



## General Information

Date of survey: \_\_\_\_\_ Insurance Renewal Date: \_\_\_\_\_

Legal Name of Organization: \_\_\_\_\_  
(please include all organizations that are to be included as insureds)

FEIN: \_\_\_\_\_

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

County: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Website Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

## Business Information

Description of organization:  Sole Proprietorship  Partnership  Corporation  Other \_\_\_\_\_

Years in business \_\_\_\_\_ Years experience \_\_\_\_\_

If in Business for less than 3 years, please attach resume and summary of experience of Manager.

Number of Employees: \_\_\_\_\_ Number of Executives/Officers/Owners: \_\_\_\_\_ Is there an employee union?  Yes  No

Is your business a subsidiary or division of another company?  Yes  No

If yes, please provide the name of the company, the address and relationship: \_\_\_\_\_

Has your business had any changes in ownership over the past 3 years?  Yes  No

If yes please provide details: \_\_\_\_\_

Has any insurance carrier cancelled, declined or refused to renew any insurance within the past 3 years?  Yes  No

If yes, please provide dates, coverage and explanation: \_\_\_\_\_

## Insurance Agent Information

Agent's Name: \_\_\_\_\_

Name of Agency: \_\_\_\_\_

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

Agency telephone: \_\_\_\_\_ Agency fax: \_\_\_\_\_

Date proposal is needed: \_\_\_\_\_ Agency e-mail address: \_\_\_\_\_

Do you currently write this account?  Yes  No

If Yes, for how long? \_\_\_\_\_ With what Carrier? \_\_\_\_\_

Is the account Sub-Brokered?  Yes  No

If Yes, please indicate Agency Name: \_\_\_\_\_

# Property and Location Information

PROVIDE THE INFORMATION BELOW OR ATTACH AN ACORD PROPERTY APPLICATION

Current Carrier: \_\_\_\_\_

Current Premium: \$ \_\_\_\_\_

Loc. No.	Address			Limit of Insurance Building		Limit of Insurance Personal Property	Number of Stories	
	<b>Construction Type</b> <input type="checkbox"/> Type 1-wood frame <input type="checkbox"/> Type 2-masonry wood-joisted <input type="checkbox"/> Type 3-metal non-combustible <input type="checkbox"/> Type 4-masonry non-combustible <input type="checkbox"/> Type 5-modified fire resistive <input type="checkbox"/> Type 6-heavy fire resistive	<b>Occupancy Type</b> <input type="checkbox"/> Retail <input type="checkbox"/> Office <input type="checkbox"/> Warehouse <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Own <input type="checkbox"/> Lease	Year Built _____	Building Square Footage _____	Square Footage You Occupy _____	<b>Burglar Alarm</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Sprinkler System</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

Loc. No.	Address			Limit of Insurance Building		Limit of Insurance Personal Property	Number of Stories	
	<b>Construction Type</b> <input type="checkbox"/> Type 1-wood frame <input type="checkbox"/> Type 2-masonry wood-joisted <input type="checkbox"/> Type 3-metal non-combustible <input type="checkbox"/> Type 4-masonry non-combustible <input type="checkbox"/> Type 5-modified fire resistive <input type="checkbox"/> Type 6-heavy fire resistive	<b>Occupancy Type</b> <input type="checkbox"/> Retail <input type="checkbox"/> Office <input type="checkbox"/> Warehouse <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Own <input type="checkbox"/> Lease	Year Built _____	Building Square Footage _____	Square Footage You Occupy _____	<b>Burglar Alarm</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Sprinkler System</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

Loc. No.	Address			Limit of Insurance Building		Limit of Insurance Personal Property	Number of Stories	
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Please indicate if Blanket Coverage is desired

Indicate the desired property deductible:  \$500  \$1000  \$2500  \$5000  Other \_\_\_\_\_

Indicate the Coinsurance % desired  80%  90%  100%  Other \_\_\_\_\_

Please list names and addresses of any mortgagees or loss payees for each location:

Loc. No.	Type	Name and Address
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	

## CGL Limits of Insurance

Current Carrier: \_\_\_\_\_ Current Premium: \$ \_\_\_\_\_

Each Occurrence/General Aggregate  \$500,000/\$500,000  \$500,000/\$1 million  
 \$1 million/\$1 million  \$1 million/\$2 million  \$1 million/\$3 million

Medical Expense  \$5,000  \$10,000  Other: \_\_\_\_\_

Damage To Rented Premises  \$100,000  Other \_\_\_\_\_

A separate liability limit will apply to Professional Services. The limit will follow the General Liability Limit shown above.

## Certificates of Insurance & Additional Insureds

List any entities that need Certificates of Insurance or Additional Insured endorsements for liability coverage.  
 For Additional Insureds, describe their interest in your business.

Loc. No.	Name & Address	Certificate of Insurance	Additional Insured
		<input type="checkbox"/>	<input type="checkbox"/>
Describe Interest			
		<input type="checkbox"/>	<input type="checkbox"/>
Describe Interest			
		<input type="checkbox"/>	<input type="checkbox"/>
Describe Interest			

## O&P Services & Receipts

Total receipts for the previous 12 months \$ \_\_\_\_\_

Total estimated receipts for the next 12 months \$ \_\_\_\_\_

Service Type	Description	Percentage
Patient Care Sales	Includes all sales of items you fabricate, alter or fit.	%
Distributor/Wholesale	Includes all items purchased from others that you resell to other facilities	%
Sales-Distributor/Wholesale	Items manufactured by you and sold to others for distribution. No patient contact.	%
Durable Medical Equipment	Includes items you sell or rent directly to patients with no altering or re-labeling.	%

## Professional Employee Information

Do you use certified professionals?  Yes  No

If yes, please complete the following chart by showing the total number of people for each category that you use in your business:

Professional	How Many	Describe Function
Certified Prosthetist		
Fitter		
Pedorthist		
Physical Therapist		
Other: _____		

Are employers ABC or BOC Certified?  Yes  No

## Business Operations Information

Is your facility ABC accredited?  Yes  No

Do you import directly from any foreign manufacturers?  Yes  No

If yes, please provide certificates of insurance evidencing foreign manufacturer's products liability insurance.

In U.S. dollars, what is the limit of their products liability insurance? \$ \_\_\_\_\_

Do you obtain certificates of insurance for products liability insurance from U.S. manufacturers of your products?  Yes  No

If yes, please provide copies of certificates.

If No, it is essential that you make every attempt to.

Are you a "Vendor" on the Products Liability Insurance carried by the U.S. manufacturers of your products?  Yes  No

\*Broad form Vendors Liability should be in place with all manufacturers for products that you rent or sell.

Do you provide professional services to patients without a physician's referral?  Yes  No

Are any products of others sold, repackaged or assembled under your label?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you involved in the sale, rental and/or service of any home medical equipment?  Yes  No

If yes, please complete the Homed Medical Equipment Application.

Does the insured use Independent Contractors?  Yes  No

If yes, are certificates of insurance obtained/maintained from all Independent Contractors?  Yes  No

Does the insured require Independent Contractors carry insurance limits equal to or exceeding the insured's limits?  Yes  No

Please describe the work performed by Independent Contractors.

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## Automobile Operations

Does the organization service any major metropolitan areas?  Yes  No

If yes, please describe: \_\_\_\_\_

What is the radius of your operations? \_\_\_\_\_ Miles

Does the company allow owners/employees to take company owned vehicles home or on personal business?  Yes  No

If yes, please describe: \_\_\_\_\_

Does the organization own or lease any vehicles that are not shown on the Vehicle Schedule of this survey?  Yes  No

If yes, please describe: \_\_\_\_\_

## Physical Damage Coverage

Please indicate the desired deductible for vehicles:

Comprehensive (ACV)  \$500  \$1000  \$2000  \$3000  Other \$ \_\_\_\_\_

Collision (ACV)  \$500  \$1000  \$2000  \$3000  Other \$ \_\_\_\_\_

Vehicle Schedule						
Veh No.	Year	Make, Model, Body Type	Cost New	VIN (Required)	GVW	Loc. No.
1.			\$			
2.			\$			
3.			\$			
4.			\$			
5.			\$			
6.			\$			
7.			\$			
8.			\$			
9.			\$			
10.			\$			

\*If more than 10 vehicles, please attach Auto Acord Schedule.

\*Cost New is required if Physical Damage Coverage is requested.

\*Gross Vehicle Weight is Required

## Additional Insured / Loss Payee

Do any of these vehicles require an Additional Insured or Loss Payee to be listed on the policy?  Yes  No

If yes, indicate the vehicle number and the name and address of the Additional Insured or Loss Payee:

Veh. No.	Type	Name and Address
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	

## Hired / Non-Owned Coverage

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Hired / Borrowed Liability: State(s): \_\_\_\_\_ Cost of Hire: \$ \_\_\_\_\_  If Any Basis

Non-Owned Liability: State(s): \_\_\_\_\_ Group Type:  Employees Number \_\_\_\_\_

Partners Number \_\_\_\_\_

Hired Physical Damage: State(s): \_\_\_\_\_ # of Days: \_\_\_\_\_ # of Vehs: \_\_\_\_\_

Coverage:  Comprehensive Deductible: \_\_\_\_\_

Collision Deductible: \_\_\_\_\_

Do you or any of your employees use their own vehicles for company business?  Yes  No

If yes, please indicate for what purpose:

Delivery of Products  Sales  Other, please describe: \_\_\_\_\_

## Driver Information

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Does the organization check MVR's?  Yes - all employees  Yes - drivers only  No

If yes, how often? \_\_\_\_\_

Does the company have written criteria for acceptable MVR's?  Yes  No

Do all drivers have a license commensurate with state or local law (CDL, etc.)?  Yes  No

Please describe the driver training program currently being used: \_\_\_\_\_

Does a file exist for each driver containing documentation for all of the above information?  Yes  No

What selection criteria are used to select new drivers? \_\_\_\_\_

Number of drivers currently employed: \_\_\_\_\_ Full time \_\_\_\_\_ Part time \_\_\_\_\_ Contract

Percent of driver turnover in the last twelve months: \_\_\_\_\_

## Vehicle Maintenance

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### Vehicle maintenance procedures:

Are daily vehicle inspection reports completed?  Yes  No

Are periodic maintenance checks done by a mechanic?  Yes  No

Are vehicle maintenance records kept?  Yes  No

Does the company employ its own mechanics?  Yes  No

Does the company store or service the vehicles of others?  Yes  No



## Umbrella and Excess Liability

Current Umbrella/Excess Liability Carrier: \_\_\_\_\_ Current Premium: \$ \_\_\_\_\_

Desired Limit of Insurance (maximum \$5 million): \$ \_\_\_\_\_

Note: these limits will apply to Excess Liability [Commercial General Liability, Employee Benefits Liability, Auto Liability, Employer's Liability, as applicable] and Umbrella Liability. The minimum required underlying limits are: Commercial General Liability – \$1 million per occurrence/\$2 million annual aggregate; Employee Benefits Liability – \$1 million each incident/\$2 million annual aggregate; Auto Liability – \$1 million per occurrence; Employer's Liability – \$500,000 bodily injury by accident/\$500,000 bodily injury by disease-each employee/\$500,000 bodily injury by disease-policy limit.

Please indicate the following underlying coverage information for Auto Liability and / or Employers Liability. If this information is not provided, Excess Auto Liability and / or Employers Liability coverage will not be included under any policy that is dependent upon the information contained in this survey.

To provide coverage excess over another auto carrier, **you must provide us with** a copy of your declarations page from your current policy and 4 years hard copy loss runs. Auto Liability Insurer\*: \_\_\_\_\_

Employers Liability Insurer\*: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Period: \_\_\_\_\_

Employers Liability (Coverage B) Limits: \$ \_\_\_\_\_ Bodily Injury by Accident  
 \$ \_\_\_\_\_ Bodily Injury by Disease-Each Employee  
 \$ \_\_\_\_\_ Bodily Injury by Disease-Policy Limit

*\*Excess Auto Liability and Employers Liability are subject to approval of the insurer providing the underlying coverage.*

## Prior Loss Information

Have there been any claims or losses in the last five years:  Yes  No

If yes, please indicate all known claims and losses for the past five years, and any pending incidents that could result in a claim being made against the organization. Include the date of loss, a short description of the claim, the status of the claim (open/closed), and the dollar amounts paid or reserved.\*

Date of Occurrence	Date of Claim	Type of Claim & Description of Occurrence	Amount Paid	Amount Reserved	Claim Status
					<input type="checkbox"/> Open <input type="checkbox"/> Closed
					<input type="checkbox"/> Open <input type="checkbox"/> Closed
					<input type="checkbox"/> Open <input type="checkbox"/> Closed
					<input type="checkbox"/> Open <input type="checkbox"/> Closed

\*Attach separate pages if needed. Provide the carrier loss runs if available.

## Application Signatures & State Fraud Statement

### APPLICABLE IN ALASKA - ALASKA FRAUD STATEMENT

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

### APPLICABLE IN ARIZONA - ARIZONA FRAUD STATEMENT

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.

### APPLICABLE IN ARKANSAS - ARKANSAS FRAUD STATEMENT

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.

### APPLICABLE IN CALIFORNIA - CALIFORNIA FRAUD STATEMENT

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. In addition, any person who knowingly makes an application for motor vehicle insurance coverage containing any statement that the applicant resides or is domiciled in this state when, in fact, that applicant resides or is domiciled in a state other than this state, is subject to criminal or civil penalties.

## **Application Signatures & State Fraud Statement (continued)**

### **APPLICABLE IN COLORADO - COLORADO FRAUD STATEMENT**

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.

### **APPLICABLE IN KANSAS - KANSAS FRAUD STATEMENT**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

### **APPLICABLE IN KENTUCKY - KENTUCKY FRAUD STATEMENT**

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.

### **APPLICABLE IN LOUISIANA - LOUISIANA FRAUD STATEMENT**

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.

### **APPLICABLE IN MAINE - MAINE FRAUD STATEMENT**

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.

### **APPLICABLE IN MARYLAND - MARYLAND FRAUD STATEMENT**

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

### **APPLICABLE IN MASSACHUSETTS - MASSACHUSETTS FRAUD STATEMENT**

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

### **APPLICABLE IN MICHIGAN - MICHIGAN FRAUD STATEMENT**

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to one year and payment of a fine of up to \$5,000.

### **APPLICABLE IN MINNESOTA - MINNESOTA FRAUD STATEMENT**

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

### **APPLICABLE IN NEBRASKA - NEBRASKA FRAUD 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 may subject the person to criminal and civil penalties.

### **APPLICABLE IN NEW JERSEY - NEW JERSEY FRAUD STATEMENT**

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

### **APPLICABLE IN NEW MEXICO - NEW MEXICO FRAUD STATEMENT**

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.

### **APPLICABLE IN NEW YORK - NEW YORK FRAUD STATEMENT**

**Other than Auto:** 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 violation.

**Auto:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits, or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.

### **APPLICABLE IN OHIO - OHIO FRAUD STATEMENT**

Any person who, with the 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.

## Application Signatures & State Fraud Statement (continued)

### APPLICABLE IN OKLAHOMA - OKLAHOMA FRAUD STATEMENT

**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.

### APPLICABLE IN OREGON - OREGON FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

In order for us to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on your part, we must show that:

- A. The misinformation is material to the content of the policy;
- B. We relied upon the misinformation; and
- C. The information was either:
  1. Material to the risk assumed by us; or
  2. Provided fraudulently.

For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on your part must either be fraudulent or material to our interests.

With regard to fire insurance, in order to trigger the right to remedy, material misrepresentations must be willful or intentional.

Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.

### APPLICABLE IN PENNSYLVANIA - PENNSYLVANIA FRAUD STATEMENT

**Other than Auto:** 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.

**Auto:** Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

### APPLICABLE IN TENNESSEE - TENNESSEE FRAUD STATEMENT

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.

### APPLICABLE IN VERMONT - VERMONT FRAUD STATEMENT

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, may be committing a crime, subjecting the person to criminal and civil penalties.

### APPLICABLE IN VIRGINIA - VIRGINIA FRAUD STATEMENT

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.

### APPLICABLE IN WASHINGTON - WASHINGTON FRAUD STATEMENT

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.

### GENERAL FRAUD STATEMENT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND CIVIL PENALTIES. (Not applicable in CO, FL, KS, MA, MN, NE, OH, OK, OR, VT, or WA.)

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS APPLICATION AND THAT THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

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

Name and title (please print): \_\_\_\_\_

Insurance Agent's Signature \_\_\_\_\_ Date: \_\_\_\_\_