# VGM INSURANCE LIABILITY APPLICATION

Effective Date_____

VGM MEMBER No._____ OPGA/POINT MEMBER No._____ AAHOMECARE MEMBER No. _____

Legal Named Insured (full name of all companies to be insured under this policy)

_____

DBA _____

Entity is: ☐ S Corp ☐ C Corp ☐ Individual ☐ Partnership ☐ Limited Partnership ☐ LLC ☐ Other

If other, please describe: _____

Type of business - Please check all that apply: ☐ Home Medical Equipment/Sleep Lab/ Pharmacy ☐ Distributor

☐ Orthotic and Prosthetic ☐ Manufacturer ☐ Manufacturer Representative ☐ Home Modification

Website _____

Mailing Address _____

Physical Address _____

City _____State _____ZIP _____County _____

Contact Person _____Email _____

Phone No. _____Fax No. _____

Mobile No. _____Preferred Contact Method ☐ Email ☐ Text ☐ Call

FEIN _____Medicare Provider No. _____

NPI No. _____

**Additional Location Information**

Location 1 Building Address: _____

Location 2 Building Address: _____

Location 3 Building Address: _____

Location 4 Building Address: _____

Location 5 Building Address: _____

Estimated Annual Gross Revenue for the upcoming year: $ _____

Annual Gross Revenue for the previous year: $_____

How many full-time equivalent employees does your company have? _____

How many years has your company been in business?

☐ 0 to 3 Years ☐ 4 to 10 Years ☐ 11 to 20 Years ☐ 20+ Years

How many years of experience does the company owner have in the field?

☐ 0 to 2 Years ☐ 3 to 5 Years ☐ 6 to 10 Years ☐ 11 to 20 Years ☐ 20+ Years

Is your company a subsidiary of another entity? ☐ Yes ☐ No

If yes, please explain: _____

Does your company have any subsidiaries? ☐ Yes ☐ No

If yes, please explain: _____

Does your company have any bankruptcies or tax/credit liens against it? ☐ Yes ☐ No

If yes, please explain if state law permits: _____

Does your company utilize independent contractors (1099s) in your business? ☐ Yes ☐ No

If yes, do they carry their own individual insurance coverage? ☐ Yes ☐ No

If yes, does your company collect certificates of insurance from these independent contractors (1099s)?

☐ Yes ☐ No

If yes, please list any independent contractors (1099s) and describe their positions within your company.

Name: _____ Position: _____

Name: _____ Position: _____

Name: _____ Position: _____

Name: _____ Position: _____

Name: _____ Position: _____

Does your company purchase foreign products from a U.S. based distributor? ☐ Yes ☐ No

If yes, please explain: _____

Does your company directly import products or components from a foreign entity? ☐ Yes ☐ No

If yes, what products are being imported? _____

If yes, what countries are the products imported from? _____

If yes, what percentage of gross revenue is derived from imported products? _____%

If yes, is there a US presence or location? _____

## Professional Liability ☐ CHECK HERE IF N/A

Please state the number of employed or contracted professionals by category and describe their duties:

Respiratory Therapists: ____ Duties: _____

Nurses: ____ Duties: _____

Pharmacists: ____ Duties: _____

Occupational/Physical Therapists: _____ Duties: _____

Other Certified
Professionals: ____ Duties: _____

Do these professionals carry their own professional liability insurance? ☐ Yes ☐ No

If yes, what limits do they carry? _____

If yes, do you keep copies of their certificates of insurance? ☐ Yes ☐ No

Does your company charge a fee for professional services separate from the sale or rental of equipment? ☐ Yes ☐ No

Do you employ or contract a medical director? ☐ Yes ☐ No

If yes, medical director's name: _____

## Limits of Liability

**Limits of Liability requested:**

☐ $300K/$300K ☐ $500K/$500K ☐ $1 Mil/$1 Mil ☐ $1 Mil/$2 Mil ☐ $1 Mil/$3 Mil

☐ $2 Mil/$3 Mil ☐ $2 Mil/$4 Mil ☐ $3 Mil/$4 Mil ☐ $4 Mil/$4 Mil ☐ $5 Mil/$5 Mil

**Excess Limits requested:** *Excess limits above $5M are subject to company approval*

☐ $1 Mil ☐ $2 Mil ☐ $3 Mil ☐ $4 Mil ☐ $5 Mil

☐ $6 Mil ☐ $7 Mil ☐ $8 Mil ☐ $9 Mil ☐ $10 Mil

**Please check if you would like a quote for:** *(Not available in all states)*

☐ Hired and Non-owned Auto ☐ Employee Benefits Liability

☐ Stop Gap *(available for ND, OH, WA, WY)* – Payroll for employees in these states $ _____

