WORKERS' COMPENSATION, PROPERTY, CYBER LIABILITY, AND BUSINESS AUTO APPLICATION

Proposed Effective Date_____

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: _____ Number of Employees _____

Website _____

Mailing Address _____

City _____ State __ ZIP _____ County _____

Physical Address _____

City _____ State __ ZIP _____ County _____

Contact Person _____ Email _____

Phone No. _____ Fax No. _____

FEIN _____ Medicare Provider No. _____

NPI No. _____ Unemployment No. _____

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

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

☐ Flood ☐ Earthquake ☐ Inland Marine ☐ Crime

☐ Fiduciary ☐ Directors and Officers ☐ Employment Practices Liability

WORKERS' COMPENSATION APPLICATON

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

*If Excess limits are desired, underlying auto limits are required to be $1,000,000

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

Owner/Officer Information

Owner/Officer Name	Title/Relationship	Percent of Ownership	Duties	Annual Payroll

Employee Class Code Breakdown

State 1 _____

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			
4693	Pharmaceutical or Surgical Goods Mfg.			
3724	Electrical Apparatus Installation or Repair & Drivers			
8018	Store: Wholesale			
8833	Hospital Professional Employees			
8871	Clerical Telecommuter Employees			
8045	Store: Drug Retail			

If the above class codes are not applicable to your state, the codes will be revised by our office accordingly.

State 2 _____

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			
4693	Pharmaceutical or Surgical Goods Mfg.			

3724	Machinery or Equipment Erection or Repair			
8018	Store: Wholesale			
8833	Hospital Professional Employees			
8871	Clerical Telecommuter Employees			
8045	Store: Drug Retail			

***Additional questions required*

If there are additional states and payroll to report, provide spreadsheet with information indicated above for each state.

Historical Insurance Information

Current Carrier(s) and Premium_____

What is your current experience modification number?_____

Please attach your experience modification worksheet (page in your current policy).

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

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

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

(Respond only if state law permits) If yes, please explain _____

Exposure Information

Does your company use subcontractors? ☐ Yes ☐ No

If subcontractors are used, you are required to obtain and file certificates of insurance from each subcontractor.

Does your company provide employee health plans? ☐ Yes ☐ No

Does your company engage in the operations of leasing employees? ☐ Yes ☐ No

Does your company have past, present, or discontinued operations involving storing, treating, discharging, applying, disposing, or transporting hazardous material? ☐ Yes ☐ No

Does your company own, operate, or lease aircraft or watercraft? ☐ Yes ☐ No

Does your company have a formal safety program? ☐ Yes ☐ No

If yes, who is responsible for managing the program?_____

If yes, is the training ☐ Formal/Documented ☐ Informal ☐ Other _____

Does your company have a formal return to work program? ☐ Yes ☐ No

If yes, does it include salary continuation? ☐ Yes ☐ No

Do your employees receive a safety training orientation? ☐ Yes ☐ No

What is the turnover rate of employees? _____%

Do employees use personal vehicles for company business? ☐ Yes ☐ No

Does your company have any out of state, international, or overnight (within state) travel? ☐ Yes ☐ No

If yes, provide details on purpose of travel, who, where, the duration, and frequency _____

_____

Does your company provide paid sick leave? ☐ Yes ☐ No

Does your company provide paid vacation? ☐ Yes ☐ No

Does your company provide a retirement/pension plan? ☐ Yes ☐ No

If yes, does your company contribute? ☐ Yes ☐ No

Does your company provide group medical? ☐ Yes ☐ No

If yes, name the healthcare provider _____

If yes, provide the percentage of employees enrolled _____%

If yes, provide the percentage paid by your company _____%

Does your company use a specific medical provider to treat insured employees? ☐ Yes ☐ No

Does your company currently participate in a MPN (Medical Provider Network)? ☐ Yes ☐ No

