

AFFINITY PRO PORTFOLIO APPLICATION**TRADE ASSOCIATION – PROFESSIONAL LIABILITY**

NOT-FOR-PROFIT ORGANIZATION DIRECTORS AND OFFICERS LIABILITY INSURANCE

EMPLOYMENT PRACTICES LIABILITY INSURANCE

FIDUCIARY LIABILITY INSURANCE

WORKPLACE VIOLENCE COVERAGE

INTERNET LIABILITY INSURANCE

CRIME INSURANCE

PROFESSIONAL LIABILITY

BUSINESSOWNERS POLICY

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY

PLEASE READ YOUR POLICY CAREFULLY

Instructions:

- Whenever used in this Application the term **Applicant** shall mean the Parent Organization and its wholly-owned/controlled subsidiaries.
- The **Applicant** is required to complete Sections 1, 2, and 10.
- The **Applicant** should complete all applicable Section(s) for which coverage is desired. (See chart below)

Check Coverage Desired	Section	Requested Limit	Requested Retention
<input type="checkbox"/> General Information	1	\$	\$
<input type="checkbox"/> Directors & Officers	2	\$	\$
<input type="checkbox"/> Employment Practices	3	\$	\$
<input type="checkbox"/> Fiduciary Liability	4	\$	\$
<input type="checkbox"/> Workplace Violence	5	\$	\$
<input type="checkbox"/> Internet Liability	6	\$	\$
<input type="checkbox"/> Professional Liability	7	\$	\$
<input type="checkbox"/> Crime	8	\$	\$
<input type="checkbox"/> Businessowners Policy	9	\$	\$
<input type="checkbox"/> General Summary	10	\$	\$

SECTION 1 – GENERAL INFORMATION
(All Applicants must complete this section)

1. Name of Parent Organization: _____

2. Address: _____

Telephone: (____) _____ Internet Address: www. _____

3. Date Established: _____ State of Incorporation: _____

4. Standard Industrial Classification (SIC) #: _____

4a. Federal Employer Identification (FEIN) #: _____

5. Please describe the nature of the **Applicant's** operations:

6. Does the **Applicant** have tax-exempt status under the U.S. Internal Revenue Code? ☐ Yes ☐ No **If no, provide an explanation.**

7. The officer of the **Applicant** designated to receive any and all notices from the **Underwriter** or their authorized representative concerning this insurance is:

_____ Name	_____ Title	_____ E-mail Address
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8. Number of Members: _____ Number of Chapters: _____

Please attach details for all "YES" answers to questions 9 – 12.

9. Does the **Applicant** publish any magazines, periodicals or newsletters? ☐ Yes ☐ No
10. Is the **Applicant** involved in product research, product development, testing and/or certification? ☐ Yes ☐ No
11. Does the **Applicant** set standards for the qualification and performance and/or certify its members?
☐ Yes ☐ No
12. Does the **Applicant** engage in any disciplinary actions as a result of peer review activities? ☐ Yes ☐ No

13. FINANCIAL INFORMATION	CURRENT FISCAL YEAR	PREVIOUS FISCAL YEAR
TOTAL ASSETS:	\$ _____	\$ _____
NET ASSETS / FUND BALANCE:	\$ _____	\$ _____
ANNUAL REVENUE:	\$ _____	\$ _____
NET REVENUE:	\$ _____	\$ _____

Please attach the most recent annual financial audit or Form 990.

**SECTION 2 – DIRECTORS AND OFFICERS
(All Applicants must complete this section)**

1. Directors and Officers Liability Insurance has been continuously in force since: _____
2. Provide a list of all direct and indirect subsidiaries or any other entity or organization the **Applicant** controls:

Name / Type of Business	Percent the Applicant Owns / Controls	Date Created / Acquired	For Profit / Non-Profit
Example:			
ABC Foundation, Inc/Charitable Children's Foundation	100%	01/01/2000	Non-Profit

☐ Additional entities listed by attachment

3. Has the **Applicant** or any person proposed for coverage herein been the subject of, or involved in, any of the following in the past five (5) years? **If yes, please attach details.**

Anti-trust, copyright or patent litigation? ☐ Yes ☐ No

Any disciplinary action by any regulatory agency or association? ☐ Yes ☐ No

Any action where a license was revoked or suspended? ☐ Yes ☐ No

Any administrative proceeding charging violation of a federal or state law or regulation? ☐ Yes ☐ No

Any other criminal actions? ☐ Yes ☐ No

It is agreed that with respect to Question #3, if such circumstances exist, any claim arising from such circumstances are excluded from the proposed insurance.

4. In the past twenty-four (24) months or the next twelve (12) months, has the **Applicant** been, or anticipate being involved in any of the following?

Mergers, acquisitions or consolidation with another entity? ☐ Yes ☐ No **If yes, provide details.**

Changes in the board of directors or senior management (other than death or retirement)? ☐ Yes ☐ No
If yes, provide details.

5. Does the **Applicant** direct or request any individual to serve as director, officer, governor or trustee of any other entity? ☐ Yes ☐ No **If yes, provide details.**

SECTION 3 – EMPLOYMENT PRACTICES

(Complete this section only if Employment Practices Liability coverage is desired.)

1. Employment Practices Liability Insurance has been continuously in force since: _____

2. Please provide the following employee count information:

U.S. based employees/volunteers:	Currently	One Year Ago	Two Years Ago
Full Time employees:	_____	_____	_____
Part Time employees:	_____	_____	_____
Temporary employees:	_____	_____	_____
Volunteers:	_____	_____	_____
Non U.S. based employees / volunteers:	_____	_____	_____

TOTAL SUM OF ABOVE

3. How many employees have been terminated or demoted in the past twelve (12) months?

Voluntary: _____ Involuntary: _____ Laid Off: _____

4. Is any reduction of employees or change of status anticipated in the next year?

Voluntary: _____ Involuntary: _____ Layoffs: _____

- | | | |
|---|------------------------------|-----------------------------|
| 5. Does the Applicant have an employee handbook? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does the Applicant use an employment application for every potential employee? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Does the Applicant have an "At Will" provision in the employment application or handbook? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Has the Applicant implemented an anti-sexual harassment policy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has the Applicant implemented an anti-discrimination policy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Does the Applicant use outside employment counsel for employment advice? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SECTION 4 – FIDUCIARY LIABILITY
(Complete this section only if Fiduciary liability coverage is desired.)

1. Fiduciary Liability Insurance has been continuously in force since: _____

2. List all plans for which coverage is requested (use attachment if necessary):

<u>Plan Name</u>	<u>Year Established</u>	<u>Assets / Contributions</u>	<u>Type*</u>	<u>Participants</u>	<u>Administrator</u>
Example: The ABC Children Corp 401K Plan	2000	\$1,000,000	2	75	self

a)

b)

c)

d)

*** 1=Employee Welfare Benefit Plan (as defined by ERISA), 2= Defined Contribution Plan (as defined by ERISA), 3= Defined Benefit Plan (as defined by ERISA), 4=Other. If type is 3 or 4 a Fiduciary Liability Supplemental Application must be completed.**

To provide additional information, please use the separate page attached to the application

3. Does any plan(s) employ the investment, trustee, actuarial, legal, administrative, custodial or benefits consulting services of any outside provider? ☐ Yes ☐ No **Please indicate such outside professionals below:**

4. Has termination been requested or contemplated for any plan? ☐ Yes ☐ No

5. Has any amendment to any plan been made or contemplated within the past two (2) years, or is any amendment now contemplated, which has resulted or might result in any reduction of benefits including, but not limited to, an increase in participants' portion of cost? ☐ Yes ☐ No **If yes, please attach details. If there has been any amendment(s), please attach copies.**