☐ Abuse and Molestation

☐ $50,000 ☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1,000,000

# Workers' Compensation

Have you had any Workers' Compensation claims in the past five years? ☐Yes ☐No

Has your coverage been canceled /non-renewed in the past three years? ☐Yes ☐No

*If yes, please provide a copy of your loss runs for the past five years.

Limit of Liability: ☐$500K/$500K/$500K ☐$1M/$1M/$1M

Do officers want to be included in Workers' Compensation insurance? ☐Yes ☐No

| Owner/Office Name | Title/Relationship | Percent of Ownership | Duties | Annual Payroll |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Employee Class Code Breakdown:** _____

| Class Code* | Job Description | Estimated Annual Payroll | No. Full-Time Employees | No. Part-time Employees |
|---|---|---|---|---|
| 8810 | Clerical Office Employees | | | |
| 8742 | Salespersons or Collectors - Outside | | | |
| 8832 | Physician & Clerical | | | |
| 7380 | Drivers, Chauffeurs, Messengers, and Their Helpers - Commercial | | | |
| 8017 | Store: Retail | | | |
| 8835** | Home, Public, and Traveling Healthcare – All Employees | | | |
| 8010 | Store: Hardware | | | |
| | Other: | | | |

**If above class codes are not applicable to your state, the codes will be revised accordingly. **Additional questions required.**

## Employment Practices Liability (EPL)

Number of Full Time Employees _____ Number of Part Time Employees _____ Number of Independent Contractors _____

Total Number of Employees _____

Do you have Employment Practices Liability Coverage? ☐ Yes ☐ No

If yes, what is the limit and carrier? _____

Have you experienced any employment-related claims/incidents or potential claims within the last 3 years, regardless if you have EPL coverage or not? ☐ Yes ☐ No

If yes, please provide details _____

Have you been named as a defendant or respondent before any federal, state or local agency within in the past 3 years? ☐ Yes ☐ No

If yes, please provide details _____

## Hired and Non-Owned Auto Liability ☐ CHECK HERE IF N/A

Does your company require or allow your employees/contractors use their personal autos to provide services on your behalf? ☐ Yes ☐ No

Will your company be renting or leasing vehicles? ☐ Yes ☐ No

If yes, for what purpose, does your business rent vehicles? _____

If yes, what is the average number of autos rented/leased annually? _____

If yes, what is the average term of lease/rental agreement? _____

If yes, does your company provide client transports? ☐ Yes ☐ No

If yes, how many annually? _____

If yes, what is the driving radius? _____

If yes, does your company require employees and/or contractors to carry minimum limits of liability of $100,000 under their personal auto policy? ☐ Yes ☐ No

If no, do you require that they carry at least state minimum limits? ☐ Yes ☐ No

If yes, it is management's responsibility to establish and enforce driver selection criteria. Does your company order MVR's annually for all employees and volunteers driving their own vehicles on your behalf for business purposes?

☐ Yes ☐ No

How often are non-owned autos used in your business? ☐ Daily ☐ Weekly ☐ Monthly

Has your company had any non-owned auto losses in the past five years? ☐ Yes ☐ No

**If yes, please provide a copy of loss runs for 5 or more years.**

**Use of the Client's Vehicle**

Does your company ever use the client's vehicle when providing services or performing operations on behalf of the business? ☐ Yes ☐ No

If yes, how often? _____

If yes, does your company verify that the client carries and maintains minimum limits of $100,000 on their personal auto policy? ☐ Yes ☐ No

If no, do you confirm that they carry at least state minimum limits? ☐ Yes ☐ No

If yes, does your company verify that coverage under the client's personal auto policy will extend to your use of the vehicle while providing the agreed upon services? ☐ Yes ☐ No

