Renewal Application

Please type your responses directly on the application, sign and submit via:

Email: Renewal@prms.com
Fax: (703) 276-9530

Helpful Hints

- **To access an online version of this application, visit www.prms.com/renewal.** Our secure online application portal will guide you step-by-step through the application process, provide you helpful hints, and allow you to upload any pertinent documentation. Use of the CORA will also ensure a more efficient renewal process. Plase note: If you choose to submit your application via .pdf the review and processing of the application will take additional time and may require follow-ups from your underwriter. Please be sure to submit your application prior to the deadline listed on your notification letter to avoid non-renewal of your policy.
- As you complete the application, we understand you may have questions, please feel free to use the "additional notes" page at the end to add any further explanation or clarification of your answers or information. Upon review, we will be in touch if we have any further questions regarding the information provided.
- It is advisable that you download and save the .pdf to your computer. Due to some incompatibility with Adobe .pdfs on some devices, smart phones such as iPhones are not recommended when completing this document.
- Your answers should reflect your *current* practice situation. If you make any adjustments to your practice after you submit the application, you may contact us to update your record. Should anything in your practice change, always alert us within 30 days to ensure that you remain fully protected.
- **Please note:** Due to the volume of renewal applications currently being submitted, the underwriter review process could take several weeks.
- **Visit www.prms.com/RenewalFaqs for a complete list of frequently asked questions with regards to the renewal application process.**

Please complete and include this cover sheet with your application submission.

First Name: _____

Last Name: _____

Practice State: _____

PRMS Customer/Client ID: _____

Thank you!

Consent to Receive Documents Electronically

Terms and Conditions

Fair American Insurance and Reinsurance Company ("FAIRCO"), the issuing carrier and manager of the PRMS brand, has developed a means of receiving your policy documents electronically. As part of the renewal process, you will receive the following electronically: communications from an underwriter, upon approval and payment of your invoice, access to your policy documents including your Certificates of Insurance and Declaration Pages.

1. You have the right at any time to request and receive any documents, notices and messages in paper format. If you wish to withdraw your request, update your contact information, receive a paper copy of any document, notice or information received electronically please email clientservices@prms.com, call (800) 245-3333, or mail your request to PRMS, 1401 Wilson Boulevard, Suite 700, Arlington VA 22209. The documents will be provided at no charge to you.
2. Your consent applies to communications relating to your application for coverage submitted and obtained through PRMS and issued by FAIRCO or your relationship with PRMS or FAIRCO and any of its affiliates.
3. Your consent does not mean that PRMS or FAIRCO must provide all documents electronically and may, at its discretion, provide documents through non-electronic means.
4. To learn how PRMS and FAIRCO will handle your data please review its Privacy Policy (www.prms.com/privacy-policy).
5. Completion of your application does not guarantee or bind coverage. You may be asked for additional information from a PRMS representative. You further understand that the application not considered complete until it is signed electronically or printed, signed and submitted.
6. To receive electronic communications you will need:

    - A computer or mobile device with Internet connectivity, sufficient storage space, and a supported Internet browser.
    - Software to view PDF documents using Adobe® Reader® (www.adobe.com/reader) or similar program.
    - A valid email address that is accessible by the applicant.

If there is a change of hardware or software needed to access or retain electronic documents, upon request, we will provide you with an update of new hardware and software requirements.

BY CHECKING 'I AGREE' YOU ACKNOWLEDGE AND CONFIRM THAT YOU HAVE REVIEWED AND AGREE TO THE ABOVE TERMS AND CONDITIONS AND YOU CAN ACCESS AND RETAIN THE ELECTRONIC RECORDS IN THE FORMAT DESCRIBED ABOVE.

☐ I AGREE

First Name: _____ Last Name: _____

Fair American Insurance and Reinsurance Company
(A Stock Insurance Company)
One Liberty Plaza, 165 Broadway
New York, NY 10006

Medical Professional Liability Insurance – Individual Renewal Application - Psychiatrist

Please type your responses directly on the application and submit via email to Renewal@prms.com or via fax (703) 276-9530. You may provide any additional details or explanations in the notes section.

First Name: _____ **Last Name:** _____ **Title (MD or DO):** _____

Email: _____**Mobile Phone:** _____ **Phone:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Website:** _____

Authorized Contact Name: _____ **Authorized Contact Email:** _____

I: Experience and Training

1. Are you currently a resident or fellow, or did you successfully complete a psychiatric residency or fellowship?

❑ Currently in psychiatry residency or fellowship. Projected date of completion: _____
❑ Completed psychiatry residency or fellowship. Date of completion: _____

2. List active license number(s) and state(s): _____

3. List any psychiatric association membership(s): _____

4. Please indicate your practice specialty. If more than one specialty, please estimate the percentage of time of each:

❑ General Psychiatry _____% ❑ Child and Adolescent Psychiatry _____% ❑ Addiction Psychiatry _____%
❑ Geriatric Psychiatry _____% ❑ Forensic Psychiatry _____% ❑ Pain Management _____%
❑ Other (please specify): _____ _____%

5. Have you successfully completed a child and adolescent psychiatry fellowship? ❑ Yes ❑ No

6. Within the last five years, have you been discharged from active military duty? ❑ Yes - Discharge Date: _____ ❑ No

7. <u>MARYLAND APPLICANTS ONLY</u>: Deductible Option: ❑ NONE ❑ $25,000 ❑ $50,000 ❑ $100,000

II: Practice Locations

1. Please provide location(s) where our coverage is requested:

A. Practice Name: _____

Practice County: _____ **Average number of weekly hours at this location:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

❑ **Check if same as mailing address above**

Practice Type:
❑ Private Practice ❑ Detention Facility
❑ Group Home ❑ Home Practice
❑ Hospital ❑ Other:_____

Practice Locations Continued

Additional practice location where our coverage is requested:

B. Practice Name: _____

Practice County: _____ **Average number of weekly hours at this location:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Practice Type:
❑ Private Practice ❑ Detention Facility
❑ Group Home ❑ Home Practice
❑ Hospital ❑ Other:_____

C. Practice Name: _____

Practice County: _____ **Average number of weekly hours at this location:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Practice Type:
❑ Private Practice ❑ Detention Facility
❑ Group Home ❑ Home Practice
❑ Hospital ❑ Other:_____

If multiple locations, please provide information for each additional practice location in the notes section of this application.

2. Please provide location(s) covered by other insurers, employers or self-insured programs.
Note: Coverage would only be considered at location(s) listed in the question above.

Practice Name	Average Number of Hours per Week at this Location

III: Practice Profile

If you answer "Yes" to 1., 2., 3. and 4., please provide an explanation in the additional notes section.

1. **Have you practiced without continuous medical professional liability insurance coverage?** ❑ Yes ❑ No
   If you were insured by an employer, you may answer NO.
2. **Has your professional liability insurance coverage ever been cancelled, refused renewal, denied, or accepted subject to any conditions or restrictions?** *Missouri applicants: please do not answer.* ❑ Yes ❑ No
3. **Do you engage in unconventional therapy?** *(e.g., psychiatric treatment not considered to be mainstream)* ❑ Yes ❑ No
4. **Do you engage in clinical trials or research?** ❑ Yes ❑ No
5. **Are records created and maintained for each patient, and do you document informed consent?** ❑ Yes ❑ No
6. **Do you engage in medication management?** ❑ Yes ❑ No
   If yes:
   - **Do you provide proper monitoring for medication levels, physiological reactions and drug interactions?**
     ❑ Yes ❑ No, please explain: _____
   - **Do you conduct an initial patient clinical evaluation before prescribing medications?**
     ❑ Yes ❑ No, please explain: _____

IV: Cybersecurity and Telepsychiatry

1. **In your practice, who is responsible for information security and compliance operations?**
   ❑ Self ❑ IT Department/Office Manager/Another Designated Individual
2. **How many people in your practice, in addition to yourself, have access to patient/medical records and financial records?**
   _____
3. **Do you, and others in your practice, engage in regular training regarding security issues and procedures, anti-fraud and cyber phishing?**
   ❑ Yes ❑ No ❑ Unsure/I don't know
4. **Where is your data stored? (Please check all that apply)**
   ❑ On the premises – desktop, non-mobile, computers
   ❑ On a laptop or other device that can be carried off premise
   ❑ In the cloud / data center / internet
5. **Please check the methods in which your data is being secured and managed:**
   ❑ Data is encrypted
   ❑ Emails are encrypted
   ❑ Data is regularly backed up in the cloud/secondary backup computer system
   ❑ None of the above
   ❑ I don't know

6. **Please check the methods in which your computer system is being secured:**
   - ❑ Wireless network is secure
   - ❑ Data is protected by an active and up-to-date firewall
   - ❑ Computers have up-to-date anti-malware/anti-virus software installed
   - ❑ Operating system and software updates are automatically or regularly installed
   - ❑ None of the above
   - ❑ I don't know

7. **Are the security policies of third-party service providers that may have access to personally identifiable information (such as EMR providers, third party billing, etc.) reviewed to ensure your data is safeguarded appropriately?**
   ❑ Yes ❑ No ❑ Unsure/I don't know

8. **Do you engage in telepsychiatry?** ❑ Yes ❑ No
   If yes, please complete the following:
   In which state(s) are your patients located when they are receiving telepsychiatry services?
   - Majority (please include the county):
     _____
   - Other states, if any (county not required):
     _____

   ❑ **Please check to confirm you have reviewed and agree to the following regarding your telepsychiatry practice:**
   - I comply with the applicable laws and regulations by the state(s) and, if prescribing controlled substances, federal government as well as the relevant agencies or exceptions. This includes, but is not limited to, prescribing requirements and an in-person examination.
   - Services are considered rendered in the patient's state, not my location.
   - The patient location is confirmed at the start of every session.
   - I am using HIPAA-compliant equipment. If the equipment vendor stores any patient information, I have a Business Associate Agreement from the vendor unless there is an exception.
   - Informed consent includes the use of telepsychiatry.
   - Patients can decline treatment via telepsychiatry.
   - I have contingency plans for emergencies and technical failures.

V. Additional Information

Please provide explanations in the additional notes section or attach any pertinent documents, if any of the following are answered "Yes" and you have not already notified PRMS.

1. Has any lawsuit, claim, investigation or civil proceeding regarding your psychiatric practice been brought against you in the past 10 years (or at any time if involving sexual misconduct)? Or are you aware of any incidents that might reasonably result in a claim, investigation or civil proceeding? ❑ Yes ❑ No
   If your response is yes, and it is <u>not related to a claim or suit PRMS managed or is already managing</u>, please explain in the additional notes section and provide a claims history report from your insurer(s) over the past 10 years.

2. Are you aware of any occurrences, accidents, conduct, circumstances, complications or unexpected outcomes for psychiatric services that might reasonably be expected to result in a claim, lawsuit, investigation, or civil investigation or proceeding known to you or which should have been known to you on the date of this application? ❑ Yes ❑ No

3. Have any of your professional licenses, certificates or hospital privileges or applications for these been declined, subject to an investigation or proceeding for any reason, or have they been voluntarily surrendered or nonrenewed in lieu of disciplinary action in the past 10 years? ❑ Yes ❑ No

4. Have you ever been – or are you currently – sexually, romantically, socially or professionally (e.g., a business venture) involved with any current or former patient, or with a key third party of a patient? ❑ Yes ❑ No

5. Have you ever been convicted of, plead guilty to, or plead no contest to a felony or other criminal proceeding? ❑ Yes ❑ No

6. Have you ever experienced any dependency upon or been treated for abuse of alcohol, narcotics or other drugs? ❑ Yes ❑ No

7. Have you ever been diagnosed with any physical or mental condition that impairs or could impair your ability to practice medicine? ❑ Yes ❑ No

8. Have you ever been denied a specialty board certification or re-certification? ❑ Yes ❑ No

VI. Practice Structure

1. **What is your practice structure? Please check all that apply.**

❑ Employer of other professionals
❑ Contractor of the services of other professionals
❑ Incorporated solo private practice
❑ Fictitious name entity or DBA
❑ Professional corporation with more than one shareholder
❑ Professional partnership/association
❑ Joint venture or LLC
❑ None of the above/not applicable to my current employment position

If your practice structure is <u>not</u> any of the above or applicable to you, you do not need to complete the remaining questions (#2 through #9) in this section.

2. What is your corporate name: _____ Year of incorporation: _____
Please provide a copy of your articles of incorporation which establish the identity of the ownership.

3. Does the Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity have any ownership interest in a hospital, nursing home, sanitarium, clinic, laboratory, any facility providing bed and board, and/or any other business enterprise? *No coverage is provided for ownership or administrative activities related to the above.* ❑ Yes ❑ No

4. Is the Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity in the business of managing or providing staffing to a hospital, nursing home, sanitarium, clinic, laboratory, any facility providing bed and board, and/or any other business enterprise? *No coverage is provided for management/administrative activities related to the above.* ❑ Yes ❑ No

5. **Please list all professionally licensed providers working within the practice.** *In order for coverage to apply, all employee/independent contractor professionals are required to carry their own individual professional liability insurance with limits of liability equal to or in excess of your coverage limits of liability.*

Full Name	Degree	Date of Hire	Partner/ Shareholder	Insurance Carrier *Please provide current certificate(s) of insurance for all providers with other carriers.*	
_____	_____	____/____/_____	❑ Yes ❑ No	❑ PRMS Client ID/Certificate #: _____	❑ Other Carrier Carrier Name: _____ Limits of Liability: _____
_____	_____	____/____/_____	❑ Yes ❑ No	❑ PRMS Client ID/Certificate #: _____	❑ Other Carrier Carrier Name: _____ Limits of Liability: _____
_____	_____	____/____/_____	❑ Yes ❑ No	❑ PRMS Client ID/Certificate #: _____	❑ Other Carrier Carrier Name: _____ Limits of Liability: _____

For additional providers, please use the notes page(s).

For the following questions, please answer with regards to your Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity OR any of your employee/independent contractor professionals, partners and/or shareholders:

If your response is "Yes" to any of the questions below, **and it is not related to a claim or suit PRMS managed or is already managing**, please explain in the additional notes section and provide a claims history report from the insurer(s) over the past 10 years.

6. Has any lawsuit, claim, investigation or civil proceeding regarding their psychiatric practice been brought against any of the above mentioned in the past 10 years (or at any time if involving sexual misconduct)? ❑ Yes ❑ No

7. Are you aware of any incidents that might reasonably result in a claim, investigation or civil proceeding with regards to any of the above mentioned? ❑ Yes ❑ No

8. Are you aware of any occurrences, accidents, conduct, circumstances, complications or unexpected outcomes for psychiatric services that might reasonably be expected to result in a claim, lawsuit, investigation, or civil investigation or proceeding known to you or which should have been known to you on the date of this application with regards to any of the above mentioned? ❑ Yes ❑ No

9. Have any professional licenses, certificates or hospital privileges or applications for these been declined, subject to an investigation or proceeding for any reason, or have they been voluntarily surrendered or nonrenewed in lieu of disciplinary action in the past 10 years with any of the above mentioned? ❑ Yes ❑ No

All Applicants: Please read the following declarations carefully. All questionnaires must be signed and dated.

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately, in writing, notify the company of such changes, and the company reserves the right to withdraw or modify any outstanding quotations.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy with Fair American Insurance and Reinsurance Company.

All written statements and materials furnished to the company in conjunction with this Application are hereby incorporated by reference into this Application and made a part hereof.

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA 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 FINES AND CONFINEMENT IN PRISON.

NOTICE TO CALIFORNIA APPLICANTS: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

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 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 AUTHORITIES.

NOTICE TO 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.

NOTICE TO 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 IN THE THIRD DEGREE.

NOTICE TO 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.

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 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.

NOTICE TO LOUISIANA 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 FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE 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.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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 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 OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.

NOTICE TO 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 (365:15-1-10, 36 §3613.1). NOTICE: IF YOU CHOOSE TO PURCHASE A CLAIMS-MADE POLICY, COVERAGE IS LIMITED TO LIABILITY FOR CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED TO THE COMPANY WHILE THE COVERAGE IS IN FORCE OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. A LOWER LIMIT OF LIABILITY APPLIES TO JUDGEMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION IV. THE AMOUNT OF COVERAGE PROVIDED BY THIS POLICY, paragraph 4, IN THE POLICY). PLEASE REVIEW THIS POLICY CAREFULLY AND DISCUSS THIS COVERAGE WITH YOUR LEGAL OR INSURANCE ADVISOR.

NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

THE APPLICANT AGREES IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, THAT THIS APPLICATION AND ANY ATTACHMENTS ARE DEEMED ATTACHED TO AND INCORPORATED INTO THE POLICY. BY TYPING MY NAME IN THE FIELD BELOW, I AGREE IT IS EQUIVALENT TO MY SIGNATURE ON THIS DOCUMENT AND I CONSENT TO CONDUCT THE TRANSACTION TO WHICH THIS DOCUMENT IS APPLICABLE BY ELECTRONIC MEANS.

_____ _____

Applicant's Personal Signature Date

Additional Notes, Explanations and Information:

Additional Notes, Explanations and Information: