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):

□ General Hospital	□ Teaching Hospital	□ For-Profit	□ Partnership
□ Psychiatric Hospital	□ Governmental	□ Not-for-Profit	□ Corporation
□ Children's Hospital	□ Convalescent or Nursing Home	□ Medicare Approved	□ Charitable
□ Research Hospital	□ Clinic	□ 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**
___ Dentists*
___ Emergency Medical Technicians
___ Interns
___ Laboratory or X-ray Technicians
___ Licensed Vocational/Practical Nurses
___ Nurse's Aides
___ Nurse Midwives*
___ Nurse Practitioners*
___ Paramedics
___ Registered Nurses
___ Respiratory Therapists
___ Pharmacists
___ Physician Assistants*
___ Physicians and Surgeons**
___ 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):

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

K: COVERAGE

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 *(CEO/President/Chairman)*	Title	Date

NOTE: This Application must be signed by the Chief Executive Officer, President or Chairman of the Applicant acting as the4 authorized agent of all individuals and entities proposed for this insurance.

REQUIRED INFORMATION

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

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