Admiral INSURANCE GROUP
a Berkley Company

MEDICAL SPA PROFESSIONAL LIABILITY and GENERAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

1) Full Name of applicant:

(Include all DBAs and subsidiaries seeking coverage under the policy for which you are applying)

2) Mailing & Location Address (If multiple locations, include an attachment with a complete list of locations):

Mailing:

Locations:

3) Website Address:

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

5) FEIN:

6) Type of Entity: ☐ Corporation ☐ Partnership ☐ Professional Association ☐ Sole Proprietor ☐ Government Entity ☐ Other (please describe):

7) Is this entity owned by, associated with or controlled by any other entity? ◯ Yes ◯ No
If Yes, provide details:

8) Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? ◯ Yes ◯ No
If Yes, provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program:

9) Within the next 12-month period, does the applicant plan to:

a. Obtain another operation or entity? ◯ Yes ◯ No

b. Add to the number of employees? ◯ Yes ◯ No

c. Expand the number of locations? ◯ Yes ◯ No

d. Eliminate current services or add new services? ◯ Yes ◯ No

e. Operate in other states? ◯ Yes ◯ No
If Yes to any of the above questions, describe:

SECTION II – STAFF

10) 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:

	Employee	Independent Contractors*	Insured on Own Med Mal Policy	Current Carrier & Limits of Liability
Physicians (no surgery)			◯ Yes ◯ No	
Physicians (surgical)			◯ Yes ◯ No	
Physician Assistants			◯ Yes ◯ No	
Nurse Practitioners / APRNs			◯ Yes ◯ No	
CRNAs			◯ Yes ◯ No	
Surgical Technicians			◯ Yes ◯ No	
Nurses (RN/LPN/LVN)			◯ Yes ◯ No	
Aestheticians			◯ Yes ◯ No	
Laser Techs			◯ Yes ◯ No	
Medical Assistants			◯ Yes ◯ No	
Massage Therapists			◯ Yes ◯ No	
Cosmetologists			◯ Yes ◯ No	
Other:			◯ Yes ◯ No	

* Attach copies of declaration pages on all individuals that carry their own malpractice.

11) Do you require all of your independent contractors to carry Professional Liability? ◯ Yes ◯ No

If No, provide details:

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

If No, provide details:

13) Do you have a Medical Director? ◯ Yes ◯ No

a. If Yes, please provide their name and medical designation
b. What is the Medical Director's medical specialty?
c. Does the Medical Director provide good faith exams or develop treatment plans? ◯ Yes ◯ No
d. Would you like to include coverage for the Medical Director's supervisory duties over PA-c, NP, or APRNs at this facility? ◯ Yes ◯ No
e. Would you like to include coverage for the Medical Director's direct patient care? ◯ Yes ◯ No
   If Yes, complete a Physicians Med Spa Application.

14) Has the applicant or any of the above employees and/or independent contractors:

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 of a criminal act other than traffic offenses? ◯ Yes ◯ No
c. Ever been treated for alcoholism or drug addiction? ◯ Yes ◯ No

d. Ever had any state professional license or license to prescribe narcotics suspended, revoked, renewal refused or restricted or ever voluntarily surrendered same? ◯ Yes ◯ No

If Yes to any of the above questions, describe:

SECTION III – FACILITY OPERATIONS

15) State sources and amounts of total revenue:

	Last 12 Months	Estimate for Next 12 Months
Fee for Service	$	$
Product Sales	$	$
Medical Equipment Rental	$	$
Other Income	$	$
Total Gross Revenue	$	$

16) Indicate the estimated number of procedures to be performed over the next 12 months in all of the following categories:

CATEGORY I – NON-INVASIVE, NON-INJECTABLE, NON-ABRASIVE SKIN CARE & DAY SPA TYPE PROCEDURES

check here if none ☐

	# of Procedures			# of Procedures	
	Last 12 months	Next 12 months		Last 12 months	Next 12 months
Body & Facial Waxing			Facials		
Hair, Manicures, Pedicures			Massage		

CATEGORY II – NON-INVASIVE PROCEDURES, INJECTABLES, ABRASIVE SKIN CARE & NON-LASER REMOVAL PROCEDURES

check here if none ☐

	# of Procedures			# of Procedures	
	Last 12 months	Next 12 months		Last 12 months	Next 12 months
Acupuncture			Microdermabrasion		
BHRT (no pellet insertion)			Microneedling		
Brown Spot Removal – Non Laser			Permanent Make Up		
Chemical Peels (Light)			Platelet Rich Plasma Therapy (PRP / PRF)		
Botox / Dermal Fillers Other Dermal injections			Plasma Pen		
Dermaplaning			P-shots / O-shots		
Electrolysis			Skin Tag / Wart Removal		
Mesotherapy / Injection Lipolysis			Testosterone Injections		
HCG			Other:		

CATEGORY III – LASER-BASED PROCEDURES, FAT EMULSION, NON-INVASIVE LIPO PROCEDURES (COLD LASER), ABRASIVE FACIAL PROCEDURES

check here if none ☐

	# of Procedures			# of Procedures	
	Last 12 months	Next 12 months		Last 12 months	Next 12 months
BHRT (pellet insertion)			Laser Skin Resurfacing		
Brown Spot Removal (Laser Based Treatment)			Pigmented Lesion Removal		
Laser Skin Tightening (e.g Fraxel)			RF Skin Tightening (e.g Thermage)		
Heavy Chemical Peels			Sclerotherapy / Vein Treatments		
IPL			Tattoo Removal (Laser Based Treatment)		
Laser Lipolysis (Non-surgical) – includes Low level, Cold, RF and Ultrasound			Vaginal Rejuvenation *(provide copies of all personnel training documents)*		
Laser Hair Removal			Velashape		

CATEGORY IV – MINOR FACIAL COSMETIC SURGERY, NON-LIPOSUCTION BASED COSMETIC SURGERY

check here if none ☐

	# of Procedures			# of Procedures	
	Last 12 months	Next 12 months		Last 12 months	Next 12 months
Blepharoplasty			PDO Threadlifts		
Ear Pinning			Threadlifts – all other		
Hair Restoration/Hair Transplant Surgery			Other:		

CATEGORY V – COSMETIC SURGERY PROCEDURES AND INVASIVE LIPO PROCEDURES

check here if none ☐

	# of Procedures		
	Last 12 months	Next 12 months	Advise who is performing each of these procedures
Abdominoplasty or Tummy Tucks			
Brazilian Butt Lift or Buttocks Augmentation			
Breast Augmentation			
Face Lifts – Full Face Laser Lipolysis			
Liposelection			
Liposuction – Tumescent or Other			
Surgical Laser Lipolysis (Smart Lipo)			
Fat Grafts / Transfers other than buttocks Describe region(s):			

CATEGORY VI – REGENERATIVE MEDICINE **

check here if none ☐

	# of Procedures			# of Procedures	
	Last 12 months	Next 12 months		Last 12 months	Next 12 months
Exosomes treatments Describe application methods:			Stem Cell treatments – other application methods – describe:		
Stem Cell – Injections			Stem Cell – IV		
Lipodissolve Stem Cell Therapy (fat based stem cell harvesting)			Other:		

** If any of these procedures are provided, complete the Regenerative Medicine Supplement.

CATEGORY VII – ALL OTHER NON-SURGICAL PROCEDURES

check here if none ☐

	# of Procedures			# of Procedures	
	Last 12 months	Next 12 months		Last 12 months	Next 12 months
Wellness visits (NOC)			Medical Marijuana Medical Card Evals		
Chiro / Osteo Manipulations – no anesthesia			Chiro / Osteo Manipulations – with anesthesia		
Compression therapy			Chelation		
Cryotherapy (Whole Body)			HBOT – elective		
Cryo – local treatment			HBOT – wound care		
Hypnotherapy			Red Light therapy		
IV hydration / therapy			Ozone Therapy		
Ketamine treatments			Vitamin Injections		
*Non-Invasive Weight Loss Treatment – Medication only			*Non-Invasive Weight Loss Treatment – All other		

* If performing **any** non-invasive weight loss treatments (medication or other), complete the Non-Invasive Weight Loss Supplemental Application.

If you offer a procedure that has not been mentioned, list them below and provide the number of estimated procedures; or you may provide an attachment with additional details:

17) Do you perform any surgery at this facility not detailed above? ◯ Yes ◯ No

If Yes, provide a list of these surgical procedures and the estimated number of surgeries for the next 12 months.

Type of Surgery	# of Procedures	Advise who is performing each of these procedures

18) What type of anesthesia care is used at the medical spa & who is it administered by?

		Administered by
Local Anesthesia Only	◯ Yes ◯ No	
Conscious Sedation	◯ Yes ◯ No	
General Anesthesia	◯ Yes ◯ No	
Other:	◯ Yes ◯ No	

19) 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

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

a. If Yes, please complete the Pain Management Supplement.

b. Specify the percentage of your practice derived from Prescription Only Pain Management. ____ %

21) Are FDA Approved Drugs ever used for "off-label" purposes? ◯ Yes ◯ No

If Yes, by whom and what is their medical designation?

List the drugs and the "off-label" purposes for which they are used.

22) Do you ever provide any services at locations other than your medical spa? ◯ Yes ◯ No

If Yes, provide the following details:

a. What services?

b. At what locations?

c. Who performs the services and what is their medical designation?

d. How many off-site procedures do you estimate over the next 12 months?

e. Will alcohol be served to these off-site patients? ◯ Yes ◯ No

23) If the applicant has a training school, provide the following (provide additional details on last page if more room is needed):

Profession for which students are being trained	Max # of students per session	# of sessions per year	% of time in clinical setting	Qualification of Faculty (MD, RN, PHD)

24) Is the school accredited by an outside accrediting entity? ◯ Yes ◯ No

If Yes, please provide the name of the accrediting entity?

25) Does completion of the courses provided result in licensing? ◯ Yes ◯ No

SECTION IV – NETWORK SECURITY AND DATA PRIVACY PROCEDURES

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

If Yes, provide the following information:

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

27) 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

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

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

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

SECTION V – COVERAGE HISTORY

30) Provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If none, state NONE.)

Carrier	Limit	Deductible	Premium	Policy Term

31) What is the retroactive date on your current policy?

32) What limits of Professional Liability are you requesting?

33) Are you currently insured under a General Liability policy? ◯ Yes ◯ No

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

If Yes, complete the General Liability Supplemental Application below.

SECTION VI – RISK MANAGEMENT AND CLAIMS HISTORY

35) Do you have a Quality Assurance and Risk Management Program in place? ◯ Yes ◯ No

36) Before and after photos

a. For which procedures are before and after pictures are taken ◯ all ◯ some ◯ none

b. Briefly describe your company policy regarding this practice:

37) Procedure consent forms

a. Are clients required to sign a form specific to the procedure to be performed prior to treatment? ◯ Yes ◯ No

b. Is staff also required to sign a form specific to the procedure when receiving services? ◯ Yes ◯ No

c. Does the applicant provide written post-operative instructions for all procedures performed? ◯ Yes ◯ No

d. Are signed consent forms maintained in the client's file? ◯ Yes ◯ No

For any No answers, provide additional detail:

38) 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:

39) Has any claim ever been made against the applicant or any of its employees? ◯ Yes ◯ No
If Yes, complete the Supplemental Claim Information Form for each and every claim.

40) Does the applicant currently have any open claims? ◯ Yes ◯ No

41) Is the applicant aware of any errors, omissions, circumstances or incidents which may result in a claim being made against them or their employees, or are there any claims that have not yet been reported? ◯ Yes ◯ No

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

SECTION VII – COMMENTS

Please provide any additional details or information that we should consider when reviewing your application for coverage. (Example: only consider specific job, detailed explanation of the coverage needed, procedures performed or types of treatment provided that were not mentioned above, further detail on any of the answers above, etc).

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.