OneBeacon
PROFESSIONAL INSURANCE®

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Homeland Insurance Company of New York | Homeland Insurance Company of Delaware
(Stock companies owned by the OneBeacon Insurance Group)

Application

MEDICAL FACILITIES AND PROVIDERS URGENT CARE AND WALK IN CLINIC APPLICATION

NOTICE: PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE MAY CONTAIN CLAIMS MADE AND REPORTED COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTED PERIOD AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Instructions:

1. If the Applicant performs or is requesting coverage for any of the following services, the Applicant must complete the applicable Supplemental Application(s) and submit such Supplemental Application(s) with this Application.

- Ambulance Services (HPA-30006-07-12)
- Hired and Non-Owned Auto (HPA-30007-07-12)
- Imaging Center (HPA-30008-07-12)
- Medical Laboratory (HPA-30009-07-12)
- Neuromonitoring-Interoperative Services (HPA-30010-07-12)
- Non-Medical Professional Services (HPA-30011-07-12)
- Pharmacy Services (HPA-30012-07-12)
- Residential Care (HPA-30013-07-12)
- Schools (HPA-30014-07-12)

A. ACCOUNT INFORMATION

1. Applicant Name	
Doing Business As	
State of Domicile	
2. Mailing Address	Street:
	City: State: Zip:
	County: Website Address:
Federal Employee I.D. # (FEIN)	
3. Risk Manager or Contact Person	Name/Title:
	Email Address:
	Telephone Number:
4. Applicant's Legal Structure	☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC
5. Tax Status	☐ For Profit – Private ☐ For Profit – Publicly Traded ☐ Not For Profit
6. Date Established	

7. List all States where the Applicant is operating and providing services:

8. Is the Applicant owned by or controlled by another entity? ☐ Yes ☐ No

If "Yes," please give details:

9. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to:

a. Merge, acquire or consolidate with another entity? ☐ Yes ☐ No

b. Sell or divest another entity or facility? ☐ Yes ☐ No

c. Discontinue any operations or services? ☐ Yes ☐ No

d. Enter into any new business activities or services (including new procedures or products being offered)? ☐ Yes ☐ No

If "Yes," please describe the essential terms of such transaction.

10. List below all subsidiaries, description of operations, date acquired and ownership.

Name & Address	Description of Operations	Relationship	Date Acquired	Ownership %	Retroactive Date

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

11. Does the Applicant own, operate or manage any business or facilities other than the operations described in this Application? ☐ Yes ☐ No

If "Yes," please provide details, including name of entity and the Applicant's ownership interest/management role.

B. FINANCIAL AND EXPOSURE DETAILS

12. List sources and amount of total revenue	Last 12 Months	Next 12 Months (Projected)
a. Charitable Contributions		
b. Government Funding		
c. Fee for Service		
d. Other Income (Describe): _____		
e. Total Gross Revenues		

13. Does the Applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No

14. Services Provided: Please provide projected exposure details for the next 12 months for Applicant and any subsidiaries or other entities seeking coverage. **Visits** – Count each patient each time they enter the Applicant's facility for healthcare related services

	Number of Annual Visits Location 1	Number of Annual Visits Location 2	Number of Annual Visits Location 3
Preventative/Diagnostic Visits:			
Alcohol Drug Testing			
Allergy Shots			
Blood Pressure Screenings			
Immunizations/Flu Shots			
Laboratory			
Occupational Health (Include PT/OT)			
Physicals			
Wellness			
Treatment Visits:			
Pain Management			
Primary Care			
Weight Loss			
Other Visits:			
Describe:			
Non Emergent Care Visits: (abrasions, cold, cough or flu, earache, sore throat, animal or insect bites, minor allergic reactions, minor burns, minor fractures, minor lacerations, sprains.)			
Emergent Care Visits: (potential life threatening conditions that are best treated immediately in the emergency room such as chest pain or pressure, coughing or vomiting blood, difficulty breathing, uncontrolled bleeding, severe head injury, high pediatric fever, serious dysfunction of or injury to any body organ or part, severe burns, severe allergic reaction or suicidal feelings.)			

15. Other Clinical Services – Please indicate any services provided:

- ☐ CLIA Waived Laboratory Services
- ☐ Aesthetic Enhancement Services/Alternative Treatments
- ☐ Pain Management with Injections and/or Nerve Block
- ☐ Pain Management – Medication Only
- ☐ Pharmacy Services – Dispensing of Pre Packaged Pharmaceuticals
- ☐ Pharmacy Services – Other – Describe: _____
- ☐ Women's Health – Describe: _____
- ☐ Employer on Site
- ☐ Digital X-Ray
- ☐ Drug Screening with MRO Services
- ☐ Sleep Health
- ☐ Sports Medicine

16. Does the Applicant provide services to any of the following:

- ☐ Correctional Facility
- ☐ Hospital
- ☐ Nursing Home, Assisted Living or other Residential Facility
- ☐ Physician Offices
- ☐ Supplemental Staffing/Nurse Registry

17. What percentage of the Applicant's patients/clients are under 18 years of age? _____%

18. Does the Applicant:

a. Prescribe medication to any patient? ☐ Yes ☐ No

b. Administer anesthesia (other than topical)? ☐ Yes ☐ No
If "Yes," what percentage of procedures require general anesthesia _____ %

c. Perform any surgical procedures? ☐ Yes ☐ No

d. Own any biomedical or other equipment used for diagnosis, monitoring or treatment purpose? ☐ Yes ☐ No
If "Yes," do qualified personnel inspect and maintain the equipment on a regular basis? ☐ Yes ☐ No
Are manufacturers' recommendations followed for all maintenance and repair of equipment? ☐ Yes ☐ No

19. Please provide information requested for each physician providing services at the Applicant's facility:

Name of Medical Director	Primary Specialty	Insurance Carrier/Policy Number/Policy Period	Check One:	Hours Per Month
			☐ Employee ☐ Contractor	
Physician Names	**Primary Specialty**	**Indicate if they are Member, Partners, Shareholder, Employee or Contracted**	**Insurance Carrier and Limits of Professional Liability**	**Hours Per Month Spent at Your Facility**

Note: If coverage is requested for any physician, a supplemental application must be completed for each such physician. Coverage for any physician is not automatically included. The policy, if issued, will determine coverage.

20. Allied Health Care Professionals (Indicate number of personnel and annual hours worked in each applicable category)

	Employees		Contractors		Volunteers	
	Number of:	Annual Hours:	Number of:	Annual Hours:	Number of:	Annual Hours:
Addiction Counselor						
Case Worker or Case Manager						
Chiropractor						
Dentist						
EMT/Paramedic						
Home Health Aide/Caregiver						
Lab Technician						
Mental Health Counselor						
Nurse – RN						
Nurse – LPN/LVN						
Nurse Aide or Assistant						
Nurse Anesthetist						
Nurse Practitioner/Advance Practice Nurse						
Occupational/Speech Therapist						
Optometrist						
Pharmacist						
Physical Therapist						
Physician						
Physician Assistant						
Podiatrist						
Psychologist						
Respiratory Therapist						
Social Worker						
Surgical Technician						
Other:_____						

21. Does the Applicant have any staff members who are not licensed or who have restricted licenses or privileges? ☐ Yes ☐ No

If "Yes," please explain:

22. Does the Applicant have written requirements that all clinical staff carry professional liability insurance? ☐ Yes ☐ No

Indicate the minimum professional liability insurance limits required for employed or contracted:

a. Physicians or surgeons:

$_____ Each occurrence/$_____ Aggregate

b. Dentists, nurse anesthetists, nurse practitioners, physician assistants and nurse midwives

$_____ Each occurrence/$_____ Aggregate

c. Allied health care professionals:

$_____ Each occurrence/$_____ Aggregate

23. Does the Applicant verify staff professional liability insurance on an annual basis? ☐ Yes ☐ No

24. LIST OF LOCATIONS:

Please list all locations associated with the Applicant and provide corresponding premises information.

Address/Occupancy	Square Footage	Age	Type of Construction	Number of Floors	Type of Fire Protection: AS = Auto. Sprinkler; H = Heat Detector; S = Smoke Detector; A = Auto. Alarm
Medical Facilities Locations					
Other Buildings					

GENERAL LIABILITY EXPOSURES: **Complete this section (Questions 25-32) if General Liability Coverage is requested.**

25. Does the Applicant sell or lease any medical equipment or products to patients or others in connection with its operations? ☐ Yes ☐ No

If "Yes," please complete the following information:

Total Annual Sales: $ _____ Total Annual Lease/Rental Receipts: $ _____

Category I. Expendable Items – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)

Total Annual Sales: $ _____ Total Annual Lease/Rental Receipts: $ _____

Category II. Non-Expendable Items – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc. and prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.

Total Annual Sales: $ _____ Total Annual Lease/Rental Receipts: $ _____

Category III. Diagnostic or treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.

Total Annual Sales: $ _____ Total Annual Lease/Rental Receipts: $ _____

Category IV. Life Sustaining or Critical Life Monitoring Equipment or Devices – This category includes dialysis or heart/lung machines, apnea monitors, or any other life dependent monitors or any other equipment or devices that if they malfunction/fail could result in death or serious deterioration in a health condition.

