application shall be the basis of the contract should a policy be issued, and that this policy application will be deemed to be attached to and part of such policy and any renewals of such policy, if issued. Further, if any information in this policy application is misleading, incomplete or false, the company may void the insurance issued pursuant to this policy application to the extent permitted by applicable law.

I agree that I will immediately notify the company in writing of any material change in the information provided in this policy application that may occur before the effective date of the requested insurance or before any renewal of the requested insurance. I understand that if I fail to provide such notice, the company may void the insurance issued pursuant to this policy application or any renewal of the requested insurance. I understand that, to the extent permitted by applicable law (and except as may be prohibited under Montana and/or Oregon law), the company may in its sole discretion modify or withdraw any quotation or agreement to bind insurance in the event of any material change in the information provided in this policy application.

No Obligation to Issue or Purchase Insurance
I understand that the policy application is not a binder of insurance. Accepting the policy application does not bind the company to issue, or me to purchase, the requested insurance regardless of whether I have made payment, in whole or in part, for the requested insurance or whether the company has deposited such payment. I understand that the requested insurance shall not be effective until I have paid a deposit to the company in the amount invoiced by the company, regardless of whether or not a policy or any renewals of such policy have been issued.

Authorization to Obtain Information
The company is hereby authorized to obtain full information from any liability insurer, healthcare insurer, hospital, healthcare provider, medical association or society, board of medical examiners, governmental agency, attorney or other person or entity concerning: (I) any medical malpractice claim, suit, licensing board proceeding, credentialing proceeding, disciplinary action or any other civil or criminal action asserted against or relating to the professional conduct of any person or entity to be covered by the requested insurance; (ii) the qualifications of any person or entity to be covered by the requested insurance to perform professional healthcare services; and (iii) such other information which, in the sole judgment of the company, may have a bearing on whether to issue the requested insurance. I agree to hold harmless any person or entity providing such information to the company and the company, its directors, officers, employees, and agents from any liability arising out of the disclosure of such information, including any liability arising out of errors and omissions in the information disclosed.

Alabama, Arkansas, Indiana, Kentucky, Minnesota, New Mexico, New York, Rhode Island, Tennessee, Texas, West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties which may include voiding of the policy if allowed by state law.

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

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 with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulated Agencies.

District of Columbia 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.

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.

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.

Maine Applicants: Per 24-A M.R.S.A. 2186(3), 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.

New Jersey Applicants: Any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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.

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.

Oregon 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 may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. For an insurer to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the insured, the insurer must show that the misinformation is material to the insurance policy, that the insurer relied on the misinformation and that the misinformation was provided fraudulently.

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.

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 may include imprisonment, fines or denial of insurance benefits.

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.

Applicant (print name of entity)	Title	Signature of Producer (signature is required for N.H. producers only)	Date
Signature of Duty Authorized Officer or Employee	Date	Printed Name of Producer	
Printed Name of Duty Authorized Officer or Employee			