MEDICAL TECHNOLOGY SOLUTIONS™

INSURANCE APPLICATION
MEDICAL TECHNOLOGY SOLUTIONS

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Atlantic Specialty Insurance Company

PLEASE NOTE: THIS APPLICATION IS FOR INSURANCE THAT IS WRITTEN ON A CLAIMS-MADE BASIS. DEFENSE EXPENSES REDUCE AND MAY EXHAUST THE LIMIT OF INSURANCE. THROUGHOUT THIS APPLICATION THE TERM "YOU" MEANS THE APPLICANT AND SUBSIDIARIES IDENTIFIED IN PART I BELOW, AND THE TERM "UNDERWRITER" MEANS THE UNDERWRITING COMPANY IDENTIFIED AT THE TOP OF THE APPLICATION.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

This application was developed in order to gain the information necessary to properly analyze your exposure to loss. The information contained will assist us in evaluating and pricing your insurance coverage.

Please note that there may be sections that do not apply to your operations. Where that is the case, you should mark those sections as "not applicable" (N/A).

If additional space is needed to answer the below questions, attach a separate document to this Application to provide complete answers. If the answer to a question is none, state "None" or "0" in the space provided.

I. APPLICANT

1. Name of Applicant:

2. Street Address:
   Mailing Address (if different):

3. City: State: Zip Code:
   Website Address: Applicant Years in Business:

4. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC
   ☐ Other (please explain):

5. Does the Applicant have a parent company? ☐ Yes ☐ No
   If "Yes," provide name:

6. If you have acquired any subsidiaries or merged any operations within the last five (5) years, identify:

Entity	Date Acquired

7. Within the last five (5) years have you changed name or ownership structure? ☐ Yes ☐ No
   If "Yes," provide full details:

8. Please provide a brief description of your operations or services:

II. COVERAGE(S) AND LIMIT(S) REQUESTED – Please note that requested coverage is not automatically provided. The Policy, if issued, will determine actual coverage.

9.

Coverages	Limit Requested	Retroactive Date	Retention Desired
Sold Product			
Clinical Trials			
Clinical Trial Medical Payments			
Product Withdrawal Expense			
Life Science Crisis Management			
Contracted Professional Services – Errors or Omissions			
Healthcare Professional Services			
Cyber Liability – Information Risk **(A completed Information Risk and Communication Liability Supplement is required).**			
Cyber Liability – Communication **(A completed Information Risk and Communication Liability Supplement is required).**			
Cyber Liability – Privacy Administrative Proceeding (Regulatory)			
Cyber First Party – Breach Consultation*			
Cyber First Party – Incident Management*			
Cyber First Party – Information Restoration*			
Cyber First Party – Hardware Replacement*			
Cyber First Party – Extortion Payments and Rewards*			
Cyber First Party – Forensic Expense*			
Other (describe):			
*For any Cyber First Party Coverage, a Cyber Liability – Information Risk must be purchased.			

10. List your top three (3) competitors:

i.

ii.

iii.

11. List your three (3) largest customers by revenue received and product or service received:

i.

ii.

iii.

12. Have you filed for bankruptcy in the last seven (7) years? ☐ Yes ☐ No

13. Have you discontinued any products or services in the last five (5) years? ☐ Yes ☐ No

If "Yes," please provide details:

14. Describe any future products or services that are under development and expected to go to market within the next 12-18 months:

If any future product expected to go to market within the proposed policy term is a wireless or networked medical device, the **Wireless and Networked Medical Device Supplement** must be completed for these new products going to market within proposed policy term.

