

**OneBeacon Insurance Company
Homeland Insurance Company of New York
York Insurance Company of Maine**

**HEALTH CARE ORGANIZATION AND PROVIDER
PROFESSIONAL LIABILITY APPLICATION**

NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE.

A. APPLICANT

1. Legal name of Applicant: _____
2. Address: _____
City: _____ County: _____ State: _____ Zip: _____
3. Telephone number: _____
4. How many years has the Applicant been in operation? _____
5. How many years has the Applicant been under present ownership? _____
6. Website: _____
7. Please list all affiliates and subsidiaries to which this insurance is to apply. Please include a complete description of the operations of each affiliate/subsidiary and the relationship to the Applicant. (Please attach a separate sheet if necessary.)

B. REQUESTED COVERAGE STRUCTURE:

- Primary Excess

Effective Date: _____ Retroactive Date: _____

Per Claim Limit: _____ Aggregate Limit: _____

Per Claim Deductible/Retention: _____ Aggregate Deductible/Retention: _____
(circle Deductible or Retention) _____

SELF INSURED RETENTION(if applicable):

- What coverage(s) does the SIR contemplate? _____
Limits of coverage provided by the SIR? _____
Do defense expenses erode the limits? _____
Is there a dedicated trust? _____
Who handles claims within the SIR? _____
Which law firm provides defense coverage? _____

C. GENERAL INFORMATION

Applicant is (please check all appropriate categories):

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Teaching Hospital | <input type="checkbox"/> For-Profit | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Psychiatric Hospital | <input type="checkbox"/> Governmental | <input type="checkbox"/> Not-for-Profit | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Convalescent or Nursing Home | <input type="checkbox"/> Medicare Approved | <input type="checkbox"/> Charitable |
| <input type="checkbox"/> Research Hospital | <input type="checkbox"/> Clinic | <input type="checkbox"/> Other Specialty | _____ |

1. Is the Applicant accredited by the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO)? Yes No
Date of last accreditation: _____
Accreditation period: _____
(Please attach a copy of the most recent survey.)

Is this facility licensed by the State? Yes No
(Please attach a copy of the most recent State license survey.)

2. Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency? Yes No
If "Yes," please explain: _____

3. Has the Applicant entered into any joint ventures or limited partnerships? Yes No
If "Yes," please explain on a separate sheet of paper.

4. Is any part of the Applicant operated/leased by a management corporation? Yes No
If "Yes," please give the name of the corporation and details of structure.
Please attach a separate sheet of paper.

5. Does the Applicant participate in any teaching programs? Yes No
If "Yes," please describe the type of programs: _____

Is the program hospital-sponsored? Yes No
If "Yes," please provide the name of the sponsoring institution: _____

6. Does the Applicant anticipate any facility expansions (increase in licensed beds) within the next year? Yes No

D. PERSONNEL

1. Indicate the number of persons employed by or working under the control of the Applicant in each of the following classifications:

- | | |
|---|-------------------------------|
| ___ Certified Registered Nurse Anesthetists** | ___ Nurse Practitioners* |
| ___ Dentists* | ___ Paramedics |
| ___ Emergency Medical Technicians | ___ Registered Nurses |
| ___ Interns | ___ Respiratory Therapists |
| ___ Laboratory or X-ray Technicians | ___ Pharmacists |
| ___ Licensed Vocational/Practical Nurses | ___ Physician Assistants* |
| ___ Nurse's Aides | ___ Physicians and Surgeons** |
| ___ Nurse Midwives* | ___ Residents* |
- Other (explain): _____

* Please provide additional information as required in Section L Additional Information

** Please provide additional information as required in Section L Additional Information
(A separate application may be required for each Physician or Surgeon prior to commencement of coverage)

E. OPERATIONS

1. SERVICES (Please indicate if the Applicant presently provides, plans to provide, or presently operates any of the following):

- | | | |
|--|--|--|
| <input type="checkbox"/> Abortion Clinic | <input type="checkbox"/> Oncology | <input type="checkbox"/> Inhalation Therapy |
| <input type="checkbox"/> Ambulance Service | <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Intensive Care Unit |
| <input type="checkbox"/> Base Hospital | <input type="checkbox"/> Off-Premises Clinic | <input type="checkbox"/> Organ Bank |
| <input type="checkbox"/> Blood Bank | <input type="checkbox"/> Day Care | <input type="checkbox"/> Organ Transplants |
| <input type="checkbox"/> Burn Units | <input type="checkbox"/> Outpatient Surgicenters | <input type="checkbox"/> Dental Services |
| <input type="checkbox"/> Cardiac Catheterization Centers | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Lifeline |
| <input type="checkbox"/> Coronary Care Unit | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Nursery |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Hospice | <input type="checkbox"/> Neonatal |
| <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Hospital Foundation | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Health Maintenance Organization | <input type="checkbox"/> Off Premises Labs | <input type="checkbox"/> Mobile Unit (blood-mobiles, mammography, CAT scan, etc..) |
| <input type="checkbox"/> Off Premises Food Service | <input type="checkbox"/> Transportation Services | |
| <input type="checkbox"/> Other (explain): _____ | | |