Total Annual Sales: $ _____ Total Annual Lease/Rental Receipts: $ _____

26. Is the Applicant included as an additional insured under the applicable manufacturer's Products Liability Coverage? ☐ Yes ☐ No

27. Have any of the products that the Applicant distributes been recalled? ☐ Yes ☐ No

    If "Yes," please provide details:

28. Does the Applicant have written procedures for examination and preserving any allegedly defective equipment or product? ☐ Yes ☐ No

29. Does the Applicant provide preventive maintenance or repairs on medical equipment leased to others? ☐ Yes ☐ No

    If "Yes," please describe:

30. Does the Applicant repackage or redesign any products or equipment it sells, rents or leases? ☐ Yes ☐ No

    If "Yes," please describe:

31. Is any of the equipment or other products sold with the Applicant's company label? ☐ Yes ☐ No

    If "Yes," please describe:

32. Does the Applicant have its own sales staff? ☐ Yes ☐ No

    a. If "Yes," are they trained by the manufacturer? ☐ Yes ☐ No

    Please attach a copy of the Applicant's policies on Sales Staff Training, Preventive Maintenance and Patient Education

C. OPERATIONS AND ADMINISTRATION

33. Is the Applicant licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

    If "No," please provide a detailed explanation:

34. 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:

35. Is theApplicant a member of any professional organizations or associations? ☐ Yes ☐ No

    If "Yes," please list professional organizations or associations.

36. Is accreditation by any governmental body or other quality/patient safety organization available for the Applicant? ☐ Yes ☐ No

If "Yes," please indicate accreditation(s) held: ☐ AAAHC ☐ CHAP ☐ CLIA ☐ JCAHO ☐ Other: _____

37. Hours of Operation: _____ Is an MD, DO, NP, or PA on site during all hours of operation? ☐ Yes ☐ No

38. What percentage of the Applicant's visits are seen by: Physicians _____% Mid Levels _____%

39. What percentage of X-rays are over read by a Board Certified Radiologist? _____% or ☐ N/A

If not 100%, explain the criteria for when over reads are required:

40. Please indicate whether the following policies and procedures have been established and are adhered to by all employees:

a. Only PA's, NP's or Physicians are accountable for conducting triage, determining acuity level/appropriateness for transfer to another appropriate facility ☐ Yes ☐ No

b. Strict rule out of myocardial infarction via detailed history/physical and liberal transfer to an acute care setting ☐ Yes ☐ No

c. Strict rule out of fractures via protocols that include: written patient instructions to return for re-examination if pain persists for 12 hours, over read by radiologists, and notifying patients of any latent abnormal findings ☐ Yes ☐ No

d. Restriction on telephone orders and advice without being seen by a PA, NP or MD ☐ Yes ☐ No

e. Vital signs (temp, bp, respiration) and pulse oximetry on all patients presenting to the facility with a respiratory complaint or shortness of breath ☐ Yes ☐ No

f. Written discharge instructions to all patients upon check out ☐ Yes ☐ No

g. Follow up/Call Back criteria for abnormal test result indicators with specific time frame for making calls ☐ Yes ☐ No

h. Follow up/Call Back criteria for high risk conditions with specific time frame for making calls ☐ Yes ☐ No

i. Follow up calls are documented in the patient chart ☐ Yes ☐ No

j. Emergent Transfer log is kept ☐ Yes ☐ No

k. Ongoing review of medical records against specific outcome criteria (patients who return within a specified amount of time with the same complaint, admission to the acute care setting post discharge, complaints, AMA's etc.) ☐ Yes ☐ No

If "No" to any part of Question 40, please explain:

41. Does the Applicant have any contractual agreements with independent contractors who provide services at its facility? ☐ Yes ☐ No

    If "Yes," please describe the services:

42. Are certificates of insurance obtained from all contracted providers evidencing liability limits equal to or exceeding the Applicant's liability limits? ☐ Yes ☐ No

43. Does the Applicant provide services to others on a contractual agreement? ☐ Yes ☐ No

    If "Yes," please describe the services and provide a copy of the contract.

44. Does Legal Counsel review all contractual agreements? ☐ Yes ☐ No

45. Is there a written, formalized Risk Management and or Patient Safety Program? ☐ Yes ☐ No

46. Is there a system to document and report incidents, adverse events and complaints? ☐ Yes ☐ No

47. Are written policies and procedures in place for reporting of any suspected abuse? ☐ Yes ☐ No

48. Has the Applicant had an incident at any facility that resulted in an allegation of sexual abuse or molestation? ☐ Yes ☐ No

    If "Yes," please describe details of the incident(s).