15. Are you or any of your officers, directors, shareholders, partners, or members the subject of any investigation or proceeding involving alleged criminal violations relating to your business? ☐ Yes ☐ No

If "Yes," provide full details:

16. Do you sell any products direct-to-consumer? ☐ Yes ☐ No

If "Yes," please identify each product and provide the number of each such product sold in the last five (5) years:

III. REVENUES FOR ALL OPERATIONS

17. **Revenues for ALL Operations**

	Current 12 Months	Projected 12 Months
Medical Device Revenue in USA		
Medical Device Revenue outside the USA		
Number of units sold worldwide		
Pharmaceutical Revenue in USA		
Pharmaceutical Revenue outside the USA		
Contracted Professional Services Revenue		
Other Revenues: Please identify:		
Total Sales		

18. Do you have any staff that provides medical services? ☐ Yes ☐ No

If "Yes," please answer questions 19 to 22.

If "No," Skip to question 23.

19. Healthcare Professionals – Staff Profile:

Please Note: This policy does not automatically provide coverage for healthcare professionals and this information is for underwriting purpose only. If you are requesting coverage, please be sure to enter a limit in Section II, Question 9 for healthcare professionals coverage.

Health Professionals	Specialty (if any)	Estimated annual hours of direct patient care interactions	Number of your Employees	Number of your Independent Contractors
Physician				
Physician's Assistant / Nurse Practitioner				
Dentist				
RN/LPN				
Pharmacist				
Genetic Counselor				
Phlebotomist				
Orthotist/Prosthetist				
Other(s) (describe):				

20. Do you require any of your employed/contracted health professionals to carry their own medical malpractice coverage? ☐ Yes ☐ No

21. Does your business have medical malpractice coverage that insures your business for the medical services provided by your health professionals? ☐ Yes ☐ No

22. Do you review and approve the professional qualifications of your employed/contracted health professionals who have direct patient care interactions? ☐ Yes ☐ No

Do you have a procedure in place to ensure your employed/contracted health professionals maintain their professional licenses? ☐ Yes ☐ No

IV. GENERAL PRODUCT QUESTIONS

23. Do you outsource any work or service to an independent third party company? ☐ Yes ☐ No

If "Yes,":

a. Please describe the work or services you are subcontracting to others to perform for you and/or on your behalf:

b. Is your intent to assume tort liability for their work or service performed for you? (not their own negligence) ☐ Yes ☐ No

If "No," do you obtain evidence of professional or other liability insurance for those individuals? ☐ Yes ☐ No

If "Yes," what limit of liability do you require?

24. Do you have products/components manufactured outside the US? ☐ Yes ☐ No

If "Yes" Identify:

a. The product(s):
b. Where each such product is manufactured:
c. Who manufactures the product(s):
d. How often do you audit your foreign manufacturers?
e. Do you utilize contracts with hold harmless agreements in place? ☐ Yes ☐ No

If "Yes," please attach copies of the contracts to this application.

f. Is the company prepared in the event the contracts may not be enforceable? ☐ Yes ☐ No
If "Yes", please explain:

25. Do any of your products require sterilization? ☐ Yes ☐ No

a. If "Yes," provide details on sterilization procedures.

b. If sterilization is outsourced:
   i. What company is doing the sterilization?
   ii. Do you have a contract with an indemnification agreement? ☐ Yes ☐ No

V. CLINICAL TRIALS

26. a. Do you have any R&D stage clinical trials only (no sold products)? ☐ Yes ☐ No

If "Yes," provide details for each of your planned or ongoing clinical trials below. If additional space is needed, provide as an attachment to this application.

Clinical Trial	Trial 1	Trial 2	Trial 3	Trial 4	Trial 5	Trial 6
Study Name						
Protocol Number						
Phase 1,2,3						
# Patients to be Enrolled by Country						
Commencement Date of Trial						
Are there participants who are part of vulnerable populations (for example, minors, the elderly, pregnant women, prisoners, cognitively impaired, or economically or educationally disadvantaged)?						

b. i. How do you recruit clinical trial participants? Please explain all methods used:

ii. Do you use social media or crowd-sourcing for participant recruitment? ☐ Yes ☐ No

c. Clinical Trial Forms:

i. At what grade level (Flesch-Kincaid scale), are your consent forms written?