2. OCCUPANCY

a. Beds:

Total Licensed Beds: _____

Total Average Annual: _____

Occupancy Breakdown (Provide average number of occupied beds in each category)

	Projected	Current Year	Prior Years			
			1	2	3	4
Acute Care						
Cribs/Bassinets						
Extended Care						
Skilled Nursing Beds						
Psychiatric						
Rehabilitation						
Chemical Dependency						
Hospice						
Other						

b. Outpatient Services (Provide the number of services performed each year)

	Projected	Current Year	Prior Years			
			1	2	3	4
Emergency Room						
Outpatient Surgery						
Other Outpatient Visits (Patient per Registration Day)						
Psychiatric Visits						
Alcohol/Drug Abuse						
Rehabilitation						
Home Health Care						
Clinic Visits						
Reference Lab						

c. Inpatient Services

	Projected	Current	Prior Years
--	-----------	---------	-------------

	Year	1	2	3	4
Inpatient Surgeries					
Deliveries (exclude c-sections and VBACs)					
Cesarean Sections					
VBACs *					

*(Please attach a copy of your VBAC policy)

d. Other:

If coverage is requested for the following, please indicate:

Nurse Anesthetist: Yes No

Physician Assistants: Yes No

Nurse Midwives: Yes No

Employed physicians: Yes No

3. ANESTHESIA SERVICES

a. Staffing is by: ___ Contracted Physicians ___ Employed Physicians ___ Residents
 ___ Certified Registered Nurse Anesthetists (CRNAs)

Number of Anesthesiologists? _____ Full-Time _____ Part-Time

Are all physicians board certified or eligible? Yes No

If "No," please explain: _____

b. If under contract, to whom is staffing contracted? _____

c. Are contract physicians required to carry professional liability insurance? Yes No

If "Yes," what limits are required? _____

Does the Applicant obtain a Certificate of Insurance? Yes No

d. Describe the minimum qualifications required for administration of general anesthesia:

e. CRNAs

(i) Do CRNAs provide anesthesia service? Yes No

If "Yes," please describe the relationship between the Applicant
 and the CRNAs below:

Are they: Employed by the Applicant? Yes No

Employed by the Anesthesiologist? Yes No

Employed by the Surgeon? Yes No

Independent? Yes No

(ii) Do CRNAs work under the direct supervision of an
 anesthesiologist? Yes No

If "No," please submit written guidelines developed with the collaborative
 physician or qualified physician designee of the primary physician or the
 dentist responsible for the patient's immediate care.

4. RADIOLOGY SERVICES

a. Staffing is by: ___ Contracted Physicians ___ Employed Physicians ___ Residents

Number of Radiologists? _____ Full-Time _____ Part-Time

Are all physicians board certified or eligible? Yes No

If "No," please explain: _____

b. If under contract, to whom is staffing contracted? _____

Are contract physicians required to carry professional liability insurance? Yes No

If "Yes," what limits are required? _____

Does the Applicant obtain a Certificate of Insurance? Yes No

c. Please state the number of X-ray machines owned or operated, and whether they are used for diagnosis or treatment or both. Please state by whom the treatment is given:

5. OBSTETRICS

a. Is the Applicant a regional referral center for newborns requiring intensive care? Yes No

If "No" does a written procedure exist for transferring all high-risk Mothers and/or babies? Yes No

b. Number of labor rooms: _____

c. Number of delivery rooms: _____

d. Does the Applicant have a separate birthing center? Yes No

e. Is the delivery room suite separate from the surgical suite? Yes No

f. Can cesarean sections be performed within thirty (30) minutes at all times? Yes No

g. Is an anesthesiologist or CRNA available in-house twenty-four (24) hours per day for the obstetrical suite? Yes No

If "No," what is the maximum time for arrival at hospital? _____

h. Is an obstetrician available in-house twenty-four (24) hours per day for the obstetrical suite? Yes No

