McNeil & Company
INSURANCE AND RISK SERVICES

HOMed O & P Plus

P.O. Box 5670
Cortland, NY 13045
Phone: (800) 822-3747
Fax: (607) 756-5051

HOME MEDICAL EQUIPMENT DEALER
O&P INSURANCE SURVEY

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: _____

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

Construction Type	Occupancy Type		Year Built	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-wood frame ☐ Type 2-masonry wood-joisted ☐ Type 3-metal non-combustible ☐ Type 4-masonry non-combustible ☐ Type 5-modified fire resistive ☐ Type 6-heavy fire resistive	☐ Retail ☐ Office ☐ Warehouse ☐ Other (describe) __________	☐ Own ☐ Lease	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No

Loc. No.	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Number of Stories

Construction Type	Occupancy Type		Year Built	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-wood frame ☐ Type 2-masonry wood-joisted ☐ Type 3-metal non-combustible ☐ Type 4-masonry non-combustible ☐ Type 5-modified fire resistive ☐ Type 6-heavy fire resistive	☐ Retail ☐ Office ☐ Warehouse ☐ Other (describe) __________	☐ Own ☐ Lease	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No

Loc. No.	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Number of Stories

Construction Type	Occupancy Type		Year Built	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-wood frame ☐ Type 2-masonry wood-joisted ☐ Type 3-metal non-combustible ☐ Type 4-masonry non-combustible ☐ Type 5-modified fire resistive ☐ Type 6-heavy fire resistive	☐ Retail ☐ Office ☐ Warehouse ☐ Other (describe) __________	☐ Own ☐ Lease	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No

☐ 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
	☐ MTG ☐ LP	
	☐ MTG ☐ LP	
	☐ MTG ☐ LP	
	☐ MTG ☐ LP	
	☐ MTG ☐ 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
		☐	☐
Describe Interest			
		☐	☐
Describe Interest			
		☐	☐
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.

_____

_____

Employee Benefits Liability ☐ N/A

Note: This coverage is optional. Complete this section only if coverage is applicable.

Current EBL Carrier: _____ Current Premium: $ _____

Current EBL Limits of Liability: ☐ Occurrence ☐ Claims-made Retro Date: _____

$ _____ Each Incident / $ _____ Aggregate

Desired EBL Limits of Liability: ☐ Occurrence ☐ Claims-made Retro Date: _____

☐ $500,000 /$500,000 ☐ $500,000/$1 million

☐ $1 million/$2 million ☐ $ _____

Does the company have an Employee Benefits handbook? ☐ Yes ☐ No

Has any claim been made or suit filed against the company and/or its employees in the past five years alleging an error or omission in the administration* of your benefit programs? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does the company have knowledge of any matter(s) involving employee benefits, benefits administration, the handling of benefit claims, or any other benefits-related matter which would cause a reasonable person to believe that a claim or suit might result? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

* Determining who is eligible to participate; enrolling new participants; terminating participants; determining benefits; processing claims; collecting funds and applying them as required; preparing reports required by government agencies; giving advice to participants or prospective participants; providing reports, booklets, pamphlets, memos or messages to participants.

Crime ☐ N/A

Current Carrier: _____ Current Premium: $_____

FIDELITY

Type of Bond:

☐ Commercial Blanket Limit of Insurance $ _____

Number of Class I Employees/Volunteers (direct contact with funds) _____

Number of Class II Employees/Volunteers (all others) _____

☐ Position Schedule

Position	Limit of Insurance
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

☐ Forgery or Alterations $ _____

MONEY AND SECURITIES

Note: $2,500 money and securities coverage is provided under the Property Coverage Extensions.

If this limit is insufficient, please indicate the desired amount of additional insurance: $ _____

Crime (Continued)

GENERAL CRIME INFORMATION

List all persons managing funds: Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Do the persons managing funds turn over this function to another for a period of 2 weeks, every year to prevent theft? ☐ Yes ☐ No

Are Invoices or Requisitions kept? (This documents what item or service is being paid for, who the vendor is, and who authorized the item or service). ☐ Yes ☐ No

Are Invoices or Requisitions, Check Register and Bank Statement cross-checked against each other? ☐ Yes ☐ No

Largest amount of petty cash kept on hand? $ _____

Is money ever stored in the building overnight? ☐ Yes ☐ No

If yes, amount and how stored: _____

All receipts are deposited in a bank within: ☐ 2 days ☐ 1 week ☐ Over 1 week

Are all incoming checks immediately stamped "For Deposit Only"? ☐ Yes ☐ No

Do all outgoing checks require 2 signatures? ☐ Yes ☐ No

If No, do checks over a certain amount require 2 signatures? ☐ Yes ☐ No

If Yes, please indicate amount $_____

By whom and how often are the accounts examined? _____

When were the accounts last examined? _____

What is your annual revenue? $ _____

Automobile Liability ☐ N/A

Current Automobile Liability Carrier: _____ Current Premium: $ _____

Current Limit of Liability : $ _____

Indicate Desired Limits Below:

$ _____ Auto Liability ☐ Hired & Non-Owned Auto Liability Only (Please complete section below)

$ _____ Medical Payments

$ _____ PIP / No-Fault (Medical Expense Benefits – Applies Only in PA)

$ _____ Additional PIP (Increased Medical Expense Benefits – Applies Only in PA)

$ _____ Uninsured Motorists/ Underinsured Motorists B.I.

☐ Stacking ☐ Non-Stacking (if applicable)

$ _____ Uninsured Motorists/ Underinsured Motorists P.D.

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
	☐ A.I. ☐ LP	
	☐ A.I. ☐ LP	
	☐ A.I. ☐ LP	
	☐ A.I. ☐ LP	
	☐ A.I. ☐ LP	

Hired / Non-Owned Coverage

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

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

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
					☐ Open ☐ Closed
					☐ Open ☐ Closed
					☐ Open ☐ Closed
					☐ Open ☐ 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.

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.

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: _____