ii. Do you require your clinical investigators to assist or determine the participants' understanding of the consent forms? ☐ Yes ☐ No

If "Yes," have you ever acted as, or do you anticipate acting as, both the sponsor and clinical investigator for your clinical trials? ☐ Yes ☐ No

If "Yes", please explain:

d. Have any of your clinical investigators been cited or investigated for violations or regulatory non-compliance in connection with any clinical trials they were involved in? ☐ Yes ☐ No

If "Yes," please provide details:

e. Have any of your clinical trials been suspended or discontinued due to safety reasons? ☐ Yes ☐ No

If "Yes," please provide details:

f. Do you have standard operating procedures regarding the suspension of a clinical trial? ☐ Yes ☐ No

g. Do you have a compliance officer or equivalent thereof? ☐ Yes ☐ No

h. Do any of your employees or contractors provide direct patient care in connection with any of your clinical trials? ☐ Yes ☐ No

If "Yes," do you have separate medical malpractice insurance coverage for this exposure or do you obtain certificates of insurance from any third party rendering these services on your behalf? ☐ Yes ☐ No

If "No," please explain:

i. Have you ever been cited for any regulatory violations in connection with any of your clinical trials? ☐ Yes ☐ No

If "Yes," provide details:

j. Do any of your clinical trials require overnight stays? ☐ Yes ☐ No

If "Yes," provide details:

k. Do you publish all clinical trial results? ☐ Yes ☐ No

VI. PRODUCT WITHDRAWAL EXPENSE **Only complete if you are requesting this coverage.**

27. Do you have a written Recall Plan? ☐ Yes ☐ No

If "Yes," please attach a copy.

28. Do you periodically test or audit your Recall Plan? ☐ Yes ☐ No

If "No," explain:

29. Has any product been recalled in the past 5 (five) years? ☐ Yes ☐ No

If "Yes", provide the following details for each recall:

(If additional space is required, attach a separate sheet to this application)

Classification of Recall (Class 1,2 or 3)	Products involved	Reason for Recall	Date of Recall	Total Expenses Incurred

VII. MEDICAL DEVICE REVENUE INFORMATION

30. Revenue by **Operation Type** (indicate % of **Total Medical Device Service Revenue only based on projections for next 12 month policy period**:

Potential Source of Revenues	**%**	**Details**
Medical Device OEM – manufacturing of your own brand products	%	
Medical Device Royalties/License Fees	%	
Medical Device Contract Manufacturing – manufacturing for others	%	
Medical Device Distribution/Sales/Marketing of products with a brand **other than your own**	%	
Repackaging or Relabeling of products manufactured by others	%	
Medical Device Sterilization/Reprocessing for others	%	
Medical Device Rentals/Leasing	%	
Medical Device Specification Design for others	%	
Medical Device Installation for others' products	%	
Medical Device Service/Repair/Warranty Work (indicate if for your own products or for others)	%	
Medical Device Refurbishing/Rebuilding/Reselling (indicate if for own products or for others)	%	
Other (specify):	%	

VIII. CONTRACTED PROFESSIONAL SERVICES – ERRORS OR OMISSIONS

31. Do you provide service work for a fee? ☐ Yes ☐ No
If "Yes," complete the following:

If "No," skip this section.

32.

Indicate percentage of contracted services revenue you receive for each service which you provide to others:			
Contract Manufacturing	%	Software Development or Product Design	%
Pre-clinical Testing & Development	%	Clinical Trial Management (indicate what clinical trial services you provide):	%
CLIA Certified Lab Services (indicate type):	%	Site Services or Clinical Site Management	%
Are there any other services you provide for others? (please specify):			

33. In the last five (5) years, have you failed to meet any deadlines in your contracts, has a client stopped paying you or asked you for a refund, or have you discontinued any services you have discontinued? ☐ Yes ☐ No

If "Yes," provide details:

34. What is your total number of current contracts?

35. What is the average dollar value of your contracts? $

36. What is the average length of your contracts?

37. If you provide service on other's products, are your service personnel trained by the OEM? ☐ Yes ☐ No

If "Yes," is the completion of that training documented? ☐ Yes ☐ No

38. If you subcontract any service work, do you train the subcontractor's service personnel? ☐ Yes ☐ No ☐ N/A

If "Yes," do you document completion of the training? ☐ Yes ☐ No

39. Please describe the work or services you are subcontracting to others to perform for you and/or on your behalf:

40. Do your products or systems development procedures include the following:

Contract/Statement of work which outlines responsibilities of all parties? ☐ Yes ☐ No ☐ N/A

Written proposal/request from customer to confirm customer performance expectations are achieved? ☐ Yes ☐ No ☐ N/A

Written contract of specifications of products and services you will provide which is signed by the customer? ☐ Yes ☐ No ☐ N/A

Written agreement outlining the scope of the project or services? ☐ Yes ☐ No ☐ N/A

Systems development methodology? ☐ Yes ☐ No ☐ N/A

41. Do you require customer sign-off for the following:

Performance milestones and interim changes that are documented and acknowledged in writing? ☐ Yes ☐ No

Final testing is performed with customer and final acceptance is acknowledged in writing by the customer? ☐ Yes ☐ No

42. Do you use a written contract or agreement with all clients or customers? ☐ Yes ☐ No

43. Do your contracts include:

a. mutual indemnification and hold harmless agreements? ☐ Yes ☐ No

b. additional insured status for you? ☐ Yes ☐ No

44. Do you require a minimum limit of liability be maintained? ☐ Yes ☐ No

If "Yes," what is the minimum limit?

Do you require certificates of insurance? ☐ Yes ☐ No

45. Does legal counsel review all contracts or agreements including changes prior to use? ☐ Yes ☐ No

46. Does legal counsel review all of your product labels, instructions for use, advertising or other marketing materials, and website content annually? ☐ Yes ☐ No

47. Do you ever accept liability for consequential or liquidated damages? ☐ Yes ☐ No

If "Yes," please explain:

IX. PRIVACY AND SECURITY

48. Do you have a formal Privacy Policy in place? ☐ Yes ☐ No

49. Are you in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)? ☐ Yes ☐ No

50. Does your medical device transmit or receive data to or from a network or to another device? ☐ Yes ☐ No

If "Yes," the **Wireless and Networked Medical Device Supplement** is required.

51. Do you develop products and/or offer services that involve processing, transmitting or storing non-public personal information for customers in branding, financial services, medical, or retail business sectors? ☐ Yes ☐ No

If "Yes," what percent of your gross revenue is derived from these activities?

☐ 0% ☐ 10% ☐ 25% ☐ 50% ☐ (other) _____%

52. Do you sell, install, maintain or service information technology products that include a security feature? ☐ Yes ☐ No

If "Yes," please describe:

What percent of your gross revenue is derived from these activities? _____%

X. COMPLIANCE & RISK CONTROL

53. In the last five (5) years, have you received any international vigilance reports? ☐ Yes ☐ No

If "Yes," provide details of each report involving death or injury:

54. When was your last Food and Drug Administration (FDA) inspection?

Were there any 483s issued? ☐ Yes ☐ No

If "Yes," please provide a copy.

Have you corrected all observations? ☐ Yes ☐ No

If "Yes," provide a copy of your response to the FDA.

55. In the last five (5) years, have you received any warning letters or untitled letters from the FDA following an inspection? ☐ Yes ☐ No

If "Yes," provide a copy of each letter and your response.

56. Are you currently in compliance with all applicable good clinical practices (GCP), good laboratory practices (GLP), good manufacturing practices (GMP), quality system (QS), or Advertising & Promotion guidelines? ☐ Yes ☐ No

If "Yes," provide details.