If "No," what is the maximum time for arrival at hospital? _____

i. Do CNM's practice at your hospital? Yes No

If "Yes," are they supervised by OB physicians? Yes No

If employed, do CNM's deliver babies at home? Yes No

j. Do Family Physicians perform obstetrical services? Yes No

k. Do Family Physicians or CNM's perform VBAC or C-Sections? Yes No

l. If the Applicant has a neonatal intensive care unit (NICU), state:

- (i) total number of neonates admitted to NICU in the past twelve (12) months: _____
 - (ii) total number of neonates admitted to NICU who were transferred from other facilities: _____
 - (iii) whether full-time attending neonatologist is on-site in NICU twenty-four (24) hours per day? Yes No
- m. If the Applicant does not have NICU, please state the total number of neonates transferred from the institution to other facilities in the past twelve (12) months: _____

6. EMERGENCY ROOM

Does the Applicant provide emergency room (ER) service? Yes No
 If "Yes," please answer the following questions:

- a. What level of service do you provide (based on the standards of the JCAHO)?
 ___ I (Tertiary) ___ II (Comprehensive) ___ III (Basic)
- b. The Applicant provides: ___ Standby Services
 ___ Basic Services
 ___ Comprehensive Emergency Services
 ___ Trauma Center
- c. Staffing is by: ___ Contracted Physicians ___ Employed Physicians ___ Residents
 Number of ER Doctors? _____ Full-Time _____ Part-Time
 Are all physicians board certified or eligible? Yes No
 If "No," please explain: _____

- d. If under contract, to whom is staffing contracted? _____
 Are contract physicians required to carry professional liability insurance? Yes No
 If "Yes," what limits are required? _____
 Does the Applicant obtain a Certificate of Insurance? Yes No

7. SURGERY

- a. When are sponge, needle & instrument counts performed? _____

- b. Are any of the following performed at your facility?
 Experimental Surgery: Yes No
 Neurosurgery: Yes No
 Open Heart Surgery: Yes No
 Weight Reduction Surgery*: Yes No

*If yes to weight reduction surgery, please complete bariatric supplement

8. SPECIAL SERVICES

- a. Ambulance: Number of vehicles: _____
Number of runs per year: _____
- b. Blood Banks: Number of donors (pints): _____
Number of pints purchased from others: _____
- c. Organ Tissue Bank: Number of donors: _____
Number of organ/tissue donations per year: _____
- d. Day Care: Number of children per day: _____
Number of days per week: _____
On-hospital premises Yes No
Open to the public Yes No

F. STAFF PRIVILEGES

1. Please indicate the number of staff physicians in each of the following categories:

_____ Active _____ Consulting _____ Emeritus
_____ Associate _____ Courtesy _____ Probationary

2. Are credentials for new staff members checked and approved prior to granting staff privileges? Yes No
If "Yes," by whom? _____
How are the Applicant's degree(s) and experience verified? _____

3. Are privileges provisional for at least six (6) months for all new staff members? Yes No
4. Does the Applicant have any staff members who are not licensed or who have restricted licenses or privileges? Yes No
If "Yes," please explain on a separate sheet of paper.
5. Do department heads evaluate the work of their staff members? Yes No
6. Is an ongoing medical audit maintained on all staff members' clinical work? Yes No
7. Are all staff privileges reviewed each year? Yes No
8. Does the Applicant require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? Yes No
9. Staff members' professional liability insurance:
a. Are all staff members required to maintain professional liability insurance? Yes No
b. Is this requirement stated in the staff bylaws? Yes No
c. What limits are required? _____
d. What evidence of compliance is required? _____

Please include a copy of the medical staff bylaws for financial responsibility.

**FOR THE FOLLOWING QUESTIONS,
PLEASE EXPLAIN ANY "NO" ANSWERS ON A SEPARATE SHEET OF PAPER.**

G. RISK MANAGEMENT

1. Is there a written, formalized risk management program? Yes No
 If "Yes," please provide a synopsis of the program: _____

2. Is the program periodically reviewed for effectiveness and necessary changes implemented? Yes No

3. Who is in charge of implementing this program and any changes?
 Name: _____ Title: _____
 Phone: _____ Fax: _____
 E-mail: _____

4. Does the Applicant have a formalized quality assurance program? Yes No
 If "Yes," please provide a synopsis of the program: _____

5. To whom does the Risk Manager or Director of Risk Management report?

 Please provide a copy of the Curriculum Vitae for the Risk Manager or Director of Risk Management.

H. CONTRACTUAL AGREEMENTS

1. a. Does the Applicant lease or rent any equipment from others? Yes No
 If "Yes," please provide a description of the equipment: _____

- b. Does the Applicant indemnify (hold harmless) the owner for liability? Yes No
 If "Yes," please submit a copy of the agreement.

