AnimalKeepers INSURANCE PROGRAM	INSURANCE APPLICATION MULTI-STATE	P.O. Box 5670 Cortland, NY 13045 Phone: (800) 822-3747 Fax: (607) 756-5051 Email: applications@ mcneilandcompany.com

GENERAL INFORMATION

Date of survey: _____ Renewal Date: _____ Date proposal needed: _____

Legal Name of Organization: _____

_____ FEIN: _____

Mailing Address: _____ County: _____

Phone #: _____ Fax #: _____

Website Address: _____

Executive Director: _____ Phone #: _____ E-Mail: _____

Best time to contact: _____

Shelter Manager: _____ Phone #: _____ E-Mail: _____

Best time to contact: _____

INSURANCE AGENT INFORMATION

Agents Name: _____ CSR or Other Contact _____

Name of Agency: _____

Address: _____

Agency Phone: _____ Fax: _____ E-mail address: _____

Do you currently write this account? ☐ Yes ☐ No

If yes, for how long? _____ Carrier Name: _____

Is the account Sub-Brokered? ☐ Yes ☐ No

If yes, please indicate Agency Name and Address: _____

_____

ORGANIZATION INFORMATION

Is your organization a 501(c)(3)? ☐ Yes ☐ No

Year organization was established: _____

Does your organization provide shelter for large, wild or exotic animals? ☐ Yes ☐ No

Is there a staff member on premise at all times? ☐ Yes ☐ No

Does your organization employ animal control officers? ☐ Yes ☐ No

If yes, a. Do the officers have citation or arrest authority? ☐ Yes ☐ No

b. Do the officers carry firearms? ☐ Yes ☐ No

c. Do the officers carry separate liability coverage? ☐ Yes ☐ No

Total Revenue (for the current year): _____

ORGANIZATION INFORMATION (CONTINUED)

EMPLOYEES & VOLUNTEERS:

Do you have a formal training procedure for employees & volunteers? ☐ Yes ☐ No

To whom do the volunteers report? _____

Do you provide personal protective equipment (latex gloves, bite gloves, restraining poles? ☐ Yes ☐ No

Do you provide training and information on zoonotic disease to employees and volunteers? ☐ Yes ☐ No

What capacity are volunteers involved?

☐ Dog walking ☐ Animal care attendant

☐ Kennel attendant (cleaning cages and runs) ☐ Other (please specify) _____

ANIMAL HEALTH ASSESSMENT:

Are the health and conditions of animals evaluated prior to placement in general population? ☐ Yes ☐ No

Are all animals vaccinated? ☐ Yes ☐ No

Do you spay or neuter? ☐ Yes ☐ No

Do you perform euthanasia? ☐ Yes ☐ No

Are all drugs and narcotics kept under lock and key with restricted access? ☐ Yes ☐ No

Is there a crematory on premise? ☐ Yes ☐ No

ANIMAL BEHAVIOR ASSESSMENT:

Is there a Certified Animal Behaviorist on staff? ☐ Yes ☐ No

Are the following temperament tests performed on each animal?

a. Food Aggression ☐ Yes ☐ No

b. Aggression toward other animals ☐ Yes ☐ No

c. Aggression toward persons/children ☐ Yes ☐ No

Are all animals leashed or in carriers when out of kennels? ☐ Yes ☐ No

Are kennels clearly labeled for animals deemed aggressive? ☐ Yes ☐ No

Do you place animals with aggressive behaviors into foster or adoptive homes? ☐ Yes ☐ No

ADOPTIVE FOSTER HOMES:

Do you have written procedures and guidelines in place for determining suitable foster/adoptive homes? ☐ Yes ☐ No

Are visitors supervised at all times while handling adoptable animals? ☐ Yes ☐ No

Does the adoption agreement contain a hold harmless waiver? ☐ Yes ☐ No

Are all foster homes required to sign a contract? ☐ Yes ☐ No

Does the contract contain a hold harmless waiver? ☐ Yes ☐ No

Do you participate in off-site adoption events? ☐ Yes ☐ No

If yes, how may per year: _____

SPECIAL EVENTS/FUNDRAISERS:

Event	# of Expected Attendees	Location	Gross Revenue	Is Alcohol Served or Sold?	Is a Waiver required of participants?
			$		
			$		
			$		

ORGANIZATION INFORMATION (CONTINUED)

Please indicate the following for this year:

# of Kennels/Cages/Compartments		
# of Employees (not including vet)		
# of Volunteers (not including vet)		
# of Employed Veterinarians		Annual Payroll: $
# of Volunteer Veterinarians		
# of Contracted Veterinarians		Do you obtain proof of insurance: ☐ Yes ☐ No
# of Board Members		Are Board Members elected: ☐ Yes ☐ No
Average # of volunteers per day	☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50+	
Average # of visitors per day		
# of animal intakes annually		
# of adoptions annually		
Pet Grooming Receipts	$	
Pet Training Receipts	$	
Boarding Receipts	$	
Gift Shop Receipts	$	
Clinical Work Receipts	$	

GENERAL LIABILITY LIMITS

Each Occurrence/General Aggregate Limit: ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000 ☐ Other: _____

☐ Occurrence ☐ Claims-made Retroactive Date: _____

Optional coverages: ☐ Waiver of Subrogation ☐ Stop Gap Liability (only applicable in monopolistic states)

VETERINARIAN PROFESSIONAL LIABILITY

☐ NO COVERAGE REQUESTED

Each Occurrence/General Aggregate Limit: ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000 ☐ Other: _____

☐ Occurrence ☐ Claims-made Retroactive Date: _____

VOLUNTEER ACCIDENT INSURANCE

☐ NO COVERAGE REQUESTED

Do you currently have Volunteer Accident Insurance? ☐ Yes ☐ No

If yes, what is the effective date? _____

EMPLOYEE BENEFITS LIABILITY

☐ NO COVERAGE REQUESTED

Each Occurrence/General Aggregate Limit: ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000 ☐ Other: _____

☐ Occurrence ☐ Claims-made Retroactive Date: _____

Does the organization 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 5 years alleging an error or omission in the administration* of your benefit programs? ☐ Yes ☐ No

If yes, please describe: _____

_____

EMPLOYEE BENEFITS LIABILITY (CONTINUED)

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 per to believe that a claim or suite 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.**

PROPERTY COVERAGE

Building & Contents Deductible: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ Other _____

Coinsurance Percentage: ☐ 80% ☐ 90% ☐ 100%

Blanket Coverage: ☐ Building Only ☐ Contents Only ☐ Building/Contents Combined ☐ None

PROPERTY SCHEDULE

Location Number	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Number of Stories

Construction Type	Occupancy Type (check all)		Year Built / Year Updated	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	☐ Office ☐ Animal Housing ☐ Medical Facility ☐ Crematory ☐ Storage ☐ Other (describe) _____	☐ Own ☐ Lease	Year Built _____ Year Updated _____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Location Number	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Number of Stories

Construction Type	Occupancy Type (check all)		Year Built / Year Updated	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	☐ Office ☐ Animal Housing ☐ Medical Facility ☐ Crematory ☐ Storage ☐ Other (describe) _____	☐ Own ☐ Lease	Year Built _____ Year Updated _____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Location Number	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Number of Stories

Construction Type	Occupancy Type (check all)		Year Built / Year Updated	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	☐ Office ☐ Animal Housing ☐ Medical Facility ☐ Crematory ☐ Storage ☐ Other (describe) _____	☐ Own ☐ Lease	Year Built _____ Year Updated _____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Type 1-Frame - Buildings where the exterior walls are wood or other combustible materials including construction where combustible materials are combined with other materials such as brick veneer, stone veneer, wood iron-clad, stucco on wood.
Type 2-Joisted Masonry - Buildings where the exterior walls are constructed of masonry materials such as adobe, brick, concrete, gypsum block, hollow concrete block, stone, tile or similar materials and where the floors and roof are combustible.
Type 3-Non-Combustible - Buildings where the exterior walls and the floors and roof are constructed of, and supported by metal, asbestos, gypsum or other non-combustible materials.
Type 4-Masonry Non-Combustible - Buildings where the exterior walls are constructed of masonry materials as described in Code 2, with the floors and roof of metal or other non-combustible materials.
Type 5-Modified Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive material with a fire resistance rating of one hour or more but less than two hours.
Type 6-Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive materials having a fire resistance rating of not less than two hours.

For additional locations please include Acord Application.

INLAND MARINE

☐ NO COVERAGE REQUESTED

Scheduled Equipment

No.	Description (Year, Make, Model, Serial No.)	Limit of Insurance	Deductible
1		$	☐$500 ☐$1,000
2		$	☐$500 ☐$1,000
3		$	☐$500 ☐$1,000
4		$	☐$500 ☐$1,000
5		$	☐$500 ☐$1,000

BUSINESS AUTO

☐ NO COVERAGE REQUESTED

Indicate the desired coverage below:

$ _____ Auto Liability

$ _____ Medical Payments

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

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

$ _____ OBEL (Applies Only in NY)

$ _____ Uninsured Motorists/ Underinsured Motorists B.I. ☐ Stacking ☐ Non-Stacking (if applicable)

$ _____ Uninsured Motorists/ Underinsured Motorists P.D.

