

LONG TERM CARE ORGANIZATION PROFESSIONAL AND GENERAL LIABILITY NEW BUSINESS APPLICATION

Α. Α	A. APPLICANT INFORMATION:						
1.	Legal Name of Facility/ FNI:						
2.	Address:						
3.	Mailing Address:						
4.	Website:						
	(Please provide copies of any brochures and/or advertising materials used to promote the facility)						
5.	How many years has the Applicant been in operation?						
	Under present ownership?						
	Management?						
6.	Applicant is: For Profit Not for Profit						

В. С	B. GENERAL INFORMATION (If answer is "Yes" to any of the following questions, please provide details.)					
1.	Is any part of the Applicant operated / leased by a management corporation?	Yes	No			
	If yes, please provide the name of the management corporation:					
	If yes, please provide a list of additional facilities owned and managed.					

List below all subsidiaries and direct affiliates, with a description of operations, acquisition/formation date and ownership interest.

Name & Address	Description of Operations	Relationship	Date Acquired	Ownership %

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

2.	Please provide a copy of your 2 most recent state surveys and advise if the Applicant ever been accused of any Medicare or Medicaid fraud or abuse violations, or paid any fines or penalties? Yes No
	If yes, please provide an overview of the situation: including dates, accusation, amounts of fines, types of penalties, steps to mitigate similar issues
3.	In the past three years, has the facility been designated as a "Special Focus Facility" (SFF)? Yes No
4.	Does the Applicant anticipate any facility expansions (increase in licensed beds or new facilities) within the next 12 months? Yes No
	If yes, please explain:
5.	Does the Applicant have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next 12 months? Yes No
	If yes, please explain:
6.	Does the Applicant own, operate or manage any businesses or facilities other than the operations described in this Application? Yes No
	If "Yes", please provide details, including name of entity and the Applicant's ownership interest/management role.
7.	What services are being provided under the AL license?

8.	Please provide % of residents receiving services for mental illness (outside of Dementia/Alzheime	er's)
9.	What acuity level and conditions would preclude the insured from accepting a resident?	
10.	How often are residents reassessed for acuity level/conditions that wouldn't meet acceptance cr	iteria of facility?
11.	For AL or IL facilities, are you affiliated with a skilled facility where you would recommend relocato advancement in acuity? Please provide your discharge protocol:	ting a resident due
12.	Applicable to FL ALF only : Please check the type of AL license associated with the facility below:	
	Extended Congregate Care	
	Limited Nursing Services	
	Limited Mental Health	
	Standard	
13.	Please provide a copy of the facility license	
	Please confirm whether or not it has never been revoked or suspended	
14.	Does your facility provide any wound care services? Yes	No
	If so, provide policy and procedure:	

1. Total Exposure:				
Bed Census	Number of Licensed	Beds / Units	Number of Oc	cupied Beds / Units
Skilled Nursing Facility				
Dementia / Alzheimer				
Sub-Acute / Rehabilitation				
Assisted Living				
Independent Living**				
	•			
** Please confirm if IL component h	nas emergency call buttons o	r pull cords		Yes No
* If applicant has more than 1 facili exposures	ty, please complete Attachm	ent #1 for all sched	duled locations a	and breakdown of
Other Professional Services:				
None				
Adult Daycare		Number of Daily	y Attendees	
Home Health Services		Number of Annual Visits:		
Hospice		Number of Annual Visits:		
Ventilator/Tracheostor	ny beds	Number of occupied beds:		
Pharmacy		Receipts:		
Other:				
Behavioral Health	Number of Residents	Behavioral Hea	lth	Number of Residents
Traumatic Brain Injury		Addiction Issues	5	
Post-Traumatic Stress Disorder		Bipolar Disorde	r	
Developmental Disabilities		Methadone Ma	intenance	
Schizophrenia		Criminal Justice	Referred	

Yes

Yes

Yes

No

No

No

Are there formal behavioral health programs provided by outside mental health professional(s)?

Are there in-house behavioral health resources and/or programs?

Is there a separate unit/section for the behavioral health residents?

C. DESCRIPTION OF SERVICES AND RESIDENT PROFILE:

2.	Resident Age Grou					
		Age Group	Number of Residents			
		Age 0-18				
		Age 19-40				
		Age 41-65				
		Age 65+				
3.	If you accept reside	ents under the age 65	5, what are the circumstances?			
4.	Please confirm if in	nsured has a pool and	d/or other body of water on premise:	Yes	No	
	riease commitmi	isureu nas a poor and	ayor other body or water on premise.	163	_	

D. ADMINISTRATION AND STAFF:							
	Name	FT/PT	Employed / Contracted	Limits of Liability	Years of Experience	Tenure at Facility	Licensed (Y/N)
Administrator							
DON							
Medical Director							
Does the Medica	l Director also act as the atte	ending ph	nysician to any i	residents?		Yes	No
If "Yes", to how r	If "Yes", to how many residents?						
Risk Management Contact:							
Phone:							
Email:							

1.	Is there a formal, documented assessment process to measure staff competency skills?	Yes	No	
2.	Does the insured have a formal cell phone policy?	Yes	No	

Physicians and Medical Director:

1.	Number of physicians:	Employed:	Affiliated:	Contracted:		
2.	2. Do you obtain and review physicians' certificates of malpractice insurance? Yes No					No
3.	3. Do you require limits of liability comparable to your own?			,	Yes	No
	If "No", define the differences in limits:					

4.	What limits do you require your physicians to carry?		
5.	Are the physicians credentialed?	Yes	No
	a. If "Yes", how often are they re-credentialed?		
	b. Do you conduct credentialing internally or with the assistance of a third party?		
	If a third party, who?		
6.	Is a physician on site or on call on a 24-hour basis?	Yes	No

Nursing Staff Census:

CATEGORY	Avg. hours worked per day	Turnover rate
RN		
LPN / VN		
CNA / Personal caregiver		

Show percentage of nursing staff by experience level:

< 5 yrs	
6 – 10 yrs.	
11 – 20 yrs.	
> 25 yrs.	

E.	POLICIE	S AND PROCEDURES:					
1.	Does t	ne Applicant have a written emergency e	vacuation plan?	Yes	No		
	a.	a. Are evacuation plans posted in all parts of the facility? Yes					
	b.	How often are evacuation / fire drills co	onducted for each shift?				
	c.	Does the staff orientation plan include	a review and "walk through" of	f any disaster plan? Yes	No		
	d.	If in a CAT prone area, please provide y	our emergency evacuation plar	n.			
2.	Please	confirm if any residents have eloped fro	m the facility.	Yes	No		
	a.	If "Yes", how many?	When?				
		What was the outcome?					
	b.	Was this reported to the prior carrier?		Yes	No		
	c.	Please provide a copy of your elopeme	nt policy and procedures.				
3.	Are yo	u aware of any abuse incidents that have	occurred at your facility?	Yes	No		
	a.	If "Yes", how many?	When?				
		What was the outcome?					
	b.	Was this reported to the prior carrier?		Yes	No		

	c. Please provide a copy of the facilities abuse policy and procedures.		
4.	Do you use Wander Guard or a similar system at all locations?	Yes	No
5.	Do you serve alcohol to your residents?	Yes	No
	a. If "Yes", do you provide to the public?	Yes	No
	(If yes, please complete Liquor Liability Supplemental Application)		
6.	Is smoking permitted in resident's rooms?	Yes	No
	a. In common areas?	Yes	No
7.	Describe specific rules applicable to smoking:		

F. PHYSICAL PREMISES AND ADDITIONAL LOCATIONS:

1. If applicant has more than 1 facility, please complete Attachment #1 for all scheduled locations.

Premises Information:							
Address:			City:		State:	Zip:	
Year Built:		# of Sto	ories: Total Square		Total Square F	Feet:	
Was the building originally designed and constructed for nursing home occupancy? Yes No							
Does this building meet applicable current NFPA life safety codes? Yes No							
Construction Type:	Construction Type: Frame Brick Non-combustible Masonry Non-combustible				Fire resistive		
Location of Smoke Detectors:	None	Hallways	Entire Facility	Con	nmon Areas	Other	
Areas Protected by Sprinkler System	None	Resident Rooms	Entire Facility	Hal	llways	Common Areas	

G. COVERAGE INFORMATION:								
Current Professional Liability Coverage:	Current General Liability Coverage:	Current Excess Coverage:						
Carrier:	Carrier:	Carrier:						
Policy Period:	Policy Period:	Policy Period:						
Limits of Liability:	Limits of Liability:	Limits of Liability:						
Claims-Made Occurrence	Claims-Made Occurrence	Claims-Made Occurrence						
If Claims Made, Retroactive Date:	If Claims Made, Retroactive Date:	If Claims Made, Retroactive Date:						
DOL DWL	DOL DWL	DOL DWL						
Deductible	Deductible	Deductible						
Self-Insured Retention:	Self-Insured Retention:	Self-Insured Retention:						
Premium:	Premium:	Premium:						

н.	CLAIMS INFORMATION: (MISSOURI RESIDENTS DO NOT ANSWER):
1.	Has any insurer cancelled, rescinded or declined professional liability insurance for the Applicant? Yes No
2.	Please attach currently valued loss run describing all claims/incidents during the past 10 years made against the Applicant or any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. (Attach additional sheets, if necessary). If "None", so state:
3.	Neither the Applicant nor any individual or entity proposed for coverage, is aware of any fact, incident, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows (Attach additional sheets, if necessary). If "None", so state:

Attachment #1

1. Facility Name:							
Facility Addres	s:						
Bed Census			Numbe	er of Licensed Beds / U	<u>Inits</u>	Number of Occupied Beds / Units	
Skilled Nursing	-						
Dementia / Alz							
Sub-Acute / Re							
Assisted Living							
Independent L	iving						
Construction Type:	Frame	В	rick	Non-combustible		onry n-combustible	Fire resistive
Location of Smoke Detectors:	None	Ha	allways	Entire Facility	Con	nmon Areas	Other
' None			esident ooms	Entire Facility	Hallways		Common Areas
W. M.							
2. Facility Name:							
Facility Addres	s:						
Bed Census			Numbe	er of Licensed Beds / U	<u>Inits</u>	Number of Occu	upied Beds / Units
Skilled Nursing	•						
Dementia / Alz							
Sub-Acute / Rehabilitation							
Assisted Living							
Independent L	iving						
Construction Type:	Frame	e Brick		Non-combustible	Maso Non-	onry -combustible	Fire resistive
Location of Smoke Detectors:	None	На	allways	Entire Facility	Common Areas		Other
' I None I			sident oms	Entire Facility	Entire Facility Hallways		Common Areas

3. Facility Name	:						
Facility Addres	ss:						
Bed Census			Numbe	er of Licensed Beds / L	<u>Jnits</u>	Number of Occi	upied Beds / Units
Skilled Nursing	g Facility						
Dementia / Ala	zheimer						
Sub-Acute / Re	ehabilitation						
Assisted Living	Ţ						
Independent L	iving						
Construction Type:	Frame	В	rick	Non-combustible	Mas Non	onry -combustible	Fire resistive
Location of Smoke Detectors:	None	e Hallways		Entire Facility	Common Areas		Other
l None l			esident ooms	Entire Facility	Hallways		Common Areas
4. Facility Name	:						
Facility Addres	SS:						
Bed Census			Numbe	er of Licensed Beds / L	Inita	Number of Occ	upied Beds / Units
<u>Bed Cellsus</u>			Nullibe	er of Licensed Beds / C	<u> </u>	Number of Occi	apieu Beus / Oilits
Skilled Nursing	Facility						
Dementia / Ala	•						
Sub-Acute / Rehabilitation							
Assisted Living							
Independent L							
Construction Type: Frame Bric			rick	Non-combustible	Mas Non	onry -combustible	Fire resistive
Location of Smoke Detectors:	None	На	allways	Entire Facility	Com	mon Areas	Other
Areas Protected by Sprinkler System None Rooms				Entire Facility	Hall	ways	Common Areas

BROKER OR AGENT CONTACT INFORMATION

Name:	
Firm:	
Address:	
Phone:	
Email:	

WARRANTY AND REPRESENTATION, FRAUD WARNINGS, AND SIGNATURE

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THIS RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY.

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares, warrants and represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. Should any of the information in this Application be false or inaccurate, this policy may be void *ab initio*, as if the policy had never existed.

The information contained in and submitted with this Application is on file with the Insurer, and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand that:

- a) If any portion of the policy to be issued is written on a "Claims Made" basis, then such portion(s) shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Insurer in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period or within the time period set forth in the policy; and
- b) the limit of liability available under the policy to be issued available to pay damages, settlements, or judgments may be reduced, and may be exhausted, by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

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

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

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

NOTICE TO 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 PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO COMMITS A FRAUDULENT INSURANCE ACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION, FINES AND CONFINEMENT IN PRISON. A FRAUDULENT INSURANCE ACT MEANS AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER OR INSURANCE AGENT OR BROKER, ANY WRITTEN,

ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR INSURANCE OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT UNDER AN INSURANCE POLICY, WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY MATERIAL FACT THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

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

NOTICE TO MAINE, TENNESSEE, VIRGINIA & WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

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

NOTICE TO OREGON 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 FINES AND CONFINEMENT IN PRISON. IN ORDER FOR US TO DENY A CLAIM ON THE BASIS OF MISSTATEMENTS, MISREPRESENTATIONS, OMISSIONS OR CONCEALMENTS ON YOUR PART. WE MUST SHOW THAT:

- A. THE MISINFORMATION IS MATERIAL TO THE CONTENT OF THE POLICY;
- B. WE RELIED UPON THE MISINFORMATION; AND
- C. THE INFORMATION WAS EITHER:
 - 1. MATERIAL TO THE RISK ASSUMED BY US; OR
 - 2. PROVIDED FRAUDULENTLY.

FOR REMEDIES OTHER THAN THE DENIAL OF A CLAIM, MISSTATEMENTS, MISREPRESENTATIONS, OMISSIONS OR CONCEALMENTS ON YOUR PART MUST EITHER BE FRAUDULENT OR MATERIAL TO OUR INTERESTS.
MISSTATEMENTS, MISREPRESENTATIONS, OMISSIONS OR CONCEALMENTS ON YOUR PART ARE NOT FRAUDULENT UNLESS THEY ARE MADE WITH THE INTENT TO KNOWINGLY DEFRAUD.

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

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Applicant (signature):						
By (Chairman and /or President – Print Name)						
	Title:	Date:				

NOTE: This Application must be signed by the Chairman or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.