



## MedEdge for Physician Assistants

MedEdge is the most comprehensive medical professional liability solution for Physician Assistants. Created by the insurance experts at NIP Programs with the specific needs of a Physician Assistant in mind, MedEdge is a customized insurance solution that includes multiple coverages and enhanced protection. Extreme Service, Superior Protection, Great Rates and Elite Experience. That's the MedEdge promise.

**What is unique about MedEdge?** After years of exhaustive research, we have assembled the most extensive coverages into a specialized medical malpractice insurance solution.

- **You Deserve Your Own Personal Advocate** – MedEdge is your own personal advocate, fighting to protect you, your interests and your career.
- **Portable Coverage** . Choosing your own policy ensures you are always protected, giving you freedom to follow your career opportunities.
- **“All-Time” Protection** . MedEdge protects you at ALL times, with your own coverage and your own dedicated policy limits.
- **Better Coverage. Great Price.** . We match and then exceed our competitors with specialty coverages they just don't have – giving you more for your money.
- **Benefit From Our Experience** . MedEdge coverage is underwritten in partnership with Lexington Insurance Company. Lexington has almost 40 years experience underwriting wide-ranging healthcare risks, providing cutting-edge risk management and exceptional claims service to help insureds protect their bottom line.
- **“Advanced” Protection** . Through our experience, we have pioneered enhancements to eliminate coverage gaps with the goal to protect you better. Our products extend protection that our competitors just can't match, and coverage that you need. We offer choices to meet your unique circumstances including practical limits of liability to respond as needed.
- **Malpractice Safeguards** . MedEdge provides a host of risk management tools and resources to help you stay educated about best practices, prevent and address claims of malpractice against you . any time . anywhere.

Our mission is simple: *To quickly, easily, effectively offer exceptional coverage and risk management products at a competitive price.*

### Submission:

**To receive a premium quotation, please complete the attached application. Be sure to complete all fields; if a question does not apply, “Not applicable” or “N/A” should be indicated.**

**Email the completed application to us at [NIPProSub@nipgroup.com](mailto:NIPProSub@nipgroup.com) or fax to (732) 791-1646.**

For more information, contact:

Israel Notoma  
inotoma@nipgroup.com  
(800) 446-7647 x363

**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA**  
2595 Interstate Drive, Suite 103, Harrisburg, PA 17110  
**ADMINISTRATIVE OFFICES: 175 Water Street, 18<sup>th</sup> Floor, New York, NY 10038**  
(A Capital Stock Insurance Company)

**PHYSICIAN ASSISTANT PROFESSIONAL LIABILITY PLUS APPLICATION**

**NOTE:** Students & Schools will **not** complete this application. Students & Schools have a separate application.

If Claims-Made coverage is chosen, please note the following: **NOTICE:** COVERAGE IS LIMITED TO LIABILITY FOR **CLAIMS** FIRST MADE AGAINST **YOU** DURING THE **POLICY PERIOD** OR AN EXTENDED REPORTING PERIOD, IF APPLICABLE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH **YOUR** INSURANCE REPRESENTATIVE.

**INSTRUCTIONS**

- 1) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Applicable).
- 2) If you need more space for responses, continue on a separate sheet of paper and indicate question number.
- 3) The application must be signed and dated by the applicant.

**INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED**

**I. CLAIM HISTORY**

- 1)  **LOSSES** Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss. **Complete our supplemental claims form for each loss/claim.**
- 2) **If you have no claims, initial here:** \_\_\_\_\_
- 3) Are you aware of any circumstance, accident or loss that has not yet been reported but which may result in a claim?  
 Yes  No **If yes**, give dates, allegations and disposition of each claim or suit on our supplemental claims form for each loss/claim

