REQUESTED EFFECTIVE DATE _____ _____ __________ 12:01AM POLICY NUMBER __________ COMPANY USE ONLY

NATIONAL FIRE & MARINE INSURANCE COMPANY

CANCER TREATMENT CENTER LIABILITY APPLICATION

I. GENERAL INFORMATION

PLEASE PRINT LEGIBLY. POLICY IS BASED ON READABILITY OF YOUR BROKERAGE FIRM/AGENCY NAME.
PLEASE ANSWER ALL QUESTIONS; IF A QUESTION IS NOT APPLICABLE, STATE "N/A".
IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM.

A.

BROKERAGE FIRM/AGENCY NAME: ______________________________

CITY, STATE, AND ZIP CODE ______________________________

BROKER/AGENT NAME ______________________________

PHONE ____ - ____ - ______ **FAX** ____ - ____ - ______ **E-MAIL** ______________________________

B. CONTACT INFORMATION

NAME ______________________________

MAILING ADDRESS ______________________________ **COUNTY** ______________________________

STREET ADDRESS (IF DIFFERENT) ______________________________

CONTACT PERSON NAME ______________________________ **TITLE** ______________________________

BUSINESS PHONE ____ - ____ - ______ **BUSINESS FAX** ____ - ____ - ______ **RESIDENCE PHONE** ____ - ____ - ______

WEBSITE ADDRESS ______________________________

***PLEASE COMPLETE THE "SCHEDULE OF RELATED ENTITIES" OR ATTACH A COPY OF YOUR ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED IN THE SCHEDULE OF RELATED ENTITIES.**

II. COVERAGES, LIMITS AND DEDUCTIBLES

PLEASE COMPLETE THE COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE.

III. GENERAL INFORMATION

A. CHECK ALL THAT APPLY:

- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ JOINT VENTURE
- ☐ CORPORATION
- ☐ PHYSICIAN OWNED
- ☐ FOR PROFIT
- ☐ HOSPITAL OWNED
- ☐ NOT FOR PROFIT
- ☐ INDEPENDENT CENTER
- ☐ OTHER ______________________________

B. LICENSES HELD BY YOUR FACILITY:

III. GENERAL INFORMATION (CONTINUED)

C. CERTIFICATION/ACCREDITATIONS HELD BY YOUR FACILITY:

☐ CMS ☐ JCAHO ☐ AAAHC ☐ ACRO ☐ ACR ☐ IMQ ☐ OTHER ______________________

PLEASE PROVIDE A COPY OF YOUR CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

D. HOW MANY CANCER CENTER TREATMENT LOCATIONS DO YOU HAVE? __________

IF YOU HAVE MULTIPLE LOCATIONS, ARE ALL LOCATIONS ACCREDITED? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS ______________________

E. MEDICAL DIRECTOR:

____

NAME OF MEDICAL DIRECTOR

_______ - _______ - _________

PHONE NUMBER

F. ANNUAL PAYROLL

TOTAL ANNUAL PAYROLL: ______________ TOTAL PROJECTED ANNUAL RECEIPTS: ______________

G. ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ______________________

____

IV. CANCER TREATMENT CENTER OPERATIONS

A. PLEASE INDICATE WHICH OF THE BELOW SERVICES ARE BEING PROVIDED BY YOUR FACILITY:

☐ RADIATION THERAPY

☐ INTERNAL RADIOTHERAPY (BRACHYTHERAPY) - RADIOACTIVE IMPLANTS

☐ EXTERNAL RADIOTHERAPY (TELETHERAPY) - EXTERNAL BEAM THERAPY, GAMMA KNIFE

☐ STEREOTACTIC RADIOSURGERY (SRS)

☐ STEREOTACTIC RADIOTHERAPY (SRT)

☐ INTENSITY-MODULATED RADIATION THERAPY (IMRT)

☐ THREE-DIMENSIONAL IMAGING

☐ CHEMOTHERAPY

☐ PAIN MANAGEMENT

☐ MIND-BODY MEDICINE

☐ NATUROPATHIC MEDICINE

☐ NUTRITIONAL

☐ UREA THERAPY

☐ CRYOTHERAPY

UTILIZATION	CURRENT (LAST 12 MONTHS) PATIENTS/VISITS	PROJECTED (NEXT 12 MONTHS) PATIENTS/VISITS
RADIATION ONCOLOGY/THERAPY		
NON-RADIOLOGICAL ONCOLOGY		
SURGICAL ONCOLOGY		
ALL OTHER		

B. ARE ANY CHANGES PLANNED TO SERVICES YOU OFFER IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
(i.e. ARE YOU ADDING OR DISCONTINUING ANY SERVICES?)

IF YES, PLEASE DESCRIBE ______________________

____

C. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE ______________________

IV. CANCER TREATMENT OPERATIONS (CONTINUED)

D. DO YOU HAVE THE FOLLOWING EQUIPMENT AT YOUR FACILITY?

1. CRASH CART WITH FULL CARDIAC LIFE SUPPORT CAPABILITIES AND NECESSARY IV FLUIDS? ☐ YES ☐ NO
2. DEFIBRILLATOR? ☐ YES ☐ NO
3. EKG? ☐ YES ☐ NO
4. OXYGEN? ☐ YES ☐ NO

E. WHAT PROVISIONS HAVE BEEN MADE FOR EMERGENCY CARE/TRANSFER PROTOCOL? PLEASE DESCRIBE. ______________________________

____

F. HOSPITAL PROVIDING EMERGENCY CARE:

____
NAME

____
ADDRESS

G. DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS? (LABORATORY, PHARMACY ETC.) ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS. ______________________________

____

H. HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE.

I. DO YOU HAVE WRITTEN POLICY AND PROCEDURES THAT ADDRESS:

1. WRITTEN PROTOCOLS REGARDING RADIATION OVERDOSE/UNDERDOSE? ☐ YES ☐ NO
2. PROCEDURES RELATING TO WRONG SITE AND/OR GEOGRAPHIC MISS? ☐ YES ☐ NO
3. GUIDELINES IN THE EVENT OF RADIATION BURN AND/OR RADIATION NECROSIS? ☐ YES ☐ NO
4. EMERGENCY TRANSFER PROTOCOLS? ☐ YES ☐ NO
5. WRITTEN AGREEMENT WITH A HOSPITAL TO PROVIDE EMERGENT HIGHER LEVEL OF CARE? ☐ YES ☐ NO
6. EQUIPMENT SAFETY PROTOCOLS SUCH AS CALIBRATION, IDENTIFYING OPERATING IRREGULARITIES, ETC.? ☐ YES ☐ NO
7. PERIODIC TRAINING AND IN-SERVICE EDUCATION? ☐ YES ☐ NO

IF "NO" FOR ITEMS 1-7 ABOVE, PLEASE EXPLAIN: ______________________________

____

J. DO YOU PERFORM ANY PROCEDURES WHICH REQUIRE ANESTHESIA SERVICES? ☐ YES ☐ NO

IF YES, WHAT PERCENT? ________%

V. MEDICAL STAFF

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN THAT PRACTICES AT YOUR FACILITY.
(NOTE: IF COVERAGE IS DESIRED FOR PHYSICIANS, PLEASE INDICATE THAT ON THE COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE, THE SCHEDULE OF MEDICAL PROFESSIONALS AND COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION.)

PHYSICIANS' NAME *AFTER EACH PHYSICIAN NAME INDICATE IF THEY ARE A MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)*	**LICENSE NUMBER**	**INDICATE SPECIALTY**	**INDICATE THE NUMBER OF HOURS PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT YOUR FACILITY**

V. MEDICAL STAFF (CONTINUED)

B. ARE EACH OF THE PHYSICIANS PRACTICING AT YOUR FACILITY BOARD CERTIFIED? ☐ YES ☐ NO

IF NO, HOW MANY ARE NOT BOARD CERTIFIED? ________

C. DO YOU HAVE ANY PHYSICIANS ON STAFF THAT DO NOT MAINTAIN STAFF PRIVILEGES AT A HOSPITAL? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN ________________________________

D. PLEASE INDICATE THE NUMBER OF HEALTH PROFESSIONALS OTHER THAN PHYSICIANS WHO WORK AT YOUR FACILITY:

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	NUMBER EMPLOYED	NUMBER VOLUNTEERS	NUMBER CONTRACTED
NURSE PRACTITIONERS			
PHYSICIAN ASSISTANTS			
LPN'S/RN'S			
RADIATION PHYSICISTS			
RADIATION THERAPISTS			
RADIATION THERAPY TECHNOLOGISTS			
NUCLEAR MEDICINE THERAPISTS			
DOSIMETRISTS			
DIETITIANS			
SIMULATION TECHNOLOGISTS			
SOCIAL WORKERS			
OTHERS (DESCRIBE)			