Indicate the desired deductible for scheduled vehicles with Physical Damage Coverage:

Comprehensive ☐ $500 ☐ $1000 ☐ $2500 ☐ $5000 ☐ Other $_____

Collision ☐ $500 ☐ $1000 ☐ $2500 ☐ $5000 ☐ Other $_____

Do the employees or volunteers use their personal vehicles on behalf of the organization? ☐ Yes ☐ No

If Yes, a. Number of employees/volunteer that utilize their personal vehicle: _____

b. Do the employees/volunteers transport animals in their personal vehicle? ☐ Yes ☐ No

c. Do you require proof of insurance from the employee/volunteer? ☐ Yes ☐ No

d. Do you have minimum requirements for personal auto policy limits? ☐ Yes ☐ No

If yes, what are the minimum limits required: _____

Are animals properly secured during transport? ☐ Yes ☐ No

Are their written standard operating procedures for use of company owned vehicles? ☐ Yes ☐ No

Is there a formal vehicle maintenance program in place? ☐ Yes ☐ No

Do all drivers have a license commensurate with applicable legal requirements (CDL, etc.)? ☐ Yes ☐ No

Is driver training provided for employees? ☐ Yes ☐ No

If Yes, please describe: _____

_____

BUSINESS AUTO (CONTINUED)

VEHICLE SCHEDULE

Veh No.	Year	Make	Model	VIN	Original Cost New	Loc. No.
1					$	
2					$	
3					$	
4					$	
5					$	
6					$	
7					$	
8					$	
9					$	
10					$	

For additional autos please include Acord Application.

CRIME

☐ NO COVERAGE REQUESTED

FIDELITY

☐ Commercial Blanket Limit of Insurance $ _____

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

List name & title of all Class 1 Employees/Volunteers

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

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

☐ Position Schedule

Position	Limit of Insurance	Excess over Blanket
_____	$ _____	☐ Yes ☐ No
_____	$ _____	☐ Yes ☐ No
_____	$ _____	☐ Yes ☐ No

☐ Computer Fraud and Funds Transfer $ _____

☐ Faithful Performance

☐ Forgery or Alterations Limit of Insurance: $ _____

How are the organizations computers secured? _____

How are online login credentials secured? _____

Does anyone have access to an organization credit card (including debit cards)? ☐ Yes ☐ No

If yes, are they authorized to make online purchases? ☐ Yes ☐ No

Does anyone have access to the organizations accounts from home? ☐ Yes ☐ No

If yes, do they use an organization-issued computer, or a personal computer? ☐ Organization ☐ Personal

If they use an organization computer, are other household members barred from using it? ☐ Yes ☐ No

CRIME (CONTINUED)

MONEY AND SECURITIES

Event	Date of Event	Limit Needed
_____	_____	$ _____
_____	_____	$ _____

GENERAL CRIME INFORMATION

Are internal account reviews conducted? ☐ Yes ☐ No

If yes, by whom and how often are accounts examined? _____

When were the accounts last examined? _____

Are Invoices or Requisitions, Check Registers and Bank Statements cross-checked against each other at reconciliation? ☐ Yes ☐ No

Do all checks require 2 signatures? ☐ Yes ☐ No

If No, do checks over a certain amount require 2 signatures? ☐ Yes in excess of: $ _____ ☐ No

Are procedures in place requiring segregation of duties so that no single transaction can be fully controlled from organization to completion by one person? ☐ Yes ☐ No

Do you prohibit employees who reconcile monthly bank statements from:

a. Signing Checks? ☐ Yes ☐ No

b. Making Withdrawals? ☐ Yes ☐ No

c. Handling deposits? ☐ Yes ☐ No

Do you maintain a list of authorized vendors? ☐ Yes ☐ No

Do you verify invoices against a corresponding purchase order, receiving report and/or vendor list prior to issuing payment? ☐ Yes ☐ No

Do you perform reference checks, including criminal history checks, on persons who frequently handle money? ☐ Yes ☐ No

EXCESS LIABILITY

☐ NO COVERAGE REQUESTED

Limit of Insurance: ☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000

Please note that the minimum underlying limits are $1 million per occurrence/$2 million annual aggregate for Commercial General Liability, $1 million CSL for Auto Liability, and $1,000,000 bodily injury by accident/$1,000,000 bodily injury by disease/$1,000,000 bodily injury by disease policy limit for Employers Liability if provided.

Please indicate the following underlying coverage information for Employers Liability. **If this information is not provided, Excess Employers Liability coverage will not be included.**

Insurer*: _____ Policy Number: _____

Effective Dates: _____ Policy Period: _____

Employers Liability (Coverage B) Limits: $_____ Bodily Injury by Accident

$_____ Bodily Injury by Disease

$_____ BI by Disease Policy Limit

**Excess Employers Liability is subject to approval of the insurer providing the underlying coverage.*

ADDITIONAL INTERESTS

List any entities that need to be listed as Additional Insured, Loss Payee or Mortgagee along with their interest.

Loc. No.	Name & Address	Loss Payee	Mortgage-holder	Additional Insured
		☐	☐	☐
Describe Interest				
		☐	☐	☐
Describe Interest				
		☐	☐	☐
Describe Interest				

CURRENT INSURANCE

Line of Business	**Name of Insurer**	**Annual Premium**
General Liability		$
Professional Liability		$
D&O / EPLI		$
Cyber Liability		$
Property		$
Business Auto		$
Crime		$
Inland Marine		$
Excess/Umbrella		$
		$

PRIOR LOSS INFORMATION

Have there been any claims or losses in the last 5 years? ☐ Yes ☐ No

If yes, please indicate all known claims and losses for the past 5 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. Attached separate pages if needed.

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

SUBMISSION REQUIREMENTS

☐ Copies of current Declaration Pages

☐ Complete list of drivers including full name, date of birth, license number, state where individual is licensed & date of hire

MANAGEMENT LIABILITY

☐ NO COVERAGE REQUESTED

NOTICE: THE EMPLOYMENT PRACTICES LIABILITY AND DIRECTORS & OFFICERS LIABILITY COVERAGE PARTS OF THE POLICY APPLIED FOR PROVIDE CLAIMS MADE COVERAGE. EXCEPT AS OTHERWISE PROVIDED, SUCH COVERAGE APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD AND REPORTED TO THE INSURER NO LATER THAN 60 DAYS AFTER THE END OF THE POLICY PERIOD. EACH APPLICABLE LIMIT OF LIABILITY SHALL BE REDUCED, AND MAY BE EXHAUSTED, BY DEFENSE COSTS PAYMENTS. IF ANY LIMIT OF LIABILITY IS EXHAUSTED, THE INSURER SHALL HAVE NO FURTHER LIABILITY FOR THE COVERAGE TO WHICH SUCH LIMIT APPLIES, INCLUDING LIABILITY FOR DEFENSE COSTS. ALL LOSS PAYMENTS, INCLUDING DEFENSE COSTS PAYMENTS, SHALL APPLY TO THE DEDUCTIBLE. NOTICE: A POLICY CANNOT BE ISSUED UNLESS THE APPLICATION IS PROPERLY SIGNED AND DATED. NOTICE: THIS APPLICATION, INCLUDING ANY INFORMATION AND MATERIALS SUBMITTED WITH THIS APPLICATION, SHALL BE HELD IN CONFIDENCE.

DIRECTORS & OFFICERS LIABILITY

Claims Made Limit: ☐ $1,000,000 ☐ $2,000,000 ☐ Other: _____

☐ Pending & Prior Litigation Exclusion: _____

EMPLOYMENT PRACTICES LIABILITY

Claims Made Limit: ☐ $1,000,000 ☐ $2,000,000 ☐ Other: _____

☐ Pending & Prior Litigation Exclusion: _____

☐ Shared Limit ☐ Separate Limits

GENERAL ORGANIZATION INFORMATION

A. Does the Applicant:

1. Currently have or previously had any disputes as to Applicant's tax exempt status? ☐ Yes ☐ No

   If "Yes" to the above, attach a detailed explanation.

B. Has the Applicant experienced within the past year, or does it expect to experience in the next year, any:

1. Bankruptcy proceedings or reorganizations or arrangements with creditors under federal or state law? ☐ Yes ☐ No
2. Location, facility, or office closings, consolidations or layoffs? ☐ Yes ☐ No
3. Changes in its operations or services? ☐ Yes ☐ No
4. Involuntary terminations of officers or senior employees? ☐ Yes ☐ No
5. Breach/violation of loan agreement or other material contractual obligation? ☐ Yes