**II. INFORMATION**

- 1) Full Name (including middle initial): \_\_\_\_\_
- 2) Type of Practice: (check  one)  Individual or  Solo Professional Corporation or  Partnership/Corporation
- 3) Active Professional License Number(s): \_\_\_\_\_ (state) \_\_\_\_\_ (state) \_\_\_\_\_ (state) \_\_\_\_\_ (state)  
*Please attach a supplement if you have additional active license numbers and attach a copy of each Professional License.*
- 4) Year Graduated PA School: \_\_\_\_\_
- 5) State where you will be providing the majority of care: \_\_\_\_\_ Percentage: \_\_\_\_\_
- 6) Email Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Website: \_\_\_\_\_
- 7) Business Name and Address: \_\_\_\_\_
- 8) City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- 9) Requested Coverage: Professional Liability (check  one)  Claims-made  Occurrence
- 10) Requested Effective Date: \_\_\_\_\_ 11) Retro Date: \_\_\_\_\_

**III. REQUESTED LIMITS:** (check  one)\*:

- \$100,000/\$300,000  \$200,000/\$600,000  \$250,000/\$750,000  \$500,000/\$1,000,000  \$1,000,000/\$3,000,000  
 \$1,000,000/\$6,000,000  \$1,300,000/\$3,900,000 (NY only)  \$2,000,000/\$6,000,000 (VA only)

**\* NOTICE: THE PER MEDICAL INCIDENT or OCCURRENCE/AGGREGATE LIMIT OF LIABILITY REQUESTED CANNOT BE HIGHER THAN THE LIMITS OF YOUR COLLABORATING/SUPERVISING MD.**

**IV. STATE EXCEPTIONS:**

- 1) Check(✓) here  if you are an Indiana resident electing to participate in the Indiana Patient’s Compensation Fund. If so, your Limit of Liability will be \$250,000/\$750,000.
- 2) Check(✓) here  if you are a Louisiana resident electing to participate in the Louisiana Patient’s Compensation Fund. If so, your Limit of Liability will be \$100,000/\$300,000.
- 3) Check(✓) here  if you are a Nebraska or New Mexico resident electing to participate in the Nebraska Patient’s Compensation Fund. If so, your Limit of Liability will be \$200,000/\$600,000.
- 4) Check(✓) here  if you are a Florida Resident. If so, your Limit of Liability will be \$250,000/\$750,000.

**V. PRACTICE PROFILE: Check off (✓) all area(s) that apply:**

**Class A** -  Physician Assistants who perform tasks ordinarily reserved for a physician and who work under the direction and supervision of a qualified license physician to assist the physician in the diagnostic management only.

**Class B** - Physician Assistants who are involved in any of the following: (check ✓ all that apply)

- 1.  Assisting in surgery – Any exposure to an Operating Room with a General Practitioner/Family Practice or General Surgeon; (if you are in the Operating Room exclusively for observation then this does not apply; no (✓) for 1.)
- 2.  Any exposure to Trauma/Emergency Room procedures or responsibilities therein (10 hours or less a week)
- 3.  Obstetrical exposure limited to prenatal or postnatal care
- 4.  Assisting in anesthesiology administration

**Class C** - Physician Assistants who are involved in any of the following: (check ✓ all that apply)

- 5.  Assisting in surgery – Any exposure to an Operating Room with  Orthopedic Surgeon,  OB/GYN Surgeon,  Cardiovascular Surgeon,  Thoracic Surgeon,  Neurosurgeon, or  Plastic Surgeon (if you are in the Operating Room exclusively for observation then this does not apply; no (✓) for 5.)
- 6.  Any exposure to Trauma/Emergency room procedures or responsibilities therein (more than 10 hours a week)
- 7.  Exposure to Obstetrical including: delivery room responsibilities
- 8.  Exposure to cardiac catheterization lab

**VI. SCOPE OF PRACTICE: Check (✓) all that apply:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diagnostic Treatment     | <input type="checkbox"/> Rehabilitation Treatment                     | <input type="checkbox"/> Pre/Post Op Procedures            |
| <input type="checkbox"/> Perform Minor Surgery    | <input type="checkbox"/> Perform Physical Exams                       | <input type="checkbox"/> Behavioral Health                 |
| <input type="checkbox"/> Initiate Treatment Plans | <input type="checkbox"/> Compile Patient Histories                    | <input type="checkbox"/> Critical Care                     |
| <input type="checkbox"/> Health Counseling        | <input type="checkbox"/> Dermatology/Cosmetic Procedures              | <input type="checkbox"/> Patient Screening                 |
| <input type="checkbox"/> Routine Lab Testing      | <input type="checkbox"/> Alternative/Complimentary Medicine Treatment | <input type="checkbox"/> Interventional Radiology Services |
| <input type="checkbox"/> Specialist Referral      | <input type="checkbox"/> Family Planning Services                     | <input type="checkbox"/> Long Term/Chronic Care            |
| <input type="checkbox"/> Pediatric Care           | <input type="checkbox"/> Prescribe/Dispense Medication                |  |
| <input type="checkbox"/> OTHER:                   |   |  |

**VII. WORK SETTING: Check (✓) all that apply:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Hospital In-Patient Unit | <input type="checkbox"/> Behavioral Health Facility | <input type="checkbox"/> Emergency/Trauma Unit      |
| <input type="checkbox"/> School/Health Dept       | <input type="checkbox"/> Outpatient Facility        | <input type="checkbox"/> Hospital Operating Room    |
| <input type="checkbox"/> Nursing Home/LTC         | <input type="checkbox"/> Surgical Center            | <input type="checkbox"/> Specialty Physician Office |
| <input type="checkbox"/> Walk-in Urgent Clinic    | <input type="checkbox"/> Primary Physician Office   | <input type="checkbox"/> Hospice                    |
| <input type="checkbox"/> Home Health Care         | <input type="checkbox"/> Correctional Facility      | <input type="checkbox"/> Staffing Agency            |
| <input type="checkbox"/> OTHER:                   |   |   |

**VIII. HIGH RISK PRACTICE PROFILE: Check (✓) below if greater than 50% of your patients have co-morbid condition:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Blood Disorder                             | <input type="checkbox"/> Seizure Disorder    |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Cardiovascular Disease                     | <input type="checkbox"/> Eating Disorders    |
| <input type="checkbox"/> Obesity          | <input type="checkbox"/> Cancer                                     | <input type="checkbox"/> Chronic Pain        |
| <input type="checkbox"/> STDs             | <input type="checkbox"/> COPD/Asthma                                | <input type="checkbox"/> ESRD                |
| <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Neurological/Neurodevelopmental Conditions | <input type="checkbox"/> Metabolic Disorders |
| <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> ETOH/Drug Abuse                            |  |
| <input type="checkbox"/> OTHER:           |   |  |

**IX. HOURS OF PRACTICE:** Check (✓) the box below that reflects your weekly practice hours:

- Full Time (Over 24 hours per week of ALL covered professional activities, including charting, and locations)  
 Part Time (24 hours or less per week of ALL covered professional activities, including charting, and locations)  
 Moon lighting (less than 500 hours in one 12 month period)

**X. CURRENT ACTIVE MEMBERSHIP:** Check (✓) all Professional Associations that apply:

- The National Association of Physician Assistants       The Association of Physician Assistants in Cardiovascular Surgery  
 The American Academy of Physician Assistants       The Association of Family Practice Physician Assistants  
 The Society of Dermatology Physician Assistants       The Association of Physician Assistants in Obstetrics & Gynecology  
 American Association of Surgical Physician Assistants       The Association of Physician Assistants In Psychiatry  
 The Association of Neurosurgical Physician Assistants       The American Society of Orthopaedic Physician's Assistants  
 OTHER: \_\_\_\_\_

**XI. RISK MANAGEMENT:** Check (✓) all that apply:

- 1) Check (✓) here  if you have taken an insurance approved patient safety or risk management course in the last three years. If so, please submit a copy of the certificate as proof of completion.
- 2) Check (✓) here  if there is a written plan of care developed for each patient.
- 3) Check (✓) here  if there is a formal referral process in place for those patients requiring additional clinical assessment, diagnosis and treatment.
- 4) Check (✓) here  if you are applying for group practice coverage and your practice has a written formalized clinical patient safety and risk management program. If so, please submit a copy of the program.
- 5) Check (✓) here  if you have ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any employer, court or administrative agency or ever been the subject of any ethics investigation at local state, or national level. ***If so, please attach a separate sheet with full particulars.***
- 6) Check (✓) here  if you have ever been denied, cancelled or refused renewal of professional liability insurance coverage. ***If so, please attach a separate sheet with full particulars. NOTE: MISSOURI RESIDENTS DO NOT RESPOND TO THIS STATEMENT***
- 7) Check (✓) here  if you have a history of substance or alcohol abuse? If so, **check here**  if you have completed rehabilitation and are substance/alcohol free for the past 2 years. ***If so, please attach a separate sheet with full particulars.***

**XII. PHYSICIAN OVERSIGHT** (Check (✓) all that apply):

- 1) Check (✓) here  if you are involved in periodic assessments of your patients by your designated supervising physician via telephone at least monthly.
- 2) Check (✓) here  if you are involved in biweekly review of patient medical records by your designated supervising physician.
- 3) Check (✓) here  if you are involved in an on-site & in-person meeting with your designated supervising physician at least quarterly.
- 4) Check (✓) here  if you are involved in annual evaluation of your performance and protocols by your designated supervising physician.
- 5) Check (✓) here  if your designated supervising physician reviews your progress notes and the treatments plans of patient encounters within 24 hours for **inpatient/acute care patients.**
- 6) Check (✓) here  if your designated supervising physician reviews your progress notes and the treatments plans of patient encounters within 24 hours for **the Emergency Department.**
- 7) Check(✓) here  if your designated supervising physician reviews your progress notes and the treatments plans of patient encounters within 48 hours **for nursing home residents**

- 8) Check (✓) here  if your designated supervising physician reviews your progress notes and the treatments plans of patient encounters within 72 hours in **all other cases**.
- 9) Check (✓) here  if your designated supervising physician evaluates all patients you treat and are receiving controlled medications at least every 3 months and patients receiving other prescriptions are seen by the designated supervising physician every 6 months.

**XIII. HISTORICAL PROFESSIONAL LIABILITY INSURANCE INFORMATION**

Please provide past policy information as requested. **List all Professional Liability policies** for each of the past five years. Begin with the current policies on the top line. *When referring to your prior coverage, please check either Claims Made or Occurrence. For Claims Made, please include your prior retro date from your expiring policy.*

Policy Period	Insurer	Limits	Premium	Prior Claims Made Policy & Prior Retro Date	Prior Occurrence Policy
				<u>Check (✓) here</u> <input type="checkbox"/> Retro Date: _____	<u>Check (✓) here</u> <input type="checkbox"/>
				<u>Check (✓) here</u> <input type="checkbox"/> Retro Date: _____	<u>Check (✓) here</u> <input type="checkbox"/>
				<u>Check (✓) here</u> <input type="checkbox"/> Retro Date: _____	<u>Check (✓) here</u> <input type="checkbox"/>
				<u>Check (✓) here</u> <input type="checkbox"/> Retro Date: _____	<u>Check (✓) here</u> <input type="checkbox"/>
				<u>Check (✓) here</u> <input type="checkbox"/> Retro Date: _____	<u>Check (✓) here</u> <input type="checkbox"/>

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 NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

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.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

**THE EARLIEST EFFECTIVE DATE FOR WHICH A POLICY MAY BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.**

**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 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 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 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, COMMITS 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.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Name of Agent: \_\_\_\_\_ License #: \_\_\_\_\_

Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_