*By signing this application, the Applicant acknowledges, understands, and agrees it is representing that all its drivers proposed for coverage do not have:*

a. *any more than two moving violations within the past three years;*

b. *any at-fault accidents within the past three years.*

c. *any convictions of Driving Under the Influence (DUI), Reckless Driving, Driving While Intoxicated (DWI), Vehicular Manslaughter, Driving Dangerously, or other similar type of offense.*

*The Applicant further acknowledges, understands, and agrees that coverage will be void and any policy issued to the Applicant will not extend to any losses, claims, accidents, or other matters attributable to or caused by any of its drivers who violate any of the above conditions.*

## Prior Liability Insurance Experience

Has your company had prior liability insurance? ☐ Yes ☐ No

If yes, please complete the section below:

Carrier Name: _____ Year: _____ Premium: _____

Carrier Name: _____ Year: _____ Premium: _____

Carrier Name: _____ Year: _____ Premium: _____

Has your company ever carried insurance that was written on a "claims-made" basis? ☐ Yes ☐ No

If yes, please provide the retroactive date: _____

**Please attach a copy of your claims-made policy declaration page.**

Has your company had any claims filed or losses paid in the last 5 years? ☐ Yes ☐ No

**Please provide a copy of loss runs for 5 or more years.**

Are you aware of any incidents, within the last 5 years, which might give rise to a suit against you? ☐ Yes ☐ No

If yes, please attach an explanation of the incidents.

Has an insurer ever canceled, non-renewed, or has there been any lapse in your liability coverage? ☐ Yes ☐ No

If yes, please explain: _____

## HOME MEDICAL EQUIPMENT/SLEEP LAB/ PHARMACY *(Complete if applicable)*

| Products sold/rented, services provided, and/or permanently installed | | *Grid must total 100% | |
|---|---|---|---|
| | Current Year | | Current Year |
| Apnea Monitor | % | Beds and LAL Mattress | % |
| Ventilators | % | Walkers/Crutches | % |
| CPAP | % | Lift Chairs | % |
| BiPAP | % | Patient Lifts | % |
| Liquid Oxygen | % | Trapeze Bars | % |
| Oxygen Cylinders | % | ADL | % |
| Oxygen Concentrators | % | Parenteral Therapy | % |
| Nebulizers | % | Enteral Therapy | % |
| Motorized Wheelchairs | % | Pharmacy | % |
| Manual Wheelchairs | % | Infusion Pump | % |
| Wheelchair Accessories | % | Sleep Study | % |
| Rollators/Knee Walkers | % | Mastectomy | % |
| Scooters/TriCarts | % | Braces/Orthotics | % |
| Repair & Service | % | Diabetic Shoes | % |
| Elevators - Sales | % | Wound Therapy | % |
| Elevators - Install | % | Cold Therapy | % |
| VPL - Sales | % | CPM | % |
| VPL - Install | % | TENS | % |
| Stair Lifts - Sales | % | Defibrillators | % |
| Stair Lifts - Install | % | Medical Alert Systems | % |
| Ceiling Lifts - Sales | % | Surgical Implants | % |
| Ceiling Lifts - Install | % | Latex Gloves | % |
| Grab/Safety Bars - Sales | % | Incontinence Supplies | % |
| Grab/Safety Bars - Install | % | Urological Supplies | % |
| Van Conversions - Install | % | Diabetic Supplies | % |
| Hand Controls in Autos - Sales | % | Uniforms | % |
| Hand Controls in Autos - Install | % | Misc. Disposables | % |
| Wheelchair Lifts in Autos - Sales | % | Misc. HME Equipment | % |
| Wheelchair Lifts in Autos - Install | % | Other (Please list) | % |
| Other Install (Please list) | % | Other (Please list) | % |
| Other (Please list) | % | Other (Please list) | % |
| **Installation of fixtures and equipment means the permanent installation to any building, structure, or automobile.* | | | |

Does your company charge a fee for respiratory therapy services separate from the sale or rental of equipment?