57. Have there been any Federal Trade Commission (FTC) violations in the last three (3) years? ☐ Yes ☐ No

If "Yes," provide details.

58. Are you aware of any off-label use of your products? ☐ Yes ☐ No

If "Yes,":

a. Indicate what revenues you can identify from this off-label use:

b. What steps are you taking, if any, to address the off-label use:

If "No,":

c. What steps, if any, would you take <u>if you became aware</u> of off-label use of your products?

59. Have you discontinued any product for safety reasons? ☐ Yes ☐ No

If "Yes," provide details:

60. Do you have a formal Enterprise Risk Management/Safety Program? ☐ Yes ☐ No

61. Are all your risk management and standard operating procedures (SOPs) audited annually? ☐ Yes ☐ No

62. Do you require all new employees to complete a training program that educates them on all company policies and procedures as well as regulatory requirements applicable to their positions? ☐ Yes ☐ No

63. Does your Quality Control Policy include the following?

- Alpha Testing ☐ Yes ☐ No
- Beta Testing ☐ Yes ☐ No
- Customer Acceptance Procedures ☐ Yes ☐ No
- Documented and practiced quality control program policy for documenting and responding to customer inquiries, complaints, requests, etc. ☐ Yes ☐ No

64. What is your Biohazard Lab Rating on premises (if applicable)?

If "not applicable" indicate with N/A.

65. Do you house animals? ☐ Yes ☐ No

If "Yes," advise what types and how many:

66. Do you have any controlled substances on premises? ☐ Yes ☐ No

If "Yes," please explain:

XI. SALES & MARKETING

Any question in this section referencing "sales staff" applies to all persons or organizations (employed, contracted, external, internal, etc.) selling, distributing, demonstrating, or providing training of your products.

67. How are your products sold (i.e. employed sales staff, contracted sales staff, independent sales staff, etc.)?

If you indicated other than employed sales staff, complete questions a. and b. below.

a. Do you require certificates of insurance and hold harmless agreements? ☐ Yes ☐ No

b. Do you regularly agree to add sales staff as additional insureds to your product liability insurance coverage? ☐ Yes ☐ No

68. Do you ever make direct product comparisons against competitor products? ☐ Yes ☐ No

69. Do you ever make verbal or written promises or guarantees in your sales and marketing presentations that would deviate from your standard written contracts? ☐ Yes ☐ No

70. Do your sales and marketing staff receive formal training regarding standard provisions in your contracts or agreements? ☐ Yes ☐ No

71. Have there been any incidents of non-compliance with company SOPs or regulatory requirements, regarding sales & marketing, within the last five (5) years? ☐ Yes ☐ No

If "Yes," provide details:

72. How often do you conduct compliance audits of your sales and marketing staff?

73. Do you do direct-to-consumer advertising? ☐ Yes ☐ No

If "Yes," please explain:

74. Do you have a formal policy specifically prohibiting direct patient care by product sales personnel? ☐ Yes ☐ No

Have there been any incidents of product sales personnel not complying with the formal policy or providing direct patient care in the last five (5) years? ☐ Yes ☐ No

If "Yes," please provide details:

75. Do any of your employees provide technical assistance or advice during a patient procedure/surgery/test? ☐ Yes ☐ No

If "Yes," provide details:

76. Do you conduct product training for the users of your products? ☐ Yes ☐ No

If "Yes,":

a. do you have a formal and documented program for each device? ☐ Yes ☐ No

XII. COVERAGE AND LOSS HISTORY

77. Attach previous loss runs and list Total Aggregate Cost (losses from ground up including defense, deductibles, and self-insured retentions (SIRs)) for the last five (5) years:

Policy Period	Insurer	# of Claims	Total Aggregate Cost	Occurrence or Claims Made	Retroactive Date	Annual Premium

78. Describe all incurred losses of $10,000 or more:

79. Have any of your products or services been the subject of more than one claim where the insurance carrier at that time bundled all those claims into one claim by related claim or batching provisions, or otherwise? ☐ Yes ☐ No

If "Yes," please identify the products or services involved and the language used by that insurance carrier to relate/batch the claim:

80. Do you have any outstanding loss control recommendations with your current carrier? ☐ Yes ☐ No

If "Yes," provide details:

NOT APPLICABLE IN MISSOURI:

81. Has your insurance ever been canceled or non-renewed by a carrier? ☐ Yes ☐ No

If "Yes," provide details:

XIII. CLAIMS, FACTS AND CIRCUMSTANCES HISTORY

82. Has the Applicant or any individual or entity proposed for coverage suffered any known intrusions, unauthorized access, or been a target of a security or virus incident of its Computer Systems in the most recent past 24 months? ☐ Yes ☐ No

If "Yes," how many intrusions occurred?

If "Yes," and if any loss was caused by any such intrusions, including lost time, lost business income, or costs to repair any damage to systems or to reconstruct data or software, please describe the loss that occurred, and state value of any lost time, income and the costs of any repair or reconstruction:

83. During the past five years, has the Applicant or any individual or entity proposed for coverage submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement? ☐ Yes ☐ No

If "Yes," please provide details:

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

84. Is the Applicant or any individual or entity proposed for coverage aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please provide details:

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

Along with this application, have you attached copies of the following information?

		Attached/Included
1.	A current list of your products and services rendered for the proposed policy term.	☐ Yes
2.	Detailed loss information for the last five (5) years for all the coverages being requested (date of loss, date reported, paid loss, open loss, loss description) from the prior insurance carriers.	☐ Yes ☐ N/A
3.	Any new sales, service/maintenance, and license agreements or contracts for your three (3) largest clients not previously provided to us.	☐ Yes ☐ N/A
4.	Most recent financial statements, if not publicly available.	☐ Yes ☐ N/A
5.	Protocols, informed consents, clinical investigator selection criteria, and Institutional Review Board (IRB) approvals for any active sponsored clinical trials during the proposed policy term.	☐ Yes ☐ N/A
6.	Most recent Form 483, including your response.	☐ Yes ☐ N/A
7.	Any warning or untitled letter within the prior year from the FDA, including your response.	☐ Yes ☐ N/A
8.	Any new direct-to-consumer advertisements, brochures, or other marketing materials, not previously provided to us.	☐ Yes ☐ N/A
9.	If any cyber coverages, including Information Risk or Communication Liability, are being requested, please complete the **Information Risk and Communication Liability Supplement**.	☐ Yes ☐ N/A
10.	If you have any Wireless or Networked Medical Devices being commercially available within the proposed policy term, you must complete the **Wireless and Networked Medical Device Liability Supplement**.	☐ Yes ☐ N/A

XIV. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: 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.

ARKANSAS, MINNESOTA, AND OHIO 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.

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.

DISTRICT OF COLUMBIA APPLICANTS: 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.

FLORIDA APPLICANTS: 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.

KANSAS APPLICANTS: 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, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or 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.

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.

LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: 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.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

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.

OKLAHOMA APPLICANTS: 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.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

XV. SIGNATURE AND AUTHORIZATION

The undersigned represents and agrees:

- S/he is an authorized representative of each person or entity proposed for this insurance.
- To the best of her/his knowledge and belief, after reasonable inquiry, the information and statements in this application, including any attachment(s), are true and complete.
- The information in this application, including any attachment(s), is material to the risk accepted by the Underwriter. If a policy is issued, it is issued in reliance upon this application, including any attachment(s). This application and any attachment(s) will be the basis for the contract. The application and any attachment(s) will be considered part of the policy.
- For North Carolina, Utah and Wisconsin accounts, this application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.
- The Underwriter is authorized to make any inquiry in connection with this application. This application and any inquiry made by the Underwriter does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.
- Any material change to the information in this application, including attachments, prior to the effective date of the policy must be reported to the Underwriter immediately.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:
Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: State: Zip: