Admiral INSURANCE GROUP | a Berkley Company

AMBULATORY SURGERY CENTERS PROFESSIONAL LIABILITY APPLICATION and GENERAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

1) Full Name of Applicant:

2) List all Subsidiaries:

3) Mailing and Location Address:

(If multiple addresses, include an attachment with a complete schedule of all locations)

4) Website address:

5) Date Established: (mm/dd/yy)

6) FEIN:

7) Type of Entity: ☐ Corporation ☐ Partnership ☐ Individual ☐ Other(specify):

8) Is this entity owned by, associated with, or controlled by, any other entity? ◯ Yes ◯ No

If Yes, provide details:

9) Is the entity physician owned? ◯ Yes ◯ No

If Yes, provide a breakdown of the MD ownership by percentage. %

10) Limits Requested:

Each Claim:$

Aggregate: $

SECTION II – STAFF

11) Please provide the number of the employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

(Note: Independent contractors are not covered by the policy unless endorsed)

	Employee	Independent Contractor	Insured on Own Med Mal Policy	Insured Limits
Physician/Surgeon's Assistants			◯ Yes ◯ No	
Nurse Practitioners			◯ Yes ◯ No	
Surgical Technicians			◯ Yes ◯ No	
Nurse (RN/LPN/LVN)			◯ Yes ◯ No	
X-Ray Technicians			◯ Yes ◯ No	
Medical Assistants			◯ Yes ◯ No	
Optometrists			◯ Yes ◯ No	
Pharmacists			◯ Yes ◯ No	
Students			◯ Yes ◯ No	
Other:			◯ Yes ◯ No	

12) Are all of the above individuals licensed in accordance with applicable State and Federal regulations? ◯ Yes ◯ No

If No, provide details:

13) Who is your Medical Director?

Medical Specialty:

a. Are the medical Director's duties administrative only? ◯ Yes ◯ No

b. Does the Medical Director provide direct patient care? ◯ Yes ◯ No

c. What medical malpractice limits is the Medical Director required to carry?

14) Provide the number of Privileged Practitioners and whether or not they carry their own individual medical malpractice coverage.

(Note: Privileged Practitioners are not covered by policy unless endorsed)

	Privileged Practitioners	Insured on Own Med Mal Policy	Insured Limits
Physician/Surgeons		◯ Yes ◯ No	
Podiatrists		◯ Yes ◯ No	
Chiropractors		◯ Yes ◯ No	
CRNA's		◯ Yes ◯ No	
Interns/Residents		◯ Yes ◯ No	
Other:		◯ Yes ◯ No	

15) Are employees/contractors references contacted prior to hiring? ◯ Yes ◯ No

a. How are references checked? ☐ Written ☐ Verbal ☐ Both
If verbal only, provide details:

b. Do you verify certification and/or professional licensure status of employees/contractors? ◯ Yes ◯ No

c. Do you question prospective employees/contractors as to any criminal record? ◯ Yes ◯ No

d. Are employees/contractors screened to rule out drug, alcohol and/or sexual abuse? ◯ Yes ◯ No
If No for any response above, provide details:

16) Is credentialing, which includes primary source verification and reference checks, performed on all providers? ◯ Yes ◯ No
If No, provide details:

17) Has the applicant or any of the above employees, independent contractors and/or privileged practitioners:

a. Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? ◯ Yes ◯ No

b. Ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? ◯ Yes ◯ No

c. Ever been treated for alcoholism or drug addiction? ◯ Yes ◯ No

d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ◯ Yes ◯ No

If Yes to any response above, provide details:

SECTION III – FACILITY OPERATIONS

18) Surgical Category/Pain Management Category – Annual Number of PROCEDURES

	NUMBER OF PROCEDURES			NUMBER OF PROCEDURES	
SURGICAL CATEGORY (other than Pain Management)	Actual Last 12 Months	Estimated Next 12 Months	**PAIN MANAGEMENT CATEGORY**	Actual Last 12 Months	Estimated Next 12 Months
Abortions			**CATEGORY A**		
Bariatric (lap band only)			Acupuncture		
Bariatric (all other)			Botox Injections		
Cardiology					
Chiropractic			**CATEGORY B**		
Cosmetic Injectable			Facet Joint Blocks		
Dental, Oral & Maxillofacial			Lesioning (Radio Frequency)		
Dermatology – Non-Cosmetic			Peripheral Nerve Block		
ENT/Otorhinolaryngology – Non- Cosmetic			Radiofrequency Nerve Ablation		
Endoscopy/Colonoscopy			Selective Nerve Root Block		
Gastroenterology			Sympathetic Blocks		
General			Trigger Point Injections		
Gender Reassignment					
Gynecology			**CATEGORY C**		
In Vitro Fertilization			Dorsal Column Stimulator Implants/Reprogramming		
Liposuction			Epidural or Spinal Catheters		
Neurology			Intradiscal Electrothermal Therapy		
Obstetrics			Percutaneous Discectomy		
Ophthalmology			Percutaneous Endoscopy Nerve Root Decompression		
Orthopedic – No Spine			Peripheral Nerve Stimulation – Percutaneous Spinal		
Orthopedic – Spine			Spinal Manipulation Under General Anesthesia		
Plastic – Cosmetic or Reconstructive			Vertebroplasty or Kyphoplasty		
Podiatry					
Rheumatology			**CATEGORY D**		
Thoracic			Discectomy – Open		
Urology – no penile implants			Peripheral Nerve Stimulation – Open		
Urology – penile implants			Spinal Infusion Implants/Pumps		
Vascular			Other:		
Other:					
			TOTALS:		

19) Does your practice include Pain Management? ◯ Yes ◯ No

If yes, specify the percentage of your practice derived from Prescription Only Pain Management. ____ %

20) Does your practice include prescribing of opioids? ◯ Yes ◯ No

If yes, provide the following details:

a. Specify the percentage of your practice derived from opioid prescriptions: ____ %

b. Do you fully comply with the CDC Guideline for Prescribing Opioids? ◯ Yes ◯ No

c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? ◯ Yes ◯ No

d. Do you also dispense the opioids? ◯ Yes ◯ No

21) Gross Revenue:

Projected	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior
$	$	$	$	$

22) Patient Selection:

a. Based on the ASA Physical Status Classification System, what percentage of patients are accepted annually.

P1 A normal healthy patient	%
P2 A patient with mild systemic disease	%
P3 A patient with severe systematic disease	%
P4 A patient with severe systematic disease that is a constant threat to life	%

23) Pediatric Exposures:

a. Indicate percentage of pediatric surgical procedures performed at your facility: ____ %

b. What pediatric surgeries do you perform? ____

c. What percentage of your patients are pediatrics? ____ %

d. Do you have a pediatric crash cart on site? ◯ Yes ◯ No

If No, provide details:

e. Do you require confirmation that anesthesiologists/CRNA's are properly trained to treat pediatric patients? ◯ Yes ◯ No

If No, provide details:

24) Normal hours of operation: ____

25) Indicate the number of operating rooms in the facility: ____

26) Indicate the number of recovery rooms (including number of beds) in the facility?

a.

Overnight recovery beds	# of beds
Less than 24 hours	
More than 24 hours	

If overnight beds were listed, describe staffing levels, qualification and patient/staff ratio:

b. Is there a written policy in place for required staffing levels when patients are kept after normal working hours? ◯ Yes ◯ No

If No, provide details:

27) Is the facility licensed by the state? ◯ Yes ◯ No

Medicare Certified? ◯ Yes ◯ No

Accredited? ◯ Yes ◯ No

If accredited: By JCAHO ◯ Yes ◯ No

By AAAHC ◯ Yes ◯ No

Other: ◯ Yes ◯ No

28) Has the applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered? ◯ Yes ◯ No
If Yes, provide details:

29) Does the applicant have Risk Management and Risk Control Programs in place? ◯ Yes ◯ No

Who from your firm should we contact regarding Admiral's Risk Management Services and Newsletters?

Name: Title:

Telephone: Email:

30) Is the patient's written authorization for the specific surgical procedure(s) and the patient's written "informed consent" required prior to surgery? ◯ Yes ◯ No
If No, provide details:

31) Is there a written policy for:

a. Patient identification ◯ Yes ◯ No

b. Surgical site verification ◯ Yes ◯ No

c. Patient positioning ◯ Yes ◯ No

d. Laser/electrical safety ◯ Yes ◯ No

e. Continuous physiological monitoring ◯ Yes ◯ No

f. Documentation of all intra-operative orders ◯ Yes ◯ No

g. Disposition of all pathology and other specimens ◯ Yes ◯ No

h. Verification of sponge, needle and instrument counts ◯ Yes ◯ No

i. Documentation of patient condition, mode of transportation for hospital transfers ◯ Yes ◯ No

j. Completion and signing of operative reports which includes a written, immediate post-surgical report ◯ Yes ◯ No
If No to any response above, provide details:

32) Prior to the start of every surgical procedure, does the surgical team conduct a “time out” that includes:

a. Final verification of the correct patient procedure, site and as applicable, implants? ◯ Yes ◯ No

b. Active communication among all members of the surgical/procedure team? ◯ Yes ◯ No

c. Consistent initiation of “time out” by a designated member of the team conducted in a ”fail-safe” mode that allows no further surgical action until any and all questions or concerns are resolved? ◯ Yes ◯ No

If No to any response above, provide details:

33) In the event of complications, what are the emergency handling procedures at the facility?

34) With what hospital does the facility have a “transfer agreement’ for handling of emergency cases?

35) What is the travel time and distance (in miles) to this hospital?

36) What is the level of anesthesia provided?

☐ Level A – Local or topical anesthesia

☐ Level B – Local or topical anesthesia and/or IV or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia (including nitrous oxide).

☐ Level C – Levels listed above plus surgical procedures with epidural anesthesia, endotracheal or laryngeal mask intubation or inhalation anesthesia, spinal or epidural.

If Level C anesthesia is provided, is it administered by an anesthesiologist or certified registered nurse anesthetist (CRNA)? ◯ Yes ◯ No

If No, provide details:

SECTION IV – NETWORK SECURITY AND DATA PRIVACY PROCEDURES

37) Do you currently purchase a standalone cyber policy? ◯ Yes ◯ No

If Yes, provide the following information:

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

38) Do you employ the following tools to protect private sensitive data?

a. Anti-Virus and Firewalls ◯ Yes ◯ No

b. Encryption ◯ Yes ◯ No

c. Formal Password Management Procedures ◯ Yes ◯ No

39) Are you compliant with the Health Information Portability and Accountability Act (HIPAA) and Health Information Technology for Economic Critical Health Act (HITECH)? ◯ Yes ◯ No

40) Have you ever experienced a security breach, data loss or denial of service attack? ◯ Yes ◯ No

If Yes, please complete a Supplemental Claim Information Form for each and every claim.

SECTION V – COVERAGE HISTORY

41) Provide the following information as respects the last five years of PROFESSIONAL LIABILITY coverage beginning with the most current coverage:

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

42) Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? ◯ Yes ◯ No

If Yes, provide details including name of carrier and dates:

43) Has any claim ever been made against the applicant or any of its employees? ◯ Yes ◯ No

If Yes, how many?

Complete the Supplemental Claim Information Form for each and every claim.

44) Is the applicant aware of any circumstances which may or may not result in any claim against them or their employees? ◯ Yes ◯ No

If Yes, provide full details on each incident including name of parties involved, date of treatment and current status of incident:

Please provide 5 years, currently valued, company loss runs.

Please attach a copy of the most recent state licensure or Medicare certification inspection report.

45) Are you interested in a quote for General Liability? ◯ Yes ◯ No

If Yes, complete the General Liability Supplemental Application below.

GENERAL LIABILITY SUPPLEMENTAL APPLICATION

SECTION I – YOUR LOCATIONS

IF YOU HAVE MORE THAN FIVE (5) LOCATIONS, PROVIDE A SPREADSHEET WITH THE INFORMATION BELOW FOR EACH LOCATION.

1)

Loc #	Facility Name	Address	Description / Use	Square Footage
1				
2				
3				
4				
5				

	Location 1	Location 2	Location 3	Location 4	Location 5
Own or Lease	◯ Own ◯ Lease	◯ Own ◯ Lease	◯ Own ◯ Lease	◯ Own ◯ Lease	◯ Own ◯ Lease
% occupied by applicant	%	%	%	%	%
Are there other occupants?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
# of beds / units (if applicable)					

SECTION II – MAINTENANCE

2) Does the Applicant have a full-time maintenance staff? ◯ Yes ◯ No

Confirm the type of maintenance, service and repair performed by the Applicant (Direct) or subcontracted (Subbed) by completing the table below.
NOTE: Direct is a percentage of total direct payroll and Subbed is a percentage of total subcontractor cost.

Type	Direct	Subbed
Snow & Ice Removal	%	%
Janitorial/Cleaning Services	%	%
General Maintenance & Repairs	%	%
Landscaping	%	%
Other:	%	%

3) Does the Applicant have written procedures for routine inspections of the premises to identify and address potential liability hazards? ◯ Yes ◯ No

If Yes, are records of the completed inspections and repairs retained for at least five years? ◯ Yes ◯ No

4) Are there any construction projects planned for the upcoming policy term? ◯ Yes ◯ No

If Yes, provide full details of project, location, total costs, payroll and sub costs:

a. Will the construction be subbed out? ◯ Yes ◯ No

b. Are signs clearly posted to warn the third party of construction and/or during routine Maintenance? ◯ Yes ◯ No

SECTION III – FIRE-LIFE SAFETY INFORMATION

5) Are all of your locations equipped with:

a. Complete sprinkler system? ◯ Yes ◯ No

b. At least two clearly marked exits on each floor? ◯ Yes ◯ No

c. Smoke detectors? ◯ Yes ◯ No

d. Emergency electrical system? ◯ Yes ◯ No

e. Heat sensors? ◯ Yes ◯ No

f. Fire escape(s)? ◯ Yes ◯ No

g. Posted emergency evacuation procedures? ◯ Yes ◯ No

h. Properly maintained fire extinguishers? ◯ Yes ◯ No

Attach a separate sheet detailing any No answers.

SECTION IV – OTHER PREMISES EXPOSURES

6) Are any of the following provided:

a. Sale of any food or drinks? ◯ Yes ◯ No

b. Recreational facilities? ◯ Yes ◯ No

c. Gym or exercise equipment available to members or the public? ◯ Yes ◯ No

d. Swimming pool on any premises? ◯ Yes ◯ No

e. Daycare or childcare services? ◯ Yes ◯ No

f. Sponsor any sporting or social events? ◯ Yes ◯ No

g. Hold any fundraising events? ◯ Yes ◯ No

h. Provide alcohol with any of your events or services? ◯ Yes ◯ No

i. Participation in trade shows, exhibits or conventions? ◯ Yes ◯ No

j. Any plans for new construction or renovations during the next twelve (12) months? ◯ Yes ◯ No

Attach a separate sheet detailing any Yes answers.

SECTION V – PRODUCTS AND EQUIPMENT SOLD OR LEASED

7) Do you loan, lease or rent equipment to others? ◯ Yes ◯ No

a. Annual gross revenue **for equipment rental**? $

b. With or without operator (technician)? ◯ With ◯ Without
Provide details:

c. Who is responsible for equipment maintenance?

8) Do you sell durable medical equipment? ◯ Yes ◯ No

If Yes, complete the following table for Medical Equipment Suppliers Revenue:

	Annual Sales	Annual Lease/Rental
Category I: Expendable Items (i.e. adhesive tape, bandages, hypodermic needles)	$	$
Category II: Non-Expendable Items (i.e. hospital beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.)	$	$
Category III: Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, transmitting devices)	$	$
Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.)	$	$

SECTION VI – ADVERTISING

9) Do you obtain proper consents and utilize contractual agreements prior to using the image/oral/written publication of any person/celebrity? ◯ N/A ◯ Yes ◯ No

10) Are you making any structure/function claims for your products on labels, websites or other marketing materials? ◯ Yes ◯ No

Do you maintain documentation that substantiates each claim you make? ◯ Yes ◯ No
If Yes, explain the documentation and length of time records are retained:

SECTION VII – ADDITIONAL INSUREDS

11) List all parties that should be considered for Additional Insured status under the General Liability.
Include a copy of the contract for each entity and a certificate of insurance evidencing GL coverage in place.