E. DO YOU SUPERVISE ANYONE OTHER THAN YOUR OWN EMPLOYEES? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE RESPONSIBILITY OF THE INDIVIDUALS AND WHAT YOUR RELATIONSHIPS ARE WITH THEM. ALSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL, THE NUMBER OF INDIVIDUALS YOU SUPERVISE. ________________________________

F. MEDICAL PROFESSIONALS.

PLEASE INDICATE THE COVERAGE DESIRED FOR MEDICAL PROFESSIONALS ON THE COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE AND COMPLETE THE SCHEDULE OF MEDICAL PROFESSIONALS IF COVERAGE IS DESIRED.

(NOTE: IF COVERAGE IS DESIRED FOR CRNA'S, DENTISTS, NURSE MIDWIVES, NURSE PRACTITIONERS, ORAL SURGEONS, PHYSICIAN ASSISTANTS, PODIATRISTS OR SURGICAL ASSISTANTS, SEPARATE APPLICATIONS MAY BE REQUIRED. PLEASE REFER TO THE INSTRUCTIONS ON THE SCHEDULE OF MEDICAL PROFESSIONALS.)

VI. RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT PROGRAM? ☐ YES ☐ NO

B. IS THERE A FULL-TIME RISK MANAGER? ☐ YES ☐ NO

IF NO, WHAT ARE THEIR OTHER RESPONSIBILITIES AND HOW MUCH TIME IS DEVOTED TO RISK MANAGEMENT? ________________________________

C. PERSON RESPONSIBLE FOR RISK MANAGEMENT

________________________ NAME ________________________ TITLE

D. IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS? ☐ YES ☐ NO

E. IS THERE A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ YES ☐ NO

1. IF YES, DOES THIS PROCEDURE REQUIRE REVIEW AND APPROPRIATE CORRECTIVE ACTION BE TAKEN? ☐ YES ☐ NO
2. IS FOLLOW-UP MADE TO ASSURE COMPLIANCE? ☐ YES ☐ NO

F. IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE? ☐ YES ☐ NO

1. IF YES, IS THE PERSON RESPONSIBLE FOR RISK MANAGEMENT A MEMBER OF THIS COMMITTEE? ☐ YES ☐ NO

VI. RISK MANAGEMENT (CONTINUED)

2. TO WHOM IS THE QUALITY ASSURANCE COMMITTEE ACCOUNTABLE?

NAME ______________________ TITLE ______________________

3. WHAT QUALITY INDICATORS ARE MONITORED (PLEASE LIST): ______________________

4. DO YOU MONITOR YOUR FACILITIES' INFECTION RATE? ☐ YES ☐ NO

G. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS WHICH IS PART OF THE QUALITY MANAGEMENT PROGRAM? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: ______________________

H. IS THERE AN ON-GOING CONTINUING EDUCATION PROGRAM FOR: NURSING STAFF? ☐ YES ☐ NO

ALLIED HEALTH PROFESSIONALS? ☐ YES ☐ NO

I. NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:

NAME ______________________ TITLE ______________________

VII. CREDENTIALING

A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF DO YOU:

1. VERIFY EDUCATIONAL BACKGROUND? ☐ YES ☐ NO
2. CHECK ALL REFERENCES INCLUDING PAST EMPLOYERS? ☐ YES ☐ NO
3. CHECK FOR PENDING LICENSE SUSPENSIONS, REVOCATIONS, OR DISCIPLINARY ACTIONS BY OTHER FACILITIES? ☐ YES ☐ NO
4. CHECK CRIMINAL HISTORY? ☐ YES ☐ NO
5. REQUIRE PRIOR MEDICAL PROFESSIONAL CLAIM HISTORY? ☐ YES ☐ NO

B. ARE CREDENTIALS OF EACH PHYSICIAN REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES? ☐ YES ☐ NO

C. IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK? ☐ YES ☐ NO

D. DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN, PODIATRIST AND DENTIST WORKING AT YOUR FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

IF YES, WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED? $ __________ / $ __________