2. a. Please identify any contract professional services performed at the hospital:
 _____ Housekeeping _____ Pathology
 _____ Laboratory _____ Pharmacy
 _____ Laundry _____ Other (explain): _____

- b. Does the Applicant require these contractors to provide evidence of insurance? Yes No
 If "Yes," what limits of liability does the Applicant require? _____
 (Please submit a copy of each contract.)

3. a. Are there any other service contracts in effect? Yes No
 If "Yes," please describe services: _____

- b. Does the Applicant indemnify (hold harmless) the service provider? Yes No
 If "Yes," please submit a copy of the contract.

I. PHYSICAL PREMISES

1. Please list below all the buildings the Applicant owns, controls, or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. Please attach a separate schedule if more space is needed.

- a. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? Yes No Smoke detectors? Yes No
- b. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? Yes No Smoke detectors? Yes No
- c. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? Yes No Smoke detectors? Yes No
- d. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? Yes No Smoke detectors? Yes No
- e. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? Yes No Smoke detectors? Yes No
- f. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? Yes No Smoke detectors? Yes No

2. Does the Applicant have a heliport/helipad? Yes No
 If "Yes," where is the pad located (e.g., parking lot, top of building, etc.)?

How far is it from the Applicant? _____

Please list the dimensions of helipad: _____

Please describe the type of construction: _____

Estimated number of landings per year: _____

J. AUTO LIABILITY EXPOSURE

How many vehicles in each of the following categories does the Applicant own or operate?

_____ Private Passenger	_____ Service
_____ Ambulance	_____ Patient Transport
_____ Emergency	
_____ Non-Emergency	
_____ Other (please describe): _____	

Current Coverage:	PL	GL	Excess	AL	EL	Helipad
Carrier						
Policy Period						
Limits						
Deductible/SIR (circle which)						
Claims Made/ Occurrence						
Retroactive Date						
# years insured by current carrier						

On a separate sheet of paper, please provide the information requested in a-f above for all other medical professional liability coverage(s) Applicant has had in the past five (5) years.

1. MISSOURI RESIDENTS - DO NOT ANSWER.

Past Coverage:

Has any insurer canceled or declined to issue professional liability insurance for the Applicant? Yes No

If "Yes," please explain: _____

2. Claims/Incidents:

Please describe all claims during the past 5 years made against the **Applicant** or any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. (Attach additional sheet(s) if necessary.)

If answer is "none," so state: _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS UNDERSTOOD AND AGREED BY THE APPLICANT THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

3. Neither the **Applicant** nor any individual or entity proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is "none," so state: _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS UNDERSTOOD AND AGREED BY THE APPLICANT THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 3 IS EXCLUDED FROM THE PROPOSED INSURANCE.

L: ADDITIONAL INFORMATION

Please disclose any information material to the risk which has not otherwise been addressed in this application (please attach additional sheets of paper if necessary).

Please provide the following:

1. Loss History for the last ten (10) years, including the current year and a breakdown of total incurred losses, paid losses, and outstanding losses, separated by year for all underlying coverages. Please provide full details of any claim paid or outstanding during this period in excess of \$100,000 (paid or reserved)
2. Employed Physician Schedule, including the name, specialty and retro date for each employed physician
3. The Applicant's most recent annual report
4. A copy of the most recent JCAHO report and response to any contingencies
5. The Applicant's most recent financial statements
6. Copy of expiring Medical Professional Liability insurance policy
7. Current balance of the self-insured trust fund*
8. Trust agreement*
9. Recent actuarial study supporting the funding of the self-insured trust*

* These items apply if Applicant has set up a self-insured trust fund.

THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER'S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE OR ISSUE A POLICY.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO MINNESOTA, OHIO, AND ARKANSAS APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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, WHICH IS A CRIME.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE,

INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

Applicant		
By (<i>CEO/President/Chairman</i>)	Title	Date

NOTE: This Application must be signed by the Chief Executive Officer, President or Chairman of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

REQUIRED INFORMATION

Produced By (<i>Insurance Agent</i>) Please print and sign name _____ _____	
Insurance Agency	
Insurance Agency Taxpayer ID or Social Security No.	Agent License No.
Address (<i>No., Street, City, State and ZIP</i>)	
E-Mail Address	

Submitted By (<i>Insurance Agency</i>)	
Insurance Agency Taxpayer ID or Social Security No.	Agent License No.
Address (<i>No., Street, City, State and ZIP</i>)	