Name and Address	Relationship to Applicant

SECTION VIII – PRODUCTS & COMPLETED OPERATIONS

Attach a separate sheet detailing any Yes answers, along with a list of products sold.

If product labels cannot be found on your website, include copies with this application.

12) Do you sell any products? ◯ Yes ◯ No
If No, skip to question 29.

If Yes, answer the following questions and include product brochures.

Describe the types of products you sell:

13) Total gross revenue **from product sales**:

a. Last twelve (12) months: $

b. Next twelve (12) months: $

14) Any herbal supplements, homeopathic remedies, and/or nutraceuticals? ◯Yes ◯No

15) Do any of your products include:

a. Caffeine exceeding 300 mg per servicing (all sources)? ◯Yes ◯No

b. Cannabidiol (CBD) hemp products? ◯Yes ◯No

c. Class I & Class II Medical Products / Devices? ◯Yes ◯No

16) Do you mix or compound any ingredients? ◯Yes ◯No

17) Is a prescription required for any of the products you sell? ◯Yes ◯No

18) Are products of others sold or re-packaged under your label? ◯Yes ◯No

19) Do all of your labels include a disclaimer that the FDA has not evaluated the claims on your labels and that your products are not intended to diagnose, treat, cure or prevent any diseases? ◯Yes ◯No

20) Do you obtain Certificates of Insurance from all suppliers evidencing Product Liability Insurance? ◯Yes ◯No

21) Are foreign products sold, distributed, or used as components? ◯Yes ◯No

22) Have any of your products been recalled, discontinued or changed? ◯Yes ◯No

23) Do you offer training or instruction to the user of your products? ◯Yes ◯No

24) Do you offer guarantees, warranties or Hold Harmless agreements with your products? ◯Yes ◯No

25) Do you install, service of demonstrate products? ◯Yes ◯No

26) Is research and development conducted or new products? ◯Yes ◯No

27) Are any new products planned in the next year? ◯Yes ◯No
If Yes, provide explanation:

28) Are you a manufacturer, wholesaler or importer of products to others? ◯Yes ◯No

If Yes, answer the following questions and attach a separate sheet detailing any No answers, along with copies of product labels (if not available on website).

a. Are all warning labels and instructions for use reviewed by outside legal counsel? ◯Yes ◯No

b. Has legal counsel reviewed your labeling and confirmed it is in compliance with regulations established by the FDA and FTC? ◯Yes ◯No

c. Have you conducted or are you planning to conduct human clinical trials to substantiate your product claims? ◯Yes ◯No

SECTION IX – PRIOR GENERAL LIABILITY COVERAGE HISTORY

29) List prior General Liability insurance carried for each of the past five (5) years. If NONE, check this box ☐

Insurance Company	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form?	Retro Date
					◯Yes ◯No	
					◯Yes ◯No	
					◯Yes ◯No	
					◯Yes ◯No	
					◯Yes ◯No	

SECTION X – CLAIMS

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

30) Has any General Liability claim, or suit been brought against you and/or any of your employees? ◯Yes ◯No
If Yes, complete a Supplemental Claim Information Form for each and every claim or suit.

31) Are any persons or entities proposed for this insurance aware of any fact, circumstance, or situation which may result in a GL claim, and has not been reported to your current GL insurance carrier? ◯None to Report ◯Yes ◯No
If Yes, provide details:

32) Are you aware of any incident, condition, circumstance, defect or suspected defect in any product, which may result in a claim or claims against you that are not listed above? ◯None to Report ◯Yes ◯No
If Yes, provide details:

Attach the following information:

- 5 years currently valued carrier loss runs
- A complete roster of physicians that are contracted with your facility
- Copies of informed consent documents

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or 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. *Applies in MD only.

Applicable in CO: 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 FL and OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.