

Type of Day Care:	# of Total Clients Served	% of services
Type I: Adult day social care provides social care and social activities such as meals, recreation and some basic health-related services such as having a nurse on staff to check pressure (Light exposures).		%
Type II: Adult day health care offers more intensive health, therapeutic, and social services for individuals with moderate to severe medical and cognitive problems including an incidental exposure (up to 25%) of clients with Alzheimer's. Activities within this category also include social activities for clients that require more intense health, therapeutic and medical care. (Moderate to heavy exposures)		%
Type III: Alzheimer's specific adult day care provides social and health services to persons with Alzheimer's or related dementia. The predominant exposure in this category are clients with this diagnosis or organizations that have an Alzheimer's or related dementia exposure greater than an incidental as outlined within the Type II description.		%

For Type II and III, please outline the types of medical services provided:

SECTION II – MANAGEMENT PRACTICES

- Does Applicant have sign in / out procedures for:
Staff? Yes No Clients/Residents? Yes No Visitors/Public? Yes No
- Type of security provided for the protection of your clients / residents?
Guards Video Cameras Other:
- What measures are taken to monitor client activities?
- Describe the procedures currently in place, which prevents the clients from wondering off or outside the premises?
- What precautions do you take to prevent non-staff members from accessing unauthorized areas of the property?
- Do you have incident reporting procedures and / or committee reviews? Yes No
- Do you have a plan for medical emergencies? Yes No
- Is there always someone trained in CPR and first aid on the premises? Yes No
- Do you have Automatic External Defibrillator(s)? Yes No
- Are staff members trained to use it? Yes No
- Do you have a written and enforced no smoking policy? Yes No
- Are "no smoking" signs posted in all areas not designated from smoking? Yes No

SECTION III – PROFESSIONAL LIABILITY

- Does the Applicant require their staff (paid & volunteer) to complete an employment application? Yes No
If no, please explain:
- Does the Applicant conduct a personal interview for each prospective staff member? Yes No
- Does the Applicant verify employment related references? Yes No
- Does the Applicant verify licenses and other credentials? Yes No
- What action does the Applicant take if any report is considered unfavorable?
- Does the Applicant share written job descriptions with all staff members? Yes No
- Name of executive director / manager:
Number of years experience in this field: Number of years at this facility:
Specialized training or education:
- What is the staff turnover rate for the last twelve (12) months?
- Does the Applicant provide workers compensation for:
All staff members Workshop Employees Contractors Consultants
- Is the staff required to report to the administrator all incidences that may result in a claim? Yes No
If yes, is a written report kept? Yes No Are they reviewed? Yes No
- Are clients referred to specialists when appropriate? Yes No
- Are files maintained to protect confidentiality of clients? Yes No
- Does the Applicant do any consulting work? Yes No
If yes, please explain:

17. If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.
18. If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least \$1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.
19. **Consultant / Independent Contractors**
 Are there written agreements with independent contractors? Yes No
 Are certificates of malpractice / professional liability insurance obtained and maintained for all contracted service providers (independent contractors)? Yes No
 Please indicate the limits of liability: \$
20. Based on the **maximum number** of clients enrolled on your **busiest** day, enter the numbers of staff and clients in each of the following categories:

TYPE OF ADULT DAY CARE	# OF CARE PROVIDERS		# OF CLIENTS
	MALE	FEMALE	
TYPE I			
TYPE II			
TYPE III			

(The ratios of staff-to-client must be at least the state required ratio)

21. Are any **staff** less than 18 years old? Yes No
(Indicate specific duties for each on a separate document.)
22. Does the Applicant use any volunteers? Yes No
(Indicate specific duties for each on a separate document.)
23. Is a minimum of one staff member certified in First Aid present at all times? Yes No
24. Is a minimum of one staff member certified in CPR present at all times? Yes No

SECTION IV – HIRING / SCREENING

1. Are employees screened to rule out drug, alcohol and sexual abuse? Yes No
2. Check all methods used in hiring all employees or independent contractors:
 Drug Testing? Criminal Background Checks – Federal Criminal Background Checks – State
 Reference Checks Personal Interview Sexual Abuse Registry Validate Driver's License
 Validate Work History Validate Education Verify Current Certification / Professional License
 Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours)
3. How are references checked: Written Verbal Both
 If verbal only, please explain:
4. Are all of the above methods done prior to binding? Yes No
 If no, please explain:

SECTION V – SEXUAL ABUSE

N/A

1. Does the Applicant's current insurance program include Abuse and Molestation Coverage? Yes No
 If yes, Occurrence or Claims Made – Retro Date: Limit of Liability: \$
 Carrier: Effective Date:
2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? Yes No
3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if the Applicant has incident of abuse? Yes No
4. Are there written complaint procedures and are they displayed prominently? Yes No
 If yes, explain:
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? Yes No
6. Are formal written procedures in place for hiring? Yes No
7. Do volunteers work directly with clients? Yes No
8. Is there formal staff training on child/sexual abuse, including how to recognize the signs? Yes No
9. What procedures are in place to make sure no relationship occurs between staff and clients?
10. Are there procedures prohibiting closed door one-on-one meetings / counseling? Yes No
11. Is there more than one person responsible for the welfare of any single patient? Yes No

- | | | | |
|-----|--|------------------------------|-------------|
| 12. | Have any incidents resulted in an allegation of sexual abuse? | Yes | No |
| | Was the case settled? Yes No | Was the case taken to trial? | Yes No |
| | Amount paid for damages to the victim: \$ | | |
| 13. | Does the Applicant run criminal background checks on employees? | Yes | No |
| 14. | Does the Applicant run criminal background checks on volunteers? | Yes | No |

SECTION VI – PREMISES / LIFE SAFETY

- | | | | |
|-----|--|-----|----|
| 1. | If the building you occupy was built prior to 1971; has it been inspected for lead paint?
If no, what is the plan for abatement? | Yes | No |
| 2. | Does the property have aluminum wiring?
If yes, has it been retrofitted with one of the PHLY approved connectors by a licensed Electrician?
(indicate which one): COPALUM? Yes No AlumiConn?
Date updated: Please supply retrofit documentation or statement from installing contractor. | Yes | No |
| 3. | Have asbestos material been:
determined not to be present removed or protected to prevent flaking? | | |
| 4. | Do you have any plans for renovations or new construction? | Yes | No |
| 5. | Does the Applicant's center exit directly to the outside?
To ground level? | Yes | No |
| 6. | Are there any non-ambulatory clients?
If yes, how many? Any located above the first floor? | Yes | No |
| 7. | Please indicate which of the following fire suppression devices are currently in use and in effect:
Automatic Sprinkler System Central Station Fire Alarm System Smoke Detectors
Manual Pull Fire Alarms Fire Extinguishers Other: | | |
| 8. | How many means of egress are there?
Are all exits clearly marked & illuminated? | Yes | No |
| 9. | Are all exit doors equipped with panic hardware? | Yes | No |
| 10. | Is there a fire escape?
If yes, please describe: | Yes | No |
| 11. | Do you have a written emergency evacuation plan?
If yes, are the emergency evacuation procedures and floor plan posted?
Have you established a central meeting point outside the building?
Does the emergency plan include notification to the fire department?
How often are drills held? | Yes | No |
| 12. | Do you have emergency lighting or backup generators in the event of a power failure? | Yes | No |
| 13. | Do you have a formal maintenance housekeeping program in place? | Yes | No |
| 14. | Do you own or rent a parking facility?
If yes, are they well lit? | Yes | No |
| 15. | Is the hot water heater set to a temperature of 120 degrees?
Do you have an equipment maintenance program in place? | Yes | No |
| 16. | Has your facility been inspected by an insurance company or independent inspection firm?
If yes, by whom?
On a separate sheet, please list any deficiencies and corrective actions in the past three (3) years: | Yes | No |
| 17. | Does the Applicant comply with board of health regulations and with building codes? | Yes | No |
| 18. | Are medical facilities, such as a first aid or nurse's station located on the premise? | Yes | No |
| 19. | Please indicate the dates of the latest updates regarding the following common hazards:
Electrical/Wiring: Plumbing: Heating:
Type of Heating: Type of Roof: Age of Roof: | | |

SECTION VII – CLAIMS MADE

N/A

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant’s rights, duties and what is and is not covered.