If yes, provide the name of the MPN _____

Does your company use written applications? ☐ Yes ☐ No

Does your company do reference checks? ☐ Yes ☐ No

Does your company do pre-hire drug testing? ☐ Yes ☐ No

Does your company do post-accident drug testing? ☐ Yes ☐ No

Does your company do pre/post-employment physicals? ☐ Yes ☐ No

Does your company document pre-existing injuries in personnel files? ☐ Yes ☐ No

Does your company have a formal written accident report? ☐ Yes ☐ No

Does your company have a set procedure for reporting claims? ☐ Yes ☐ No

Provide the average claim reporting time _____

Does your company provide job specific training? ☐ Yes ☐ No

Does your company have an employee orientation program? ☐ Yes ☐ No

If yes, is the orientation ☐ Verbal Only? ☐ Verbal and documented?

Does your company have any interchange of labor? ☐ Yes ☐ No

If yes, please explain ☐ Another business ☐ Subsidiary ☐ Between departments ☐ Other _____

Are your company owners active in daily operations? ☐ Yes ☐ No

Has your company had loss control services performed in the last year? ☐ Yes ☐ No

Has your company had Cal/OSHA visit in the last year? ☐ Yes ☐ No

If yes, provide explanation in a separate document.

Does your company have a safety director or risk manager? ☐ Yes ☐ No

If yes, provide their name and title _____

If yes, is the position full time or an additional responsibility of another employee? _____

Does your company have MSDS available for all chemicals and products used? ☐ Yes ☐ No ☐ N/A

Does your company have any material handling exposures? ☐ Yes ☐ No

If yes, explain & answer the following questions _____

Does your company provide forklift training? ☐ Yes ☐ No

Does your company have annual certification? ☐ Yes ☐ No

Does your company have all machinery/equipment properly guarded? ☐ Yes ☐ No

Does your company have any use of Baler equipment? ☐ Yes ☐ No

What is the condition of your company's equipment? ☐ New ☐ Good ☐ Average

Does your company train/certify all equipment operators? ☐ Yes ☐ No

Provide your company's maximum height at which your employees work _____

What type of lift is used? ☐ Ladder ☐ Scaffolding ☐ Scissor Lifts ☐ N/A

Does your company have written lock out/tag out/block out procedures in place? ☐ Yes ☐ No ☐ N/A

Does your company have a respiratory program in place? ☐ Yes ☐ No ☐ N/A

Does your company provide personal protective equipment (PPE)? ☐ Yes ☐ No

If yes, does your company have strict enforcement of utilization? ☐ Yes ☐ No

If yes, what types of PPE are provided ? _____

Does your company have a written blood born pathogen program? ☐ Yes ☐ No

Does your company repair any products? Yes No If yes, explain: _____

__Driving Exposure Information – Complete if employees perform any driving of owned company, leased/rented, or personal vehicles**__

Do your employees drive out of state? ☐ Yes ☐ No

What is the average daily radius of operations? ☐ <50 ☐ 50-200 ☐ 200+

What is the maximum radius of operations? _____miles

Do you perform MVR checks? ☐ Yes ☐ No If yes, how often? _____

Does your company have a formal distracted driving policy in place? ☐ Yes ☐ No

How many automobiles does the company own (not including trailers)? _____

What is the maximum weight manually lifted? _____lbs.

If greater than 40 lbs., what types of supplemental lifting devices are used? _____

Are vehicles company-owned? ☐ Yes ☐ No If yes, types of vehicles? _____

Are vehicles taken home? ☐ Yes ☐ No If yes, Number of vehicles? _____ Number of drivers? _____

Does your company have a vehicle/fleet maintenance program? ☐ Yes ☐ No

If yes, who does the servicing? ☐ Outside vendor ☐ In-house mechanics ☐ Other

Does your company provide group transportation for employees?

If yes, how is it provided? ☐ Car ☐ Truck ☐ Van ☐ Bus

If yes, number of employees transported per vehicle? _____

Do you have a written plan to deal with employees who have poor driving records? ☐ Yes ☐ No

Do your employees transport patients? ☐ Yes ☐ No If yes, how often? _____

Do your employees deliver to patients' homes? ☐ Yes ☐ No If yes, how often? _____

Does your company transport oxygen? ☐ Yes ☐ No

If yes, list the type of tanks delivered on average per vehicle per day _____

If yes, explain the procedures in placed for securement while being transported _____

__Only complete the section below if Home Health Exposure (Class 8835) is present:**__

Number of shifts? _____

Does your company ever allow employees to work more than three consecutive 12-hour shifts?

What are your hours of operation? _____

Is there ever 24 continuous hours of care in a client's home? ☐ Yes ☐ No

Is your company affiliated with a franchise ☐ Yes ☐ No If yes, what franchise? _____

What types of services are provided? _____

Does your company have any volunteer workers ☐ Yes ☐ No If yes, how many? _____

Do any of your employees work from home ☐ Yes ☐ No

What percentage of patients are bedridden? _____%

Is a PUC/DMV filing required? ☐ PUC ☐ DMV ☐ N/A

List the number of employees who live or work out of state: Live _____Work _____

What is the average number of patients seen per day, per employee? _____

Are all employees given combative patient training? ☐ Yes ☐ No

Is slip resistant footwear provided and enforced? ☐ Yes ☐ No

Are employees trained in the following? (Check all that apply)

☐ Proper Lifting Techniques ☐ Passenger Assistance ☐ Defensive Driving Techniques ☐ None of the above

How are employees paid? ☐ Hourly ☐ Piece rate ☐ Commission ☐ Flat salary

Please provide the number of W-2s issued in the last year? _____

Percentage of union employees _____% Percentage of non-union employees _____ %

Does your company provide CPR training? ☐ Yes ☐ No If yes, provide the number of employees certified _____

Provide the actual hourly wage for employees in governing class $_____/hour

Does your company do orthopedic back testing? ☐ Yes ☐ No

Does your company do audio hearing tests? ☐ Yes ☐ No

Does your company have formal job descriptions on file? ☐ Yes ☐ No

Please provide your company's employee to supervisor ratio. ☐ Better than 4-1 ☐ 5-1 ☐ 6-1 ☐ 7-1 ☐ >7-1

Please provide the number of years your company has been at its current location _____

Please provide the age of your company's occupied building _____

Is your company's building/premises ☐ Owned ☐ Leased

Please provide the condition of your company's building/premises ☐ Excellent ☐ Very good ☐ Average

Is your company a licensed facility? ☐ Yes ☐ No If yes, explain: _____

Is your company accredited by CARF (Commission on Accreditation of Rehabilitation Facilities)? ☐ Yes ☐ No

Does your company treat HIV and/or AIDS? ☐ Yes ☐ No

Does your company have patient/resident handling or lifting equipment? ☐ Yes ☐ No

Does your company have written patient/resident handling protocols? ☐ Yes ☐ No

Does your company provide ongoing in-service training? ☐ Yes ☐ No If yes, how often? _____

Does your company provide food service? ☐ Yes ☐ No If yes, explain: _____

Percentage of ambulatory residents/patients _____% Percentage of non-ambulatory residents/patients _____%

Please indicate the percentage of operations in each of the following categories or mark not applicable ☐ N/A

Abortion Clinic _____% Acupuncture/Acupressure _____% Blood Bank/Donor Clinic _____%

Drug/Alcohol Rehabilitation Treatment Clinic _____% Family Practice _____% Industrial Clinic _____%

Med Lab/Testing _____% Specialist _____% Mobile Operations _____% Urgent Care Clinic _____%
Walk-In Clinic _____% Weight Control Clinic _____%

Please indicate the percentage of staff in each of the following categories or mark not applicable ☐ N/A

