



Better Medicine • Better Lives



Physician Application for Medical Professional Liability Insurance

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

With your completed application, you are required to submit the following information:

- Current declarations page which provides a retroactive date and indicates limits of liability for you and any entity for which you are requesting coverage.
- Written confirmation of the purchase of or your intent to purchase a reporting endorsement (“tail coverage”) from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage.
- Please check the following specialties that apply. **Note:** An additional application will be provided.

<input type="checkbox"/> Anesthesiology/Pain Management	<input type="checkbox"/> Ophthalmology
<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Orthopedics
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Physical Medicine & Rehabilitation
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Radiology
<input type="checkbox"/> Hand Surgery	<input type="checkbox"/> Surgery (General, Thoracic & Vascular)
<input type="checkbox"/> Family Physician performing Obstetrics	
- If you are requesting coverage for your employed Advanced Practice Provider, a separate application is required.
- Current business letterhead and advertisements (including website material).
- Curriculum Vitae (C.V.)
- A loss run report. To obtain this information, please call your prior carrier(s) and request a currently valued loss run for the past five (5) years.

Additional information may be requested.

COPIC

7351 E Lowry Boulevard, Ste. 400 ■ Denver, CO 80230

phone 720/858-6000 ■ fax 720/858-6004 ■ toll free 800/421-1834 ■ www.callcopic.com

APPLICANT DATA

1. Last name _____	First name _____	M.I. _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F
2. DOB _____	3. SSN _____	4. NPI # _____	
5. Legal Residence (Physical Street/Home Address) _____			
City _____	State _____	ZIP _____	Cell phone # _____
Rural Mailing Address/P.O. Box (if applicable) _____		City _____	State _____ ZIP _____
Home phone # _____		Personal/Confidential E-mail address _____	
6. Primary practice location _____			
Address _____		City _____	County _____ State _____ ZIP _____
Office # _____		Primary fax # _____	
Website address _____			
Primary contact name _____		E-mail address _____	
Phone # _____			
7. Office/Practice Post Office Box (if preferred mailing address) _____			
City _____	County _____	State _____	ZIP _____
8. Billing Address (if statements should be sent to a different location than practice location):			
Firm Name _____		Address _____	
City _____	County _____	State _____	ZIP _____ Phone # _____
9. Please select the mailing address you prefer for each of the following:			
Confidential documents (acknowledgement of incident report, claim correspondence, etc.):			
<input type="checkbox"/> Office <input type="checkbox"/> Office P.O. Box <input type="checkbox"/> Residence <input type="checkbox"/> Residence P.O. Box			
Policy related documents (application, policy, endorsements, etc.):			
<input type="checkbox"/> Office <input type="checkbox"/> Office P.O. Box <input type="checkbox"/> Residence <input type="checkbox"/> Residence P.O. Box			
<i>If you are approved for coverage under a group policy, policy related documents will be sent to the address selected by the policyholder.</i>			

COVERAGE REQUESTED

10. Requested Effective Date _____ Requested Retroactive Date _____		
Note: If you are requesting prior acts coverage, a separate Supplemental Prior Acts Application will be required.		
11. Liability limits <input type="checkbox"/> \$500,000/\$1 million <input type="checkbox"/> \$1 million/\$3 million <input type="checkbox"/> \$1.5 million/\$3 million <input type="checkbox"/> \$2 million/\$4 million <input type="checkbox"/> Other: _____		
12. Practicing as (check one): <input type="checkbox"/> Individual <input type="checkbox"/> Joining Group <input type="checkbox"/> Forming Group <input type="checkbox"/> Joining Hospital Name of Group or Employer: _____ <input type="checkbox"/> Other: _____		
13. List each professional corporation in which you have an ownership and need coverage under the policy:		
Name	Description of Interest	% of Practice
An additional entity application may be needed for the organization(s) listed above.		

IF YOU PRACTICE IN A STATE WITH A PATIENT COMPENSATION FUND

14. If approved for COPIC coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under a patient compensation fund? Yes No N/A*

15. Have you been a qualified health care provider under the Fund at all times subsequent to the retroactive date requested above and as shown on the insurance declarations page(s) attached to the application? Yes No N/A*

**"N/A" means that you do not practice within a Fund state and, therefore, this question is not applicable.*

PROFESSIONAL LIABILITY INSURANCE HISTORY

16. Name of Company (current)	Policy Limits \$ ____ / \$ ____	Period of Coverage: ____ to ____ (mm/yy) (mm/yy) Retroactive Date: _____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits \$ ____ / \$ ____	Period of Coverage: ____ to ____ (mm/yy) (mm/yy) Retroactive Date: _____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits \$ ____ / \$ ____	Period of Coverage: ____ to ____ (mm/yy) (mm/yy) Retroactive Date: _____	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence

17. If your current insurance is claims-made, will "tail" coverage be purchased? Yes No N/A

18. Has any professional liability insurer ever canceled, declined to issue, refused to renew, offered renewal with a surcharged rate, required that you accept a deductible, or issued coverage with any restrictions or exclusions? * Yes No
*Missouri applicants do not answer this question.

19. Have you ever practiced without professional liability insurance? Yes No

LICENSES

20. List all states in which you have ever been licensed to practice medicine, the license number for that state, the date the license was issued and the number of hours you will work in each state as of the requested effective date of coverage. (If extra space is needed, please attach additional sheets.)

State _____ License # _____ Date issued _____ # hours/week _____

State _____ License # _____ Date issued _____ # hours/week _____

State _____ License # _____ Date issued _____ # hours/week _____

21. Are you ABMS or AOA Board Certified? Yes No
If "no," have you ever failed any licensing or Board Certification Examinations? Yes No

22. Have you ever been denied a medical license or certification by a specialty board? Yes No

23. If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? Yes No N/A

PRACTICE HISTORY/TRAINING/EDUCATION

24. You must provide a current C.V. If you have any gaps in practice over 90 days, an explanation must be included.

PRACTICE CHARACTERISTICS

25. What is your Specialty? _____ Percentage of your practice devoted to your Specialty _____ %

26. What is your Subspecialty? _____ Percentage of your practice devoted to your Subspecialty _____ %

27. Average number of hours worked per week 1-15 16-20 21-25 ≥ 26
When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds.

28. Do you maintain any other medical professional liability coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes," please explain. _____		
29. After the Requested Effective Date, do you plan to practice/consult outside your principal state of practice in the next 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes," do you or will you maintain professional liability insurance for this exposure?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please describe the nature of your out-of-state practice and indicate the number of hours per week devoted to it. _____		

30. Do you provide telemedicine services outside of your principle state of practice?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes," please provide additional information. _____		
31. Are you employed or contracted as a medical director for an agency, business, or organization outside of your trained specialty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32. Do you practice "Concierge Medicine?"	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Note: For purposes of this question, "Concierge Medicine," also known as direct care, is a relationship between a patient and a healthcare provider in which the patient pays monthly or annual fees.		
If "no," please skip to question #33.		
If "yes," what percentage of your practice is based on this model? _____ %		
What is your current total patient count? _____		
33. Do you work in an Urgent Care?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes," percentage of practice _____ %		
If "yes," do you hold a current ATLS and ACLS certification?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
34. Do you provide services at a correctional facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
35. Please describe your practice (choose only one):	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Intensivist/Critical Care Specialist
	<input type="checkbox"/> N/A	
If you answered "N/A" to question #35, please skip the next question and proceed to question #36.		
Please indicate the percentage of your total practice devoted to in-patient care of hospitalized patients. _____ %		
36. Do you practice in an Emergency Department (ED)?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For the purpose of this question, answer "no" if you only provide backup/consult call or work in the ED only for the purpose of maintaining privileges.		

PROCEDURES PERFORMED

All "yes" answers require explanation. Please attach additional sheets, if necessary.

37. Do you perform or supervise anyone who performs aesthetic or cosmetic procedures?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
38. Do you perform Sclerotherapy (the injection of sclerosing agents) into the vertebral column?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
39. Do you participate in non-IRB clinical trials?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
40. Do you use any non-FDA approved devices, drugs, or procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
41. Do or will any of your employees practice at a location geographically separate from you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes," please provide details on an additional sheet. Please include in your explanation the distance of the employee's separate practice location from your practice location and a summary of the employee's duties and responsibilities while practicing there. In addition, please explain how these employees are supervised consistent with their duties and the frequency of and methods by which that supervision occurs.		
42. Do you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
43. Do you perform surgery or obstetrical procedures at a location more than 50 miles or one hour from your office location(s)? ..	<input type="checkbox"/> Yes	<input type="checkbox"/> No
44. Do you perform surgery or obstetrical procedures in a surgical suite more than 50 miles or one hour from a hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

45. Do you perform procedures or use equipment not used by a majority of physicians in your specialty or perform "invasive" procedures for which you were not resident trained or for which you do not hold hospital privileges?..... Yes No

"Invasive" refers to procedures by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation.

If applicable, please list all such procedures:

<u>Procedure</u>	<u>Do you maintain Hospital Privileges?</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY PRACTICE PHYSICIANS ONLY

46. Do you perform:

- Prenatal care beyond the first trimester?..... Yes No
- Second-trimester abortions?..... Yes No
- Obstetrical procedures?..... Yes No
- VBAC's?..... Yes No

FAMILY PRACTICE WITH OB & OB/GYN PHYSICIANS ONLY

47. Do you offer obstetric ultrasound images or videos created solely for nonmedical reasons or without an ultrasound report for the medical record or any nonmedical use of ultrasound imaging, such as "keepsake ultrasounds"?..... Yes No
- Do you hold a current certification in Advanced Life Support in Obstetrics (ALSO)?..... Yes No
- Do you perform elective home delivery? Yes No
- Do you supervise or employ Nurse Midwives who manage the active labor and any subsequent delivery for Vaginal Birth after Caesarean (VBAC)? Yes No
- If yes, is a physician physically on premises and immediately available for the entire course of care?..... Yes No
- Average number of deliveries performed per year _____
- Average number of C-sections performed per year _____

OTHER PERSONNEL TO BE COVERED

48. Will you/your entity employ or contract with any allied health practitioners who will work at any of your office locations?..... Yes No

If "yes," please provide the census information requested below. If you are practicing as part of a group practice, one person may complete this section if the information applies to all physicians in the group.

<u># to be insured</u>	<u># to be insured</u>	<u># to be insured</u>
Advanced Practice Nurses _____	Embryologists _____	Psychologists _____
Anesthesiologist Assistants _____	Nurse Midwives _____	Psychotherapists _____
Aestheticians _____	Nurse Practitioners _____	Optometrists _____
*CRNA/Nurse Anesthetists _____	Pharmacists _____	Surgical Assistants _____
Cytotechnologists _____	Physician Assistants _____	

***Nebraska Applicants Only:** Nurse Anesthetists are required to complete a special application form; please contact your agent or the COPIC Underwriting Department for the appropriate application form.

The COPIC policy provides no individual coverage to any employee or independent contractor in any of these classifications working in your office unless he/she is specifically named on the Declarations Page. Please contact your underwriter for more information.

OTHER INFORMATION

All "yes" answers require an explanation. Please attach additional sheets, if necessary.

49. Has any disciplinary action ever been taken regarding any healing arts license which you hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure and any allegations which are currently pending.).....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
50. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
51. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
52. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? Note: You must answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do <u>not</u> involve alcohol or drugs.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
53. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
54. Have you incurred or suffered any chronic illness or physical injury in the past 24 months OR are you currently a registrant in any state's medical marijuana registry?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
55. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
56. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, health plan, managed care organization or other medical review committee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
57. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
58. Have you ever been accused of sexual misconduct or harassment by one of your employees, an associate's employee or an employee of a hospital or surgery center; or have you been accused by a patient or been investigated by any state regulatory authority for boundary violations of a sexual nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
59. Have you ever been reported to the National Practitioners Data Bank?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CERTIFICATES:

60. Please record below all organizations you would like listed as a certificate holder on your policy (e.g., hospitals, HMOs, IPAs, etc.).

<u>Name</u>	<u>Address (including city, state and zip code)</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

By adding a certificate holder's name and address to the above list, you give COPIC your permission to allow the certificate holder to obtain your certificate of insurance.

CLAIMS INFORMATION

Important information regarding questions 61 and 62 (including sub-questions):

1. The word "claim" as used in questions 61 and 62 below refers to:
 - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to question 61 and 62 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 8).

61. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? Yes No

62. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

- a. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
- b. A letter from an attorney regarding your medical treatment of a patient? Yes No
- c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? Yes No
- d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes No
- e. Any other circumstances that might reasonably lead to a claim or suit? Yes No
- f. If yes, to any of the above, have they been reported to your current or prior professional liability insurance carrier? Yes No

SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

8. Status of claim (check applicable answer):

- | | | |
|---|---|---|
| <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Court outcome in your favor | <input type="checkbox"/> Awaiting mediation |
| <input type="checkbox"/> Suit filed but dropped by claimant | <input type="checkbox"/> Court outcome in favor of plaintiff: | <input type="checkbox"/> Awaiting court action: |
| <input type="checkbox"/> Summary judgment in your favor | | |

Amount of Loss payment:	Reserve Amount:
\$ _____	\$ _____

Suit settled out of court

a. Date claim paid: _____

b. Amount paid: \$ _____

c. Did you want to settle this claim? Yes No

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes No
If "yes," amount was \$ _____

Signature: _____

Date: _____

Name (Printed): _____

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! As a condition of being insured, I understand and agree to the requirement to submit to a health and skills assessment by a physician of COPIC's choice. This assessment may be required at COPIC's discretion.

I hereby declare that all answers and statements in this application are true and complete and that no material fact or circumstance has been omitted or withheld. I understand that these answers and statements are material and, as such, will be relied upon by the company to determine whether to issue my liability insurance. If I or any other person making application or providing information on my behalf misstate(s) or fail(s) to disclose any material information, my application may be declined. If my application is approved and it includes any material misstatement or failure to disclose pertinent information, COPIC has the right to cancel my insurance. COPIC also has the right to decline coverage for a specific claim if COPIC would have declined to issue insurance or limited my coverage if I had not made the material misstatement or omission.

Further, I recognize and agree that as a prerequisite to acceptance of this application and in consideration for issuing this liability insurance, COPIC and/or its assigns may conduct a professional/peer review investigation of me and/or my practice. As part of such peer review investigation, I consent to the release of any prior Practice Quality Report and to periodic chart and medical record reviews conducted by the COPIC Practice Quality personnel, as COPIC may request or direct. I agree to abide by any recommendations arising from that review.

I authorize any state board of medical examiners or medical board, or any licensure, hospital board or committee, hospital records department, insurance company, professional society or association, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC or its assigns. This authorization applies regardless of whether I am currently affiliated with the above persons or entities, or have been in the past. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC policy, I hereby consent to COPIC's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations (including professional societies or associations), professional liability insurance carriers, and state and federal regulatory entities, including but not limited to medical boards and boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. This release applies to the following information: my name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank. To the fullest extent permitted by law, I hereby release all providers of such information, including COPIC, its employees and agents, from any and all liability therefore.

Physician signature _____ Date _____

Please PRINT your name _____

RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

INSURANCE FRAUD WARNINGS

The following Insurance Fraud Warnings are required to be provided with all applications.

ALABAMA

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 restitution fines or confinement in prison, or any combination thereof.

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for 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.

COLORADO

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.

DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA

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.

KENTUCKY

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.

LOUISIANA

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.

MAINE

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 denial of insurance benefits.

MARYLAND

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.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

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.

NEW YORK

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.

OHIO

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.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON

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.

RHODE ISLAND

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.

TENNESSEE

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.

VIRGINIA

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 and civil damages.

WASHINGTON

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.

WEST VIRGINIA

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.

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.