N/A (Please proceed to signature section)

Policy Effective Date:

Line of Business:

- | | | |
|---|-----|----|
| 1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant?
If yes, please provide details: | Yes | No |
| 2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying?
If yes, please provide details: | Yes | No |

SECTION VIII - AUTOMOBILE

Owned Automobiles

- | | | |
|---|-----|----|
| 1. Are all vehicles listed on the ACORD application titled to the Applicant?
If no, please explain: | Yes | No |
| 2. Where does the Applicant keep their own vehicles?
Garage Driveway Parking Lot Other: | | |
| 3. Are keys locked and secured away from non-drivers when not in use? | Yes | No |
| 4. Are vehicles with eight or more seating capacity equipped with an audible backup warning device? | Yes | No |
| 5. Does the Applicant provide transportation for:
Staff Clients / Residents Visitors / Public Meals
If yes for clients / residents, is more than one staff member required in the vehicle?
If yes for meals, what precautions do you take to prevent food spoilage? | Yes | No |
| 6. Does the Applicant transport clients / residents for other human services agencies?
If yes, please explain: | Yes | No |
| 7. Does the Applicant provide transportation for field trips?
If the Applicant does not provide transportation, how is it provided?

If vehicles are hired for field trips, are they hired with a driver? | Yes | No |
| 8. Does the Applicant’s employees / volunteers transport clients in their own vehicles?
If yes, how often? | Yes | No |
| 9. Are vehicles checked after passengers disembark to make sure no one is left behind? | Yes | No |
| 10. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? | Yes | No |
| 11. Does the Applicant require seat belts to be worn by all occupants? | Yes | No |
| 12. Does the Applicant have a vehicle maintenance program in place? | Yes | No |
| 13. Does the Applicant’s organization utilize GPS fleet telematics devices?
If yes, please check off the fleet telematics being utilized:
Plug in Hard wired Mobile Phone Other: | Yes | No |
| 14. What percentage of the Applicant’s fleet is provided with these fleet telematics devices? | % | |

Hired and Non-Owned

- | | | | |
|--|-----|----|------------|
| 1. Does the Applicant hire vehicles?
If yes, what type of vehicles does the Applicant hire? | Yes | No | N/A |
| Does the Applicant obtain Certificates of Insurance?
What minimum limits does the Applicant require? \$ | Yes | No | |
| 2. Does the Applicant hire from a transportation company?
If yes, with drivers? | Yes | No | |
| 3. Total number of hired vehicles: _____ Annual cost of hire: \$ _____ | | | |
| 4. How many drive personal vehicles for business use regularly? F/T: _____ P/T: _____ Vol: _____
How many drive personal vehicles for business use occasionally? F/T: _____ P/T: _____ Vol: _____
Does the Applicant obtain proof of insurance for employees / volunteers who use their own autos? | Yes | No | |
| Does the Applicant update these records at least yearly?
What minimum limits does Applicant require? \$ | Yes | No | |

Drivers

- | | | | |
|--|-----|----|------------|
| 1. Does the Applicant obtain a written authorization to release driver information from all of the Applicants staff upon hiring?
Does the Applicant obtain MVRs on all drivers?
If yes, how often? | Yes | No | N/A |
| 2. What are the Applicant’s procedures for dealing with driver accidents or violations? | | | |
| 3. Are all drivers at least twenty-one (21) years of age? | Yes | No | |
| 4. How many drivers (employees and volunteers) aged twenty-one (21) to twenty-five (25) transport clients in agency vehicles? | | | |
| 5. Do any drivers have a Commercial Driver’s License (CDL)? | Yes | No | |
| 6. Explain the Applicant’s driver safety program: | | | |
| 7. Is training provided for new employees / volunteers prior to their transporting clients?
If yes, please explain: | Yes | No | |
| 8. Does anyone besides employees or volunteers drive Applicant’s vehicles?
If yes, please explain: | Yes | No | |
| 9. Does the Applicant allow personal use of the Applicant’s agency vehicles?
If yes, by whom and for what reasons? | Yes | No | |

SECTION IX – SWIMMING POOLS

N/A

- | | | |
|--|-----|----|
| 1. Is there a training lifeguard on duty?
If yes, how many? _____ During what hours? _____ | Yes | No |
| 2. The pool area includes:
Jacuzzi _____ Whirlpool _____ Hot Tub _____ Spa _____ Kiddie Pool _____ Water Slide _____ Trampoline _____ | | |
| 3. Is the pool completely fences with a self-locking gate?
If yes, what is the height? _____ | Yes | No |
| 4. Pool location: Indoor _____ Outdoor _____ | | |
| 5. Is there a diving board?
If yes, what is the height? _____ | Yes | No |
| 6. Are depths clearly marked? | Yes | No |
| 7. Is life saving equipment readily accessible? | Yes | No |
| 8. Is walking surface around the pool non-skid and in good condition? | Yes | No |
| 9. Is the staff trained in water safety? | Yes | No |
| 10. Are all areas of the pool, including the bottom, visible at all times? | Yes | No |
| 11. Are “swim at your own risk” signs posted with pool rules?
Do the posted rules meet state and local regulations? | Yes | No |
| 12. Is the storage of pool chemicals secured? | Yes | No |

- | | | |
|---|-----|----|
| 13. How often is the pool cleaned? | | |
| 14. Do you have specific guidelines regarding closing the pool due to water contamination? | Yes | No |
| 15. Are all swimming pools and spas compliant with the Virginia Graeme Baker Pool and Spa safety act? | Yes | No |
| If no, provide time table and action plan: | | |

SECTION X – FIELDTRIPS / OFF PREMISES TRAVEL	N/A
---	------------

- | | | |
|--|-----|----|
| 1. Are field trips taken (or do you anticipate field trips during the next 12 months)? | Yes | No |
| If yes, answer the following: | | |
| 2. Describe the field trips: | | |
| | | |
| 3. Does the Applicant travel off premises for other events such as fundraising events? | Yes | No |
| 4. Describe those trips: | | |

SECTION XI – SPECIAL EVENTS	N/A
------------------------------------	------------

- | | | |
|--|-----|----|
| 1. Are any pets or animals kept on premises? | Yes | No |
| Describe animals, caging, and type of interaction: | | |
| | | |
| 2. Are special classes provided? (Exercise, Dance, etc.) | Yes | No |
| If yes, please explain: | | |
| | | |
| 3. Are special classes taught by an independent contractor on your premises? | Yes | No |
| 4. Does Applicant request / maintain Certificates of Insurance from all sub-contractors? | Yes | No |
| 5. Does the Applicant have any operations other than Adult Day Care? | Yes | No |
| If yes, please explain: | | |

SECTION XII – KITCHEN EXPOSURE	N/A
---------------------------------------	------------

- | | | |
|--|-----|----|
| 1. Is cooking permitted on the premises? | Yes | No |
| 2. Is the actual cooking of food prepared and cooked by the staff? | Yes | No |
| 3. Are there fire extinguishers in the cooking area available? | Yes | No |
| 4. The cooking equipment is: Residential Commercial | | |
| 5. Cooking equipment is equipped with: | | |
| Nothing Hoods Ducts Exhaust Fans | | |
| Automatic Fire Suppression System Automatic Fuel shut off control | | |
| 6. How often is the cooking equipment cleaned? | | |
| Is the cleaning equipment: Cleaned by you Cleaning Contractor | | |

WINTER WEATHER FREEZE PROTECTION

The Winter Weather Freeze Section is mandatory on all risks that have a prior winter freeze loss greater than \$25,000 or 10% of the building TIV in the past 5 years OR a location in states commonly experiencing freezing temperatures.