Physician/MD_____% PhD_____% Psychiatrist_____% Psychologist_____%

Physician's Asst._____% Nurse Practitioner_____% RN _____% Licensed Voc. Nurse _____%
CNA _____% Social Worker _____% Counselor_____% Dietary_____% Dentist/Surgeon_____%
Registered Dental Asst._____% Dental Hygienist_____% Chiropractor_____% Physical
Therapist_____% Physiotherapist_____% Occupational Therapist_____% Administrative_____%

PROPERTY APPLICATION

Location No. _Physical Address _____

City _____State __ ZIP _____ County _____

Building Type: ☐ Retail Store ☐ Warehouse ☐ Office ☐Other

If other, please explain. _____

Burglar Alarms: ☐ Central ☐ Local ☐ None

Fire Alarms: ☐ Central ☐ Local ☐ None

Sprinklers: ☐ Yes ☐ No If yes, what percentage? _____

Roof Type: ☐ Clay/Concrete Tile ☐ Built Up w/Gravel ☐ Built Up w/o Gravel (Smooth Surface)

☐ Asphalt Shingles ☐ Metal ☐ Wood Shingles/Shakes ☐ Single Ply Membrane

Construction Types: ☐ Frame ☐ Jointed Masonry ☐ Non-combustible ☐ Masonry Non-combustible

Year Built _____ Total Square Feet of Building _____ Total Square Feet You Occupy _____

Last Update: Plumbing/Year_____ Wiring/Year _____ Roof/Year _____ AC/Heat/Year _____

Year Number of Stories _____

Office Furniture Limit $_____ Product Inventory Limit $_____

Requested Business Income Limit $_____

Deductible Options: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Is any portion of the building vacant? ☐ Yes ☐ No If yes, what percentage? _____

Do you own the building? ☐ Yes ☐ No If yes, what is the requested building limit? _____

If yes, is it owned under the same legal business name indicated on this application? ☐ Yes ☐ No

If no, please list the legal business name and address.

Legal Business Name _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

If the building is not owned, are you contractually required to carry building coverage on the address listed above?

☐ Yes ☐ No

If yes, what is the contractually required building limit? _____

Is the building occupied 100% by your business? ☐ Yes ☐ No

If no, list the other occupants' type of business (retail, office, wholesale, etc.) and the business performed.

Type of Business _____ Business Performed _____

Type of Business _____ Business Performed _____

Location No. __Physical Address _____

City _____State __ ZIP _____ County _____

Building Type: ☐ Retail Store ☐ Warehouse ☐ Office ☐Other

If other, please explain. _____

Burglar Alarms: ☐ Central ☐ Local ☐ None

Fire Alarms: ☐ Central ☐ Local ☐ None

Sprinklers: ☐ Yes ☐ No If yes, what percentage? _____

Roof Type: ☐ Clay/Concrete Tile ☐ Built Up w/Gravel ☐ Built Up w/o Gravel (Smooth Surface)

☐ Asphalt Shingles ☐ Metal ☐ Wood Shingles/Shakes ☐ Single Ply Membrane

Construction Types: ☐ Frame ☐ Jointed Masonry ☐ Non-combustible ☐ Masonry Non-combustible

Year Built _____ Total Square Feet of Building _____ Total Square Feet You Occupy _____

Last Update: Plumbing/Year_____ Wiring/Year _____ Roof/Year _____ AC/Heat/Year _____

Number of Stories _____

Office Furniture Limit $_____ Product Inventory Limit $_____

Requested Business Income Limit $_____

Deductible Options: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Is any portion of the building vacant? ☐ Yes ☐No If yes, what percentage? _____

Do you own the building? ☐Yes ☐No If yes, what is the requested building limit? _____

If yes, is it owned under the same legal business name indicated on this application? ☐ Yes ☐ No

If no, please list the legal business name and address.

Legal Business Name _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

If the building is not owned, are you contractually required to carry building coverage on the address listed above?

☐ Yes ☐ No

If yes, what is the contractually required building limit? _____

Is the building occupied 100% by your business? ☐ Yes ☐No

If no, list the other occupants' type of business (retail, office, wholesale, etc.) and the business performed.

Type of Business _____ Business Performed _____

Type of Business _____ Business Performed _____

Do you have more locations? Copy this page and complete for each additional location.

Historical Insurance Information

Current Carrier(s) and Premium _____

Have you had any property claims during the past five years? ☐ Yes* ☐ No ☐ N/A

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

Has your coverage been cancelled/non-renewed in the past five years? ☐ Yes ☐ No ☐ N/A

(Respond only if state law permits)

If yes, please explain _____

Transit Exposures (complete if applicable)

Do you ship any products or inventory? ☐ Yes ☐ No

If yes, describe the covered property _____ Limit of Insurance $_____

Do you transport any property? ☐ Yes ☐ No

If yes, what is the maximum amount in any one vehicle? $_____

What is the total value of property in transit at any given time? $_____

Off-Premises Exposures (complete if applicable)

Is there property being stored at any location not listed on the application? ☐ Yes ☐ No

If yes, provide location _____ Amount of Inventory $_____

Does any property remain in the possession of a salesperson or other company employee overnight? ☐ Yes ☐ No

If yes, provide approximate amount $ _____

Pharmacy Exposures (complete if applicable)

What is the average and maximum values of the prescription drug supply?

Average $ _____ Maximum $_____

How long would it take to replace an inventory of pharmaceuticals? _____

How is the store secured? _____

How is the prescription drug department secured? _____

How is access limited to the prescription filling and pharmaceutical storage areas? _____

CYBER APPLICATION

Number of Employees (Full Time & Part Time) _____ Revenue Last Fiscal Year $ _____

Limit of Liability Requested: ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $5,000,000

In the last 5 years, has the company suffered any cyber event, unscheduled network outage over 4 hours, loss or claim that would fall within the scope of the policy for which you are applying?

☐ Yes ☐ No If yes, provide details on an attached sheet.

Do you use up-to-date anti-virus and anti-malware protection on all of your endpoints? (desktops, laptops, servers, etc.)

☐ Yes ☐ No

Are all of your Internet access points secured by firewalls?

☐ Yes ☐ No

Do you restrict employees' and external users' IT systems privileges and access to personal information on a business-need-to-know basis?

☐ Yes ☐ No

Do you perform backups of business-critical data on at least a weekly basis off the network?

☐ Yes ☐ No

Do you encrypt all of your mobile devices (laptops, flash drives, mobile phones, etc.) and confidential data?

☐ Yes ☐ No

Have you implemented a multifactor authentication solution for all external connections to your IT network?

☐ Yes ☐ No

Have you implemented a multifactor authentication solution for all access to email?

☐ Yes ☐ No

Have you implemented a multifactor authentication solution for all access to cloud provider services?

☐ Yes ☐ No

Have you implemented a multifactor authentication solution for all privilege user accounts?

☐ Yes ☐ No

How many PII, PHI or PCI records does the applicant collect, process, store, transmit, or have access to?

☐ No records ☐ <100K ☐ 250K-500K ☐ 500K-1M ☐ >1M

What is the estimated annual volume of payment card transactions (credit cards, debit cards, etc.)?

☐ No card transactions ☐ <100K ☐ 100K-500K ☐ 500K-1M ☐ >1M

Do you require a secondary means of communication to validate the authenticity of funds transfers (ACH, wire, etc.) requests by at least 2 employees before processing a request in excess of $25,000?

☐ Yes ☐ No

Do you enforce procedures to remove content (including third party content) that may infringe or violate any intellectual property or privacy right?

☐ Yes ☐ No

BUSINESS AUTO APPLICATION

Liability Limit: ☐ $1,000,000 ☐ $500,000 *If Excess limits are desired, underlying Auto limits are required to be $1,000,000

Uninsured/Under-insured Motorist: Will Match Selected Liability Limits
Uninsured Motorist Property Damage Coverage Desired? ☐ Yes ☐ No (Not available in all states)

Comprehensive Deductible Desired: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Collision Deductible Desired: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

If you require liability only coverage on any or all of your vehicles, please provide a list of the corresponding vehicles following the submission of this application.

Towing Coverage Desired?* ☐ Yes ☐ No Rental Reimbursement Desired? ☐ Yes ☐ No *Only applicable for PP vehicles.

Med Pay: ☐ $5,000 PIP: ☐ Basic (Not available in all states)

Radius of Operations: (Distance one way in miles) ☐ <50 ☐ 50-200 ☐ 200+

If over 200 miles, please explain. _____

Please attach schedule of drivers and vehicle information or complete the tables below.

Driver's Name	Birth Date	License #	State

Have any of the drivers listed above had any violations in the past five years? ☐ Yes ☐ No

If yes, please explain. _____

Auto Use: R = Retail C = Commercial S = Service

Year, Make, Model	VIN Number	Garaged Location Address	Auto Use	Cost New	Ownership of Vehicle
					☐ Owned ☐ Leased
					☐ Owned ☐ Leased
					☐ Owned ☐ Leased

Are there additional insureds associated with any of the vehicles listed above? ☐ Yes ☐ No

If yes, please list name, address, and vehicle:

Additional Insured _____ Address _____ Vehicle _____

Additional Insured _____ Address _____ Vehicle _____

Historical Insurance Information

Current Carrier(s) and Premium _____

Have you had any auto claims during the past five years? ☐ Yes* ☐ No

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

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

(Respond only if state law permits)

If yes, please explain _____

Exposure Information

Are all vehicles listed above owned by and registered to the company? ☐ Yes ☐ No

If no, who are they registered to? _____

Do any employees use their personal automobiles for business purposes? ☐ Yes ☐ No

If yes, are they required to carry a minimum liability limit of $500,000? ☐ Yes ☐ No

Please identify any vehicles that have special equipment (such as lifts, wraps, etc.) and the value of the equipment _____

Do you obtain motor vehicle records for employees who drive on behalf of the business? ☐ Yes ☐ No

Are there any vehicles owned by the business but not scheduled on this application? ☐ Yes ☐ No

Are any company vehicles used by employees for personal use? ☐ Yes ☐ No

If yes, what percentage? _____

Are any company vehicles used by family members for personal use? ☐ Yes ☐ No

If yes, please provide the name, birth date, license number, and vehicle used

Name _____ Birth Date _____ License Number _____ Vehicle _____

Name _____ Birth Date _____ License Number _____ Vehicle _____

Name _____ Birth Date _____ License Number _____ Vehicle _____

Does the business transport oxygen tanks? ☐ Yes ☐ No

If yes, please list the type of tanks delivered on average per vehicle per day _____

Please explain the procedures in place regarding the securement of the oxygen tanks/containers while being transported _____

Do you have any vehicles that only transport oxygen? ☐ Yes ☐ No

If yes, what vehicles? _____

Indicate which safety/risk control measures are in place:

☐ Driver training provided to all drivers upon start date ☐ Seat belt policy

☐ Calling and/or text messaging policy ☐ Vehicle maintenance program

***Please provide a copy of any current policies in place**

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.

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.

Workers Compensation: Failure to answer truthfully may result in forfeiture of workers compensation benefits.

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.

Workers Compensation: Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to s 609.52, subdivision 3.

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.

Workers Compensation Warning: Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: 1. obtaining any benefit or payment, 2. increasing any claim for benefit or payment, or 3. obtaining workers' compensation coverage under this act, shall be guilty of a felony punishable pursuant to Section 1663 of Title 21 of the Oklahoma Statutes.

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.