49. Are complete records kept on all patients or clients? ☐ Yes ☐ No

50. Is an Informed Consent process in place? ☐ Yes ☐ No

51. Please indicate all of the screening/hiring procedures used for professionals and others who provide patient care services for Applicant's operations:

    a. Verification of educational background ☐ Yes ☐ No

    b. Verification of previous employers/employment history ☐ Yes ☐ No

    c. Verification of personal references ☐ Yes ☐ No

    d. Verification of hospital privileges for physicians and dentists ☐ Yes ☐ No

    If "Yes," how often does the Applicant update its list of specific privileges _____

e. Verification of any pending license suspensions or revocations, or any pending disciplinary actions by other facilities ☐ Yes ☐ No

f. Criminal background check: ☐ County ☐ State ☐ Federal ☐ None

g. Require information on any professional liability or work related claims that have previously been made against any individual ☐ Yes ☐ No

h. Require information on any allegations of sexual abuse or molestation previously made against any individual ☐ Yes ☐ No

i. Drug/alcohol testing ☐ Yes ☐ No

52. Does the Applicant have written job descriptions? ☐ Yes ☐ No

53. Before staff can provide care, is a competency based checklist used to assess and document their skills? ☐ Yes ☐ No

D. CURRENT AND REQUESTED COVERAGE -

Please note that the requested coverage is not automatically provided. The policy, if issued, will determine actual coverage.

54. Requested Effective Date of Coverage	55. Requested Expiration Date of Coverage

56. Coverage requested:

☐ Professional Liability
☐ Claims Made ☐ Occurrence
Retroactive Date _____ (If Claims Made)

☐ General Liability
☐ Claims Made ☐ Occurrence
Retroactive Date _____ (If Claims Made)

☐ Non Owned Automobile Liability Sublimit $ _____
(Note: Non Owned and Hired Automobile Liability Supplemental Application must be completed)

☐ Employee Benefit Administration Liability Retroactive Date _____

# of Employees _____

57. Limits of Liability Requested (Each Claim/Aggregate):

☐ $100,000/$300,000 ☐ $250,000/$750,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000
☐ $2,000,000/$6,000,000 ☐ Other: _____ ☐ Excess Limits: _____ (Complete ACORD Application)

58. Deductible Requested: (Deductible applies to each and every claim and applies to any combination of claim payments and claim expenses)

☐ No Deductible ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other: _____

59. Is the Applicant currently enrolled in a Patient Compensation Fund? ☐ Yes ☐ No

60. Is the Applicant requesting to include Independent Contractors as Insureds? ☐ Yes ☐ No

61. Please describe any additional insureds to be included, their interest and requested coverage.

Name & Address	Descriptionof Operations	Interest	Coverage Desired
			☐ PL ☐ GL
			☐ PL ☐ GL
			☐ PL ☐ GL

62. Provide the following information for Professional Liability Insurance and General Liability Insurance for the current policy year and previous three years:

Policy Period	Carrier	Limits	Ded/SIR	CM or Occ	Retroactive Date	Premium

E. CLAIMS HISTORY

63. MISSOURI RESIDENTS - DO NOT ANSWER. Has any insurer canceled or declined to issue Professional or General Liability insurance for the Applicant? ☐ Yes ☐ No

If "Yes," please provide details:

64. During the past five (5) years, has any claim that would fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐ Yes ☐ No

If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed):

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 QUESTION 64 IS EXCLUDED FROM THE PROPOSED INSURANCE.

65. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonable 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 QUESTION 65 IS EXCLUDED FROM THE PROPOSED INSURANCE.

F. REQUIRED INFORMATION

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.

- Currently valued loss history for a minimum of the last 5 years from any and all previous carriers. The loss history should include the current year and a breakdown of total incurred losses, paid losses and outstanding losses separated by year for all coverages being requested;
- Most current audited or accountant-prepared financial statements with notes;
- If Applicant is newly formed, Pro Forma financial statements;
- Current accrediting agency (JCAHO, CARF, etc.) report with recommendations and the facility's response to any contingencies;
- Copy of the Applicant's Risk Management and Quality Improvement Plan;
- Copies of all marketing or advertising brochures used by Applicant's facilities.

G. 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.

NOTICE TO 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.

NOTICE TO 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.

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.

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 of the third degree.

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 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.

NOTICE TO 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.

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 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 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.

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 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.

H. SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. 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.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we 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.

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:
Email Address	

Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:
NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.	