These states include but are not limited to: AL, AR, AZ, CO, CT, DE, DC, GA, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY

- | | | | | |
|----|--|-----|----|-----|
| 1. | Can the Applicant reliably confirm that all areas of the Applicant's building with fire sprinkler piping and/ or domestic water lines can be maintained at 45° F or higher?
This includes exterior accessed sprinkler riser rooms, as well as attics, crawl spaces, and stairwells if they have water lines in them. | Yes | No | N/A |
| | a. If not, select all freeze protection measures currently in place:
Temperature monitoring and remote heating control system (Wi-Fi temperature controls)
PHLYSense
Other water detection/ notification/ alarm system
Backup electrical generator, ensuring building heat at all times
Insulation around water pipes in cold areas*
Heat tracing for water pipes in cold areas*
Antifreeze fire sprinkler system in cold areas*
Space heaters or heated forced air in attics, crawl spaces, stairwells with fire sprinklers
Other: | | | |
| | * Cold areas are defined as portions of a building that cannot be maintained at all times reliably at or above 45° F. | | | |
| 2. | Fire Protection and Testing | | | |
| | a. Is the building provided with an Automatic Fire Sprinkler System (AS)? | Yes | No | N/A |
| | i. If yes, what type of sprinkler system is installed? Wet-Pipe Dry-Pipe Both | | | |
| | ii. If yes, approximately what percentage (%) of the building is sprinklered? % | | | |
| | iii. If yes, has the system been tested & inspection by qualified sprinkler contractor within past 12 months & includes a formal winterization review? | Yes | No | N/A |
| | iv. If yes, are the alarms tied to a 24 hour UL listed monitoring company? | Yes | No | N/A |
| 3. | Emergency Water Response (domestic and AS water lines) | | | |
| | a. Are water shutoff valves (domestic and AS water lines) marked and readily accessible? | Yes | No | N/A |
| | b. Are water shutoff valves exercised (closed and reopened) at least annually? | Yes | No | N/A |
| | c. Is the staff qualified to respond and shut off the water main during normal business hours and off hours? | Yes | No | N/A |
| 4. | Automatic Water Shutoff Devices | | | |
| | a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? | Yes | No | N/A |
| 5. | Unused/ Vacant Spaces | | | |
| | a. Does Applicant have a formal process to turn off and drain domestic water lines for these spaces? | Yes | No | N/A |
| 6. | Seasonal Occupancies ONLY: | | | |
| | a. Is there a full-time caretaker/ maintenance personnel on the premise?
If yes, select required duties of the caretaker: | Yes | No | N/A |
| | Regular walkthroughs of the building | | | |
| | i. How often each day? | | | |
| | Trained in the location(s) of water shut off valve(s) | | | |
| | Inspects taps and leaves them dripping in freeze weather events | | | |
| | Shuts off or drains pipes during freezing temperatures | | | |
| | Monitors building temperatures ensuring heat is maintained at required levels | | | |
| | Responds to power outages | | | |
| | i. List of required procedures | | | |
| | b. If no caretaker is present, has the building been properly winterized including water turned off, pipes drained, heat maintained, proper pipe insulation, etc.? | Yes | No | N/A |

CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:
 Address of Applicant:
 City: State: Zip:
 Website: www:
 Nature of Operations:

1. Annual sales or revenue: \$

2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? Yes No
 If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
 - a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
 - b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
 - c. Credit or Debit Card Information

3.
 - a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? Yes No
 - b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? Yes No
 - c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? Yes No
 - d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? Yes No

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

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 THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). **(NOT APPLICABLE IN AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NY, OH, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, LA, MD, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON (IN ALABAMA, MAYBE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF).

APPLICABLE IN CALIFORNIA: 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 PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

APPLICABLE IN 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.

APPLICABLE IN 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.

APPLICABLE IN 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.

APPLICABLE IN KANSAS: 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, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS 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.

APPLICABLE IN 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 A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN 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.

APPLICABLE IN 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 CIVIL FINES AND CRIMINAL PENALTIES.

APPLICABLE IN 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 A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

APPLICABLE IN 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.

APPLICABLE IN 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.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON: 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.

APPLICABLE IN VERMONT: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

APPLICABLE IN 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. THIS APPLIES TO AUTO INSURANCE.

NAME (PLEASE PRINT/TYPE)

TITLE

(MUST BE SIGNED BY THE PRESIDENT, BOARD CHAIR, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER

(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER

(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)