



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

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

Hired and Non-Owned Auto Liability *(Complete if applicable)*

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

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

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

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

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

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 *(Complete if applicable)*

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 *(Complete if applicable)*

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.

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

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

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 (Complete if applicable)

Loss Runs for the past 5 years are required for a quotation.

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					

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 Workers' Compensation Cyber/Data Breach Business Auto
- Employment Practices Liability Directors and Officers Crime Fiduciary

FRAUD WARNING

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY, INCLUDING READING AND EXECUTION OF THE WARRANTY 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 false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in 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 FLORIDA: 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 of the third degree.

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.

The above has been read and understood by the Applicant.

Name (Please print)

Title (Must be Authorized Representative)

Signature

Date

The above signed warrants that they are authorized and have the power to complete and execute this Application, including the Warranty Statement on behalf of the Applicant and the Applicant's respective Directors, Officers or other insured parties.