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

E. WHAT ARE THE MINIMUM LIMITS OF LIABILITY THAT YOU REQUIRE NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT YOUR FACILITY TO CARRY? $ __________ / $ __________

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

F. HAS THE LICENSE OF ANY PHYSICIAN, PODIATRIST, OR DENTIST BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ______________________

G. HAVE YOU MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK OF ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF DURING THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ______________________

VIII. PHYSICAL PLANT

A. PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY YOU. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.

ADDRESS OF PROPERTY TO BE INSURED	USE/OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	FIRE PROTECTION*
PATIENT CARE BUILDINGS:						
OTHER BUILDINGS:						

*FOR EACH BUILDING INDICATE IF THERE IS A:
SPRINKLER SYSTEM - FULL, PARTIAL OR NO SPRINKLER SYSTEM
SMOKE DETECTOR, HEAT DETECTOR
FIRE ALARM - CENTRAL STATION OR LOCAL ALARM

B. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: ____________________

IX. GENERAL LIABILITY

IF GENERAL LIABILITY COVERAGE IS DESIRED, COMPLETE THIS SECTION AND INDICATE COVERAGE IS DESIRED ON THE COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE. OTHERWISE, SKIP TO PART XII.

A. IS THERE A PREVENTIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR THE BIO-MEDICAL EQUIPMENT AND SURGICAL MACHINES OR DEVICES AT THE FACILITY? ☐ YES ☐ NO

1. HOW OFTEN ARE NON-EXPENDABLE MEDICAL OR SURGICAL MACHINES OR DEVICES INSPECTED AND MAINTAINED? ____________________
2. WHO PERFORMS THE MAINTENANCE ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS
3. IF INDEPENDENT CONTRACTOR, WHAT IS THE MINIMUM GENERAL LIABILITY LIMIT THAT YOU REQUIRE THEM TO CARRY? $ __________ / $ __________
4. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

B. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE PREVENTIVE MAINTENANCE, INSPECTION AND REPAIR OF THE EQUIPMENT? ____________________

C. DO YOU LEND OR DONATE YOUR BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE? ☐ YES ☐ NO

IF YES, DESCRIBE: ____________________

D. DO YOU RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? ____________________

E. DO YOU USE AN ADVERTISING AGENCY? ☐ YES ☐ NO

IF YES, WHAT IS THE MINIMUM PROFESSIONAL LIABILITY LIMIT THAT YOU REQUIRE THEM TO CARRY?

$ __________ / $ __________

1. ARE YOU INCLUDED AS AN ADDITIONAL INSURED ON THE AGENCY'S POLICY? ☐ YES ☐ NO
2. IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF YOUR FACILITY? ☐ YES ☐ NO

IX. GENERAL LIABILITY (CONTINUED)

F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE CHANGES PLANNED INCLUDING THE TIME FRAME AND THE ESTIMATED COST. ____________________

____

G . PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJECTED NUMBER OR AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS:

HABITATIONAL RISK: INDICATE IF AN: ☐ APARTMENT ☐ DWELLING ☐ HOTEL

NUMBER OF UNITS: __________ YEAR BUILT: __________

1. ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER? ☐ YES ☐ NO
2. FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? ☐ YES ☐ NO

☐ PAY PARKING RECEIPTS PER YEAR: __________

☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS RECEIPTS PER YEAR: __________

3. DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED. ____________________

____

H. DO YOU LEASE OR RENT SPACE TO OTHERS? ☐ YES ☐ NO

IF YES, INDICATE THE FOLLOWING:

____

CITY, STATE, AND ZIP CODE

____________________ ______________________________________

SQUARE FOOTAGE OCCUPANCY/USE OF SPACE

1. DOES YOUR LEASE REQUIRE THE TENANT TO CARRY GENERAL LIABILITY INSURANCE WITH AT LEAST A $1,000,000 LIMIT? ☐ YES ☐ NO
2. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO
3. IS THE TENANT REQUIRED TO LIST YOU AS AN ADDITIONAL INSURED ON THEIR GENERAL LIABILITY POLICY? ☐ YES ☐ NO

X. EXCESS LIABILITY

IF EXCESS COVERAGE IS DESIRED, PLEASE COMPLETE THIS SECTION. OTHERWISE, SKIP TO PART XIII.

A. HAVE YOUR EXCESS PROFESSIONAL OR COMMERCIAL GENERAL LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, WHAT WAS THE PRIOR LIMIT AND WHEN WAS IT INCREASED? ______________________________

____

XI. INSURANCE HISTORY

****NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATE OF MISSOURI.**

A. HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS. ______________________________

____

B. PLEASE CHECK WHICH TYPE OF NOTICE YOUR PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE THEY WILL FORMALLY RECOGNIZE A CLAIM UNDER THEIR POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

☐ WRITTEN NOTICE FROM YOU THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

XI. INSURANCE HISTORY (CONTINUED)

C. HAVE YOU CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS AND HAVE YOU FORWARDED THEM TO YOUR CURRENT INSURER? ☐ YES ☐ NO

IF YES, DATE AND NAME OF CONDUCTOR:

____ MM ____ YYYY ________________ NAME OF CONDUCTOR

D. PLEASE PROVIDE YOUR INSURANCE HISTORY FOR THE LAST FIVE YEARS:

POLICY PERIOD	MOST RECENT YEAR	YEAR 1 PRIOR	YEAR 2 PRIOR	YEAR 3 PRIOR	YEAR 4 PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (C-M) OR OCCURRENCE (O)					
PREMIUM					
GENERAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (C-M) OR OCCURRENCE (O)					
PREMIUM					
EXCESS LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (C-M) OR OCCURRENCE (O)					
PREMIUM					

E. INDIVIDUAL LOSSES (COMBINED PAID AND RESERVED AMOUNTS OF $50,000 OR MORE INCLUDING EXPENSES).

PLEASE PROVIDE A DETAILED DESCRIPTION OF INDIVIDUAL LOSSES (1) OPEN AND; (2) CLOSED CLAIMS WITH COMBINED PAID AND RESERVED AMOUNTS OF $50,000 OR MORE INCLUDING EXPENSES.

1. YEAR ____ MM ____ YYYY DOLLAR AMOUNT: $ ________

   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY

   DESCRIPTION: ________________

2. YEAR ____ MM ____ YYYY DOLLAR AMOUNT: $ ________

   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY

   DESCRIPTION: ________________

3. YEAR ____ MM ____ YYYY DOLLAR AMOUNT: $ ________

   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY

   DESCRIPTION: ________________

XII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION BEFORE AN INSURANCE PROGRAM CAN BE QUOTED:

A. **PLEASE PROVIDE A COPY OF YOUR CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.**

B. **FINANCIAL INFORMATION.** LAST THREE (3) YEARS AUDITED FINANCIAL STATEMENTS OR PRO FORMA (IF NEW FACILITY) INCLUDING AUDITOR'S OPINION.

C. **MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.**

D. **COPY OF YOUR LETTERHEAD.**

E. **LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.**

F. **LOSS INFORMATION.** RECENTLY VALUED LOSS RUNS FROM INSURANCE CARRIERS COVERING THE LAST TEN (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS. COMPLETE DETAILS MUST BE PROVIDED FOR ANY COMBINED PAID AND RESERVED LOSS AT $50,000 OR MORE INCLUDING EXPENSES.

G. **ANNUAL REPORT** (IF ONE IS PUBLISHED).

H. ALL CURRENT **ADVERTISING MATERIALS.**

I. ORGANIZATIONAL CHART INCLUDING THE **NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.**

J. **COPY OF YOUR CURRENT INSURANCE POLICY.**

XIII. IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES

IMPORTANT NOTICE:
THIS INSURANCE MAY CONTAIN CLAIMS-MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE.

PLEASE READ AND REVIEW THE POLICY CAREFULLY.

PLEASE READ AND SIGN

ON BEHALF OF THE ENTITY APPLYING FOR COVERAGE HEREIN:

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO MATERIAL FACT HAS BEEN KNOWINGLY SUPPRESSED OR MISSTATED.

I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY.

I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY PHYSICIAN, DENTIST, FIRM OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND COVERAGE.

BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT THERE IS NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED A COMPLETED APPLICATION; (2) OFFERED A PREMIUM QUOTE; AND (3) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND THAT IF THE PREMIUM OR FIRST INSTALLMENT IS PAID BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF THESE TERMS ARE NOT COMPLIED WITH, THERE WILL BE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER INDIVIDUALS OR ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND, IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REQUESTED, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

____________________	____________________	__________
SIGNATURE OF AUTHORIZED INDIVIDUAL	TITLE	DATE

XIII. IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES (CONTINUED)

IF **ARKANSAS**:

Initial Here

ALL APPLICATIONS, REGARDLESS OF THE FORM OF TRANSMISSION, SHALL CONTAIN A STATEMENT, THE SAME OR SUBSTANTIALLY SIMILAR TO THE FOLLOWING:

"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."

IF **COLORADO**:

Initial Here

EACH INSURANCE COMPANY SHALL PROVIDE ON ALL PRINTED APPLICATIONS FOR INSURANCE, OR ON ALL INSURANCE POLICIES, OR REQUIRED BY LAW, WHETHER PRINTED OR ELECTRONICALLY TRANSMITTED, A STATEMENT, IN CONSPICUOUS NATURE, PERMANENTLY AFFIXED TO THE APPLICATION OR INSURANCE POLICY SUBSTANTIALLY THE SAME AS THE FOLLOWING:

"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."

IF **DISTRICT OF COLUMBIA**:

Initial Here

ALL INSURANCE APPLICATION FORMS SHALL CONTAIN A CONSPICUOUS WARNING IN LANGUAGE THE SAME OR SUBSTANTIALLY SIMILAR TO THE FOLLOWING:

"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."

IF **FLORIDA**:

Initial Here

ALL APPLICATION FORMS SHALL CONTAIN A STATEMENT THAT IS APPROVED BY THE OFFICE OF INSURANCE REGULATION OF THE FINANCIAL SERVICES COMMISSION WHICH CLEARLY STATES IN SUBSTANCE THE FOLLOWING:

"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."

IF **KANSAS**:

Initial Here

EACH INSURER SHALL HAVE ANTIFRAUD INITIATIVES REASONABLY CALCULATED TO DETECT FRAUDULENT INSURANCE ACTS AS SET FORTH IN 40-2,118, INCLUDING AN ANTIFRAUD PLAN SUBMITTED TO THE COMMISSIONER NO LATER THAN JULY 1, 2007. EACH INSURER THAT SUBMITS AN ANTIFRAUD PLAN SHALL NOTIFY THE COMMISSIONER OF ANY MATERIAL CHANGE IN THE INFORMATION CONTAINED IN THE ANTIFRAUD PLAN WITHIN 30 DAYS AFTER SUCH CHANGE OCCURS. SUCH INSURER SHALL SUBMIT TO THE COMMISSIONER IN WRITING THE AMENDED ANTIFRAUD PLAN. ANY ANTIFRAUD PLAN, OR ANY AMENDMENT THEREOF, SUBMITTED TO THE COMMISSIONER FOR INFORMATIONAL PURPOSES ONLY SHALL BE CONFIDENTIAL AND NOT BE A PUBLIC RECORD AND SHALL NOT BE SUBJECT TO DISCOVERY OR SUBPOENA IN A CIVIL ACTION UNLESS THE COURT DETERMINES OTHERWISE. THIS ACT SHALL APPLY TO ALL INSURANCE APPLICATIONS, RATINGS, CLAIMS AND OTHER BENEFITS MADE PURSUANT TO ANY INSURANCE POLICY.

IF **KENTUCKY**:

Initial Here

ALL APPLICATIONS SHALL CONTAIN A STATEMENT IN A FORM APPROVED BY THE DEPARTMENT OF INSURANCE THAT CLEARLY STATES IN SUBSTANCE THE FOLLOWING:

"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."

IF **LOUISIANA:**

Initial Here

ALL APPLICATIONS FOR INSURANCE SHALL CONTAIN A STATEMENT, PERMANENTLY AFFIXED TO OR INCLUDED AS A PART OF THE APPLICATION, THAT CLEARLY STATES IN SUBSTANCE THE FOLLOWING:

"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."

XIII. IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES (CONTINUED)

IF **MAINE:**

Initial Here

ALL APPLICATIONS FOR INSURANCE USED BY INSURERS IN THIS STATE, REGARDLESS OF THE FORM OF TRANSMISSION, MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT PERMANENTLY AFFIXED TO THE APPLICATION OR CLAIM FORM:

"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."

IF **NEW JERSEY:**

Initial Here

INSURANCE APPLICATION FORMS SHALL CONTAIN A STATEMENT IN A FORM APPROVED BY THE COMMISSIONER THAT CLEARLY STATES IN SUBSTANCE THE FOLLOWING:

"ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

IF **NEW MEXICO:**

Initial Here

ALL APPLICATIONS FOR INSURANCE SHALL CONTAIN A STATEMENT PERMANENTLY AFFIXED TO THE APPLICATION WHICH STATES SUBSTANTIALLY AS FOLLOWS:

"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."

IF **NEW YORK:**

Initial Here

ALL APPLICATIONS PROVIDED TO APPLICANTS FOR COMMERCIAL INSURANCE DELIVERED OR PROVIDED TO ANY PERSON RESIDING OR LOCATED IN THIS STATE ON AND AFTER FEBRUARY 2, 1994 IN CONNECTION WITH COMMERCIAL INSURANCE POLICIES TO BE ISSUED OR ISSUED FOR ISSUANCE OR ISSUANCE FOR DELIVERY IN THIS STATE, SHALL CONTAIN THE FOLLOWING STATEMENT:

"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."

IF **OHIO:**

Initial Here

THE DEPARTMENT WILL REVIEW APPLICATIONS TO ENSURE THAT THE REQUIRED FRAUD WARNING IS INCLUDED.

ALL APPLICATIONS FOR GROUP OR INDIVIDUAL INSURANCE ISSUED BY AN INSURER, FOR USE BY PERSONS IN APPLYING FOR INSURANCE SHALL CLEARLY CONTAIN A WARNING SUBSTANTIALLY AS FOLLOWS:

"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."

IF **OKLAHOMA:**

Initial Here

EVERY INSURANCE POLICY OR APPLICATION SHALL CONTAIN A STATEMENT THAT CLEARLY INDICATES IN SUBSTANCE THE FOLLOWING:

"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."

THE ABSENCE OF SUCH A STATEMENT SHALL NOT CONSTITUTE A DEFENSE IN ANY PROSECUTION.

IF **OREGON:**

Initial Here

FRAUD WARNING STATEMENTS ARE NOT REQUIRED BY LAW, HOWEVER THE DIVISION SUPPORTS THE USE OF FRAUD WARNINGS. THEY MAY BE INCLUDED ON INSURANCE APPLICATIONS. THEY MAY APPEAR IN POLICIES AND DECLARATION PAGES ONLY IF THE STATEMENT IS PART OF THE APPLICATION FOR INSURANCE.

XIII. IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES (CONTINUED)

IF **PENNSYLVANIA:**

ALL APPLICATIONS FOR INSURANCE SHALL CONTAIN OR HAVE ATTACHED THERETO THE FOLLOWING NOTICE:

Initial Here

"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."

IF **TENNESSEE:**

ALL APPLICATIONS FOR INSURANCE REGARDLESS OF THE FORM OF TRANSMISSION PROVIDED AND REQUIRED BY AN INSURER SHALL CONTAIN A STATEMENT, PERMANENTLY AFFIXED TO THE APPLICATION, THAT CLEARLY STATES IN SUBSTANCE THE FOLLOWING, OR WORDS TO THAT EFFECT:

Initial Here

"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."

IF **VIRGINIA:**

ALL APPLICATIONS FOR INSURANCE PROVIDED AND REQUIRED BY AN INSURER SHALL CONTAIN A STATEMENT, PERMANENTLY AFFIXED TO, OR INCLUDED AS A PART OF THE APPLICATION, THAT CLEARLY STATES IN SUBSTANCE THE FOLLOWING:

Initial Here

"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."

IF **WASHINGTON:**

EFFECTIVE NO LATER THAN JANUARY 1, 2007, ALL APPLICATIONS AND ALL CLAIM FORMS MUST CONTAIN A STATEMENT, PERMANENTLY AFFIXED TO THE APPLICATION OR CLAIM FORM, THAT CLEARLY STATES IN SUBSTANCE THE FOLLOWING:

Initial Here

"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."

IF **WEST VIRGINIA:**

APPLICATIONS FOR INSURANCE, REGARDLESS OF THE FORM OF TRANSMISSION, MAY CONTAIN THE FOLLOWING OR A SUBSTANTIALLY SIMILAR WARNING:

Initial Here

"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."