6. Has any plan been spun-off (sold), transferred or terminated? ☐ Yes ☐ No **If yes, please attach details.**

7. Are there or have there been within the last three (3) years any known or alleged violations of ERISA or any similar statutory or common law (including applicable amendments, rules and regulations) of the United States, Canada or any state or other jurisdiction to which a plan is subject? ☐ Yes ☐ No **If yes, please provide details.**

8. Does the **Applicant** have any information to suggest or indicate that any of the plans it sponsors may be under governmental or regulatory investigation with regard to the applicable plan's funding, administration or investment strategies? ☐ Yes ☐ No **If yes, please attach details.**

9. Is a Form 5500 filed on an annual basis for each plan? ☐ Yes ☐ No **If yes, provide a copy of the most recent 5500; if no, please provide details.**

10. Does the **Applicant** serve in a Fiduciary capacity for any multi-employer plan or trust? ☐ Yes ☐ No **Note that multi-employer plans or multiple-employer trusts are not eligible for coverage under the proposed policy(ies).**

SECTION 5 – WORKPLACE VIOLENCE
(Complete this section only if Workplace Violence coverage is desired.)

Please attach a copy of your employee and customer complaint/grievance procedures.

1. Workplace Violence Insurance has been continuously in force since: _____
2. The **Applicant's** total number of work locations: _____
3. Does the **Applicant**:
have an employee complaint/grievance resolution procedure? **If yes, please attach a copy.** ☐ Yes ☐ No
have a written policy on workplace violence that is communicated to all employees? ☐ Yes ☐ No
train employees to recognize, report, and respond to potentially hostile situations? ☐ Yes ☐ No
have a process for performing background checks for all potential employees? ☐ Yes ☐ No
4. In the past twelve (12) months, has the **Applicant** been involved with any layoffs, staff reductions, or facility closings? ☐ Yes ☐ No **If yes, provide details.**

5. Has the **Applicant** or any person proposed for coverage herein been the subject of, or involved in, any incidents of workplace violence in the last five years? ☐ Yes ☐ No **If yes, provide details.**

SECTION 6 – INTERNET LIABILITY
(Complete this section only if Internet Liability coverage is desired.)

1. Internet Liability Insurance has been continuously in force since: _____
2. Please identify the internet site(s) for which coverage is sought, the date each site first went on-line, and (if known) the average number of page views per month:

<u>Internet site address</u>	<u>Date on-line</u>	<u>Average page views per month</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does the **Applicant** conduct transactions (e-commerce) on the site or is the site informative only?
☐ Transactional / E-commerce (Please complete questions 4, 5 & 6)
☐ Informational Only (Please go to question 6)
☐ Both (Please complete questions 4, 5, & 6)
4. The **Applicant's** projected annual gross revenues from the internet site: \$ _____
5. Please describe the type and purpose of the transactions performed on the site:

6. What percentage of monthly page views on the **Applicant's** internet site originates outside the U.S. and Canada? _____%

Network Security:

7. Do you have a firewall? ☐ Yes ☐ No **If yes, identify the hardware / software used.**

8. Do you have a virus protection program in place? ☐ Yes ☐ No **If yes, identify the software used.**

9. Do you have a process for managing computer accounts, including removing outdated access accounts in a timely fashion? ☐ Yes ☐ No

PART 7 – PROFESSIONAL LIABILITY – TRADE ASSOCIATION SERVICES
(Complete this section only if Professional Liability coverage is desired.)

NOTICE: This professional liability coverage is provided on a claims-made basis; therefore, only claims which are first made against you, and reported to the Company, during the policy term, any subsequent renewal of this policy or any extended reporting period are covered, subject to policy provisions.

1. Professional – Trade Association Liability Insurance has been continuously in force since: _____
2. Please list all services which you provide to others for a fee or services that you provide to your members:
Please attach a copy of your standard contract for such services.

Description of services rendered:

Total gross billings: \$_____ Number of years provided: _____

Description of services rendered:

Total gross billings: \$_____ Number of years provided: _____

Description of services rendered:

Total gross billings: \$_____ Number of years provided: _____

3. Does your consulting service(s) require that you have or maintain a professional designation in order to provide the professional service(s)? ☐ Yes ☐ No **If yes, describe the services you provide in such professional capacity and the license(s) required:**
- _____

4. Please list any publications that you sponsor or produce and attach a sample copy:

Name of Publication	Number of Years In Production	Average Circulation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Does the **Applicant**:

provide training to your membership or other third parties? ☐ Yes ☐ No

provide job placement services and job postings for your membership? ☐ Yes ☐ No

administer or sponsor any group insurance programs for your members? ☐ Yes ☐ No

sponsor group purchasing arrangements or establish preferred vendor lists for their members? ☐ Yes ☐ No

SECTION 8 – CRIME

(Complete this section only if Crime coverage is desired.)

(Coverages under the Crime Policy are written on an Occurrence Basis)

Desired Coverage(s):

Limit

Deductible

Insuring Agreement A1: Employee Theft and Client Coverage	\$ _____	\$ _____
Insuring Agreement A2: ERISA Fidelity	\$ _____	\$ _____
Insuring Agreement B: Forgery or Alteration	\$ _____	\$ _____
Insuring Agreement C: Theft, Disappearance & Destruction – Inside the Premises	\$ _____	\$ _____
Insuring Agreement D: Theft, Disappearance & Destruction – Outside the Premises	\$ _____	\$ _____
Insuring Agreement E: Money Orders and Counterfeit Paper Currency	\$ _____	\$ _____
Insuring Agreement F: Computer and Funds Transfer Fraud	\$ _____	\$ _____

1. Third Party – “Off-Premises” Coverage – ☐ Yes ☐ No **If yes, please complete the Third Party Crime Protection Plus Supplemental Form**

2. Coverage requested on a: Discovery Basis ☐ Loss Sustained Basis ☐

3. Current Insurer: _____ Limit \$ _____
Deductible: \$ _____ Premium: \$ _____

Hiring Procedures/Employment Practices:

4. Do you conduct a prior employment check on all new hires? ☐ Yes ☐ No
5. Do you conduct a criminal background check on all new hires? ☐ Yes ☐ No
6. Are credit reports checked when screening new employees? ☐ Yes ☐ No

Audit Procedures:

7. Are all subsidiaries and locations, or majority owned and operated companies, included in the audit? ☐ Yes ☐ No
8. Have all recommendations made by the accountant been adopted? ☐ Yes ☐ No
9. Do you have an internal audit department? If not, is there someone who is responsible for internal control procedures? _____ ☐ Yes ☐ No

Internal Controls:

10. Are two signatures required on checks? If so, over what amount? \$ _____ ☐ Yes ☐ No
If two signatures are not required, who has authority to sign checks? Please provide their name and position.

11. Do employees who reconcile the bank statements also:
- | | | |
|---|------------------------------|-----------------------------|
| a. sign checks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. make withdrawals? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. make deposits? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. have access to blank checks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. have access to computer systems that print checks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. have access to facsimile, signature stamp or check signing machines? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
12. Are your internal control systems designed so that no one employee can control a transaction from beginning to end? (e.g. approve a voucher, request and sign a check) ☐ Yes ☐ No
13. How often is blank check stock inventoried? _____
By whom? _____
14. Are all incoming checks stamped "For Deposit Only" immediately upon receipt? ☐ Yes ☐ No

Money, Securities and Payroll Exposure:

15. Please indicate maximum exposure for each location if requesting Insuring Agreement C or D:
- | <u>Location(s)</u> | <u>Cash</u> | <u>Retail Checks</u> | <u>Credit Card</u>
<u>Receipts and Non-</u>
<u>Retail Checks*</u> | <u>Is there a Safe?</u> |
|--------------------|-------------|----------------------|---|--|
| _____ | \$ _____ | \$ _____ | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | \$ _____ | \$ _____ | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | \$ _____ | \$ _____ | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | \$ _____ | \$ _____ | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

* A non-retail check is a check presented to you and immediately endorsed "for deposit only" and then recorded in your accounting process so that it could be re-created if it were stolen, lost or destroyed.

SECTION 9 – BUSINESSOWNERS INSURANCE

(Complete this section only if Businessowners coverage is desired)

(Coverages under the Businessowners Policy are written on an Occurrence Basis)

The Philadelphia Insurance Companies Businessowners program is for entities which have a Directors & Officers or a Professional Liability policy with our company. Please confirm that you are an applicant / insured under one of these Philadelphia Insurance Companies programs, and that you understand BOP is only available to you as a customer of one of these programs. ☐ I agree

Program Eligibility Requirements:

- Office- based businesses only (**Maximum allowable square footage- 10,000 square feet**)
- Coverage for events is excluded under this policy, except where specifically added by endorsement. Coverage is available via a separate Special Events Policy through Philadelphia Insurance Companies

BUILDING COVERAGE IS NOT OFFERED UNDER THIS PROGRAM

1. Location Address: _____
City: _____ State: _____ Zip: _____
2. Please list any additional offices on an attached sheet. ☐ Check here if there are locations attached.
3. Prior insurance carrier: _____
Effective Dates: _____ Premium: \$ _____
4. Was prior insurance coverage a ☐ Businessowners Policy or a ☐ Package Policy

Desired Businessowners Coverage:

5. Contents coverage \$ _____
Deductible: ☐ \$250 ☐ \$500 ☐ \$1,000 ☐ \$2,500
6. Hired auto: ☐ Yes ☐ No 10b. Non-Owned Auto: ☐ Yes ☐ No
7. Number of buildings: _____ Rent: ☐ Own: ☐ Percent occupied: _____%
8. Construction type: _____ Year built: _____ Square feet: _____

9. Liability & Medical expenses: \$1,000,000 (automatic coverage):

10. Tenants fire legal liability:

Limits: ☐ \$50,000 ☐ \$100,000 ☐ \$250,000 ☐ \$500,000 ☐ \$1,000,000

11. Employee dishonesty w / Additional location(s):

Limits: ☐ \$500 ☐ \$10,000 ☐ \$25,000 ☐ \$50,000 ☐ \$100,000

12. Forgery or Alteration: ☐ Yes ☐ No (This option can only be purchased with Employee Dishonesty Coverage)

13. Valuable papers: ☐ Yes ☐ No

14. Money & Securities-On Premises: \$ _____ Money & Securities-Off Premises: \$ _____

15a. Computer hardware: \$ _____ 15b. Computer software: \$ _____

16a. Interior glass: ☐ Yes ☐ No Square footage: _____ 16b. Signs: \$ _____

17. Please list any entities the Named Insured desires to have listed as an additional insured/loss payee on the policy and the nature of their interest to the policyholder:

Name:	
Address:	Interest:
Name:	
Address:	Interest:
Name:	
Address:	Interest:
Name:	
Address:	Interest:

SECTION 10 – GENERAL SUMMARY
(All Applicants must complete this section.)

With respect to all of the coverage which the Applicant has applied for in this Application, complete the following questions. All information in this Application, including all attachments, are deemed as if attached hereto and are material to the underwriting of this insurance.

Loss Experience:

1. As of this date, or the date on which the **Applicant** first applied for prior similar coverage and has maintained such prior similar coverage continuously in force, no person applying for this coverage is aware of any facts or circumstances, or unresolved job dispute which he or she has reason to suppose might give rise to a future claim that would fall within the scope of any of the proposed coverages for which the Applicant has applied, except: None ☐ or as noted below:
2. Have any claims, suits, or demands for arbitration that would fall within the scope of the proposed insurance been made against the Applicant, its predecessor(s) or any past or present principal, partner, officer or employee within the past five (5) years? None ☐ or as noted below:

With regard to questions 1. and 2., it is understood and agreed that if any such claim, act, error, omission, dispute or circumstance exists, then such claim and/or claims arising from such act, error, omission, dispute or circumstance is excluded from coverage that may be provided under this proposed insurance and, further, failure to disclose such claim, act, error, omission, dispute or circumstance may result in the proposed insurance being void, and/or subject to rescission.