☐ Yes ☐ No

Is your company accredited by: ☐ ACHC ☐ BOC ☐ CEAC ☐ CHAP ☐ HQAA ☐ JCAHO ☐ Other _____

What year was your company first accredited? _____

Does your company customize, modify, or repair any products? ☐ Yes ☐ No

Does your company have products manufactured for the business? ☐ Yes ☐ No

If yes, does your company private label products? ☐ Yes ☐ No

If yes, what products and percentage of revenue is private labeled? _____

_____

Does your company provide warranties or guarantees other than those provided by manufacturers? ☐ Yes ☐ No

Does your company rent/lease products or provide services to:

☐ Hotels ☐ Resorts ☐ Casinos ☐ Retailers *(e.g., big box stores, malls, grocery stores, etc.)*

If so, how are the products provided? ☐ Rented per customer ☐ Rented/Leased in bulk

Who is responsible for providing instruction on product use? _____

## Elevator Installation ☐ CHECK HERE IF N/A

Does your company install elevators? ☐ Yes ☐ No

If yes, what is the percentage of residential installation _____% and commercial installations? _____%

If yes, does your company have manufacturer trained installers? ☐ Yes ☐ No

If yes, does your company collect documentation verifying the shaft installers are insured and bonded?

☐ Yes ☐ No

If yes, does your company collect documentation verifying that maintenance is required and offered?

☐ Yes ☐ No

If yes, does your company collect documentation verifying training on usage to the end user? ☐ Yes ☐ No

## Pharmacy Operations ☐ CHECK HERE IF N/A

Does your company offer pharmacy services? ☐ Yes ☐ No

If yes, is the pharmacy owner a registered pharmacist? ☐ Yes ☐ No

If yes, does your company operate a closed or open-door pharmacy? ☐ Closed-door ☐ Open-door

If you operate an open pharmacy, are there any other business exposures, such as a gift shop, restaurant, etc.? ☐ Yes ☐ No

If yes, please describe: _____

_____

If yes, please list any full and part-time pharmacists and whether they have a professional liability policy. Attach a separate sheet if needed.

Name _____ ☐ Yes ☐ No If yes, carrier: _____

Name _____ ☐ Yes ☐ No If yes, carrier: _____

Name _____ ☐ Yes ☐ No If yes, carrier: _____

*It is recommended that you maintain in your records a copy of a certificate showing proof of individual professional coverage for each full and part-time pharmacist from an AM Best A (Excellent) or higher rated carrier. VGM Insurance works with a number of nationally recognized carriers to provide Pharmacists Individual Professional coverage.*

If yes, what is the estimated annual gross revenue for over-the-counter medications? (aspirin, cold medicine, etc.) $_____

If yes, what is the estimated annual gross revenue for prescription drugs? $_____

### Compounding Pharmacy Operations ☐ CHECK HERE IF N/A

Does your pharmacy compound medications? ☐ Yes ☐ No

If yes, does your company compound in a clean room? ☐ Yes ☐ No

If yes, does your company compound under a laminar air flow hood? ☐ Yes ☐ No

If yes, is your company ☐ 503A (Traditional) ☐ 503B (Outsourcing)?

If 503B, please provide more details: _____

If 503A, is your company seeking 503B approval? ☐ Yes ☐ No

If yes, ☐ Sterile ☐ Non-Sterile?

If yes, is your company PCAB Certified? ☐ Yes ☐ No

If yes, is your company ☐ Sterile Certified or ☐ Non-Sterile Certified?

Is your company QCPP Certified? ☐ Yes ☐ No

**Infusion Therapy Operations** ☐ **CHECK HERE IF N/A**

Does your company administer Infusion Therapy? ☐ Yes ☐ No

If yes, does your company have an ambulatory suite? ☐ Yes ☐ No

If yes, how many chairs? _____

If yes, is your company hospital-based? ☐ Yes ☐ No

If yes, what are the top three infusion therapies your company administers? _____

_____

If yes, what is your company's average number of monthly infusion patient visits: _____

If yes, what is your company's average number of monthly enteral patient visits: _____

If yes, does your company employ nurses for infusion therapy? ☐ Yes ☐ No

If yes, how many? _____

If yes, please describe their duties: _____

_____

If yes, does your company employ technicians for infusion therapy? ☐ Yes ☐ No

If yes, does your company place PICC lines? ☐ Yes ☐ No

If yes, who is responsible for placing the PICC lines? _____

## Sleep Studies ☐ CHECK HERE IF N/A

Does your company provide sleep study services? ☐ Yes ☐ No

If yes, complete the below questions.

Who is interpreting or analyzing the results? _____

Who employs this individual? _____

Are tests administered by a certified polysomnographic technologist? ☐ Yes ☐ No

What is the number of PSTs on staff? _____

Please describe the testing procedure: _____

_____

Is there a fee for these services? ☐ Yes ☐ No

Where is the testing done? (Please check all that apply)

☐ Patient's home ☐ Your Company's Facility ☐ Hospital

Do patients stay overnight at your facility? _____

What is the ratio of staff to patients? _____

## ORTHOTICS AND PROSTHETICS ☐ CHECK HERE IF N/A

**Gross Revenue Sources** *(Must be divided into percentages and must equal 100%)*

**Patient Care Sales:** Includes all sales of items you make, fit, or alter for individual patients _____%

**Supplier/Distributor:** Includes items purchased from others that you resell to another facility or distributor _____%

**Supplier/Manufacturer:** No patient contact. Includes items manufactured by you and sold to facilities _____%

**Durable Medical Equipment and Soft Goods:** Includes items sold or rented directly to patients with no altering or re-labeling of parts. Includes pharmacy prescriptions, over-the-counter, and disposables _____%

Is your company ABC or BOC Certified? ☐ Yes ☐ No

If yes, please select certification: ☐ ABC ☐ BOC

**Please indicate the number of professionals in each category:**

ABC or BOC Certified Prosthetists/Orthotists: _____ Fitters: _____Pedorthists: _____Physical Therapists: _____

How many patient visits does your company have annually? _____

Does your company render professional services directly to patients without physician referral? ☐ Yes ☐ No

If yes, please explain: _____

Does your company perform or assist in any surgical procedures? ☐ Yes ☐ No

If yes, please explain: _____

## MANUFACTURER REPRESENTATIVE/DISTRIBUTOR/ MANUFACTURER ☐ CHECK HERE IF N/A

Which of the following entity types best describes your business?

☐ **Manufacturer Representatives** are entities working on a purely commission basis selling products for one or several different companies.

☐ **Distributors** are entities who sell to dealers, who then sell directly to the public.

If selected, are you a distributor of Pharmaceuticals? ☐Yes ☐No

If "Yes", please provide details: _____

☐ **Manufacturers** manufacture a product or products, including patented products using a third-party manufacturer.

Are you paid on commission? ☐ Yes ☐ No

If yes, list your company's total annual estimated commission from all manufacturers, including commissions earned by independent contractors (1099s): $ _____

Complete the following table by listing the products or services used in your business, entity type, number of years that the product or service has been part of your business, and the percentage of gross revenue or commission.

| Products and Services | Entity Type (from list above) | No. of Years | % of Gross Revenue or Commission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are any of the products biologics? ☐ Yes ☐ No

If yes, are they shipped directly to the hospital or facility? ☐ Yes ☐ No

If no, how long do you store the products at your facility? _____

If no, are the products time or temperature sensitive? ☐ Yes ☐ No

Do others manufacture, assemble, package, or install products under your company's name or label? ☐ Yes ☐ No

If yes, please describe: _____

Does your company employ nurses, physicians, or any other healthcare professionals? ☐ Yes ☐ No

If yes, please list: _____

Is your company present in the operating room at any time? ☐ Yes ☐ No

Does your company assist, train others, or give advice about the use of any surgical products? ☐ Yes ☐ No

Who designs the products your company distributes/represents/manufactures? _____

Are the products patented? ☐ Yes ☐ No

If yes, who owns the patents? _____

Has your company discontinued, or are you considering discontinuing, any product to be covered by this insurance policy? ☐ Yes ☐ No

If yes, please explain: _____

Does your company manufacture products or components? ☐ Yes ☐ No

Does your company export products or have foreign operations? ☐ Yes ☐ No

Are products your company sells subject to regulation by any government agency? ☐ Yes ☐ No

Does your company intend to manufacture or distribute any new products in the next 12 months? ☐ Yes ☐ No

If yes, please explain: _____

Does your company provide warranties or guarantees other than those provided by manufacturers? ☐ Yes ☐ No

Does your company service, maintain or repair any products? ☐ Yes ☐ No

If yes, please explain: _____

Does your company provide certificates of insurance (vendor's certificates) to anyone? ☐ Yes ☐ No

Does your company obtain certificates of insurance that include your company as an additional insured from all manufacturers and/or suppliers? ☐ Yes ☐ No

Does your company keep up-to-date advertisements and sales brochures for all products? ☐ Yes ☐ No

Does your company follow protocol for any recall of products? ☐ Yes ☐ No

## Manufacturer Representative ☐ CHECK HERE IF N/A

When placing the order with the manufacturer, where is the product shipped?

☐ Hospital/Surgical Center ☐ Manufacturer Representative

If shipped to a Hospital/Surgical Center, how long are the products typically stored before use? _____

_____

Is the product ever warehoused at your location? ☐ Yes ☐ No

On surgery day, who selects the product and hands it to the surgical staff? _____

Please describe this process: _____

_____

Does your company utilize independent contractors (1099s)? ☐ Yes ☐ No

If yes, do they have their own professional liability coverage? ☐ Yes ☐ No

Are employees and independent contractors (1099s) trained by the manufacturer? ☐ Yes ☐ No

If no, please describe the training process: _____

## Manufacturing ☐ CHECK HERE IF N/A

Does your company manufacture, assemble, package, or install products for others under their name or label?

☐ Yes ☐ No

If yes, please explain: _____

Does your company have written quality control and testing procedures in place? ☐ Yes ☐ No

Does your company save quality control and testing records? ☐ Yes ☐ No

If yes, how long are they kept? _____

Do your company's records indicate when each product is manufactured? ☐ Yes ☐ No

Do your company's records show when and to whom each unit is sold? ☐ Yes ☐ No

Do your company's records show suppliers of component parts used in products? ☐ Yes ☐ No

Does your company maintain records of changes in product designs? ☐ Yes ☐ No

Does your company's legal counsel regularly review all instructions, operating manuals, warnings, advertisements, and warranties, relative to product safety or intended use? ☐ Yes ☐ No

Are your company's products designed, tested, manufactured, and labeled to meet or exceed all applicable government and industry standards? ☐ Yes ☐ No

If no, please explain: _____

Does your company have a written program to withdraw known or suspected defective products from the market? ☐ Yes ☐ No

If yes, please attach a copy of your program.

Has your company ever recalled products from the market? ☐ Yes ☐ No

If yes, please explain: _____

Is your company currently considering recalling products from the market? ☐ Yes ☐ No

If yes, please explain: _____

## EXCESS LIABILITY ☐ CHECK HERE IF N/A

*Loss Runs for the past 5 years are required for a quotation. This includes all loss runs for your excess and underlying policies.*

Has your company had any Excess Liability claims filed or losses paid in the past five years, or are you aware of any incidents that might give rise to a suit against you? ☐ Yes ☐ No

Vehicles: Number of Private Passenger Vehicles _____

Number of Light Trucks _____

Number of Heavy Trucks _____

Does your company own any aircraft or watercraft? ☐ Yes ☐ No

**Underlying Policy information required for quote. Underlying limits must be at least $1,000,000.**

| | Carrier | Policy Number | Policy Period | Limits | Liability Premium |
|---|---|---|---|---|---|
| Automobile | | | | | |
| Work Comp | | | | | |
| Other | | | | | |

**If your Excess policy covers Commercial Auto Liability, please answer the following questions.**

**Driver Safety**

Do you have a documented drivers' orientation or training program? ☐ Yes ☐ No

Are driver MVRs checked prior to hiring? ☐ Yes ☐ No

Are driver MVRs checked annually? ☐ Yes ☐ No

Upon completion of initial review of MVRs, are they kept on file for further review? ☐ Yes ☐ No

Do you have a continuous MVR Monitoring Services ☐ Yes ☐ No

Do you have a formal driver safety manual? ☐ Yes ☐ No

If "yes", are all driver required to sign and acknowledge that they have read and understand the driver safety manual rules and requirements? ☐ Yes ☐ No

Do you have driver/vehicle monitoring? ☐ Yes ☐ No

If "yes" is driver coaching available based on monitoring feedback? ☐ Yes ☐ No

Are safety meetings held? ☐ Yes ☐ No

Average age of drivers _____ Driver turnover percentage % _____

## ADDITIONAL COVERAGE OPTIONS

Would you like to receive a discount on your Medicare/Medicaid surety Bond?

☐Yes ☐No

I would also like to receive a competitive quote for the following:

Property☐ Worker's Compensation ☐ Cyber/Data Breach☐

Business Auto☐ Employment Practices Liability☐ Direct and Officers☐

**FRAUD WARNING**

**YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY, INCLUDING READING AND EXECUTION OF THE WARRANY AND FRAUD STATEMENTS CONTAINED BELOW.**

**Applicant's warranty statement**: The undersigned states, represents and warrants that, to the best of his/her knowledge and belief and upon reasonable inquiry, the particulars and Statements set forth and the information contained in documents, if any, attached to this Application are true and accurate and agree that such particulars, statements and information are material to the acceptance of any risk assumed by the Company. The undersigned further declares and agrees that, if any claim, incident or event taking place prior to the effective date of any insurance applied for pursuant to this Application may render inaccurate, untrue or incomplete any statement, particular, or information contained in or attached to the Application, he or she will, as a condition to the effectiveness of any insurance issued pursuant to this Application, immediately report such in writing to the Company, and the Company may in its sole discretion withdraw or modify any outstanding quotations, proposed terms and/or any authorization or agreement to bind the insurance. The signing of the Application does not bind the applicant to purchase the insurance, nor does the review of the Application by the Company bind the Company to issue a policy. It is understood that the Company is relying on the Application and all attachments thereto in the event the policy is used. It is agreed that this Application, including any attachments thereto and material submitted therewith, shall be the basis for the issuance of any policy as to which this Application applies and the Application and any attachments thereto may be attached to and become a part of the policy issued.

Any person who knowingly and with intent to defraud any insurance company or other entity or person submits 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 to the Application, statement of claim or any other submission, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

## SPECIFIC STATE FRAUD WARNINGS
## PLEASE CAREFULLY REVIEW THE BELOW WARNING THAT IS APPLICABLE TO THE APPLICANT

**APPLICABLE IN CT, GA, HI, IL, IA, MA, MI, MS, MO, MT, NE, NV, NC, ND, SC, SD, VT, WI & WY:** Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit with the intent to defraud or deceive any insurer is guilty of a crime and may be subject to criminal and civil penalties and denial of insurance benefits

**APPLICABLE IN ALABAMA**: 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. Workers Compensation: Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining workers compensation benefits for himself or herself or any other person is guilty of a Class C felony.

**APPLICABLE IN ALASKA:** 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.

**APPLICABLE IN ARIZONA:** 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.

**APPLICABLE IN ARKANSAS:** 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.

**APPLICABLE IN CALIFORNIA:** For your protection, California law requires the following to appear on this form: 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.

**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 DELAWARE:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**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 IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**APPLICABLE IN INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**APPLICABLE IN KENTUCKY:** Any person who knowingly and with intent to defraud
any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

**APPLICABLE IN LOUISIANA:** 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.

**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 MARYLAND:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**APPLICABLE IN MINNESOTA:** A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

**APPLICABLE IN NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**APPLICABLE IN NEW JERSEY:** Any person who knowingly files a statement of claim containing any false or misleading information 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 NEW YORK:** GENERAL: 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

**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 OREGON:** 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 thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

**APPLICABLE IN PENNSYLVANIA:** GENERAL: 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 RHODE ISLAND:** 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.

**APPLICABLE IN TENNESSEE:** 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 TEXAS:** 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.

**APPLICABLE IN VIRGINIA:** 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 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 WEST VIRGINIA:** 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.

**APPLICABLE IN FLORIDA: Pursuant to s.817.234, Florida Statutes any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in s 775.082, s 775.083, or s 775.084, Florida Statutes.**

The above has been read and understood by the Applicant.

| _____ | _____ |
|---|---|
| Name (Please Print) | Title |
| _____ | _____ |
| Signature | Date |

(Must be signed by a principal, partner or officer of the Applicant who is duly authorized to execute this Application on behalf of and as binding on the Applicant)