Claimant Name: _____

Indicate: ☐ Claim/Suit ☐ Incident/Potential claim

This claim is: ☐ OPEN ☐ CLOSED

Date claim / incident was reported to the insurance carrier: _____

Provide a full description of the engagement, the events leading up to the claim, allegation asserted, against your firm and the current status of the matter.

Demand Amount: \$ _____ **Totals Defense Costs & Loss Paid to Date: \$** _____

Claimant Name: _____

Indicate: ☐ Claim/Suit ☐ Incident/Potential claim

This claim is: ☐ OPEN ☐ CLOSED

Date claim / incident was reported to the insurance carrier: _____

Provide a full description of the engagement, the events leading up to the claim, allegation asserted, against your firm and the current status of the matter.

Demand Amount: \$ _____ **Totals Defense Costs & Loss Paid to Date: \$** _____

Claimant Name: _____

Indicate: ☐ Claim/Suit ☐ Incident/Potential claim

This claim is: ☐ OPEN ☐ CLOSED

Date claim / incident was reported to the insurance carrier: _____

Provide a full description of the engagement, the events leading up to the claim, allegation asserted, against your firm and the current status of the matter.

Demand Amount: \$ _____ **Totals Defense Costs & Loss Paid to Date: \$** _____

Claimant Name: _____

Indicate: ☐ Claim/Suit ☐ Incident/Potential claim

This claim is: ☐ OPEN ☐ CLOSED

Date claim / incident was reported to the insurance carrier: _____

Provide a full description of the engagement, the events leading up to the claim, allegation asserted, against your firm and the current status of the matter.

Demand Amount: \$ _____ **Totals Defense Costs & Loss Paid to Date: \$** _____

To provide additional information, please use the separate page attached to the application

3. Has any policy or application for similar insurance on your behalf or on the behalf of any of your principals, partners, officers, employees, or on behalf of any predecessors in business ever been declined, canceled, or renewal refused? Yes No
If yes, provide details. (Not Applicable in Missouri)

Material Change:

If there is any material change to the answers of this Application's questions prior to the policy inception date, the **Applicant** must notify the Underwriter in writing. Any outstanding quotation may be modified or withdrawn.

FRAUD NOTICE STATEMENTS

NOTICE TO 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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO ALASKA RESIDENTS APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

NOTICE TO ARKANSAS RESIDENT 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 ARIZONA RESIDENTS APPLICANTS: "FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO COLORADO RESIDENTS 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 RESIDENTS 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 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 LOUISIANA RESIDENTS 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 MAINE RESIDENTS 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 A DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

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

RESIDENTS OF 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."

RESIDENTS OF NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES."

RESIDENTS OF 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."

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

RESIDENTS OF OKLAHOMA APPLICANTS: "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."

RESIDENTS OF OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

RESIDENTS OF 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."

RESIDENTS OF TENNESSEE 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."

RESIDENTS OF TEXAS APPLICANTS: IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF 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 AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF 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."

Signature

The Undersigned warrants that to the best of his/her knowledge and belief the statements set forth herein are true. The Undersigned further declares that any occurrence or event that takes place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Underwriter. The Underwriter may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Underwriter is hereby authorized to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The signing of this Application does not bind the Undersigned to purchase the insurance, nor does the review of this Application bind the insurance company to issue a policy. It is agreed that this Application shall be the basis of the contract should a policy be issued.

Name (Please Print/Type)

Title **(MUST BE SIGNED BY THE PRESIDENT,
CHAIRMAN OR EXECUTIVE DIRECTOR)**

Signature

Date

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the **Applicant** and their respective Directors, Officers or other insured persons.

Produced By: (Section to be completed by Producer/Broker)

Producer

Agency

Producer License No:

Agency Taxpayer ID or SS No.:

Address (Street, City, State, Zip)

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the question number to which you are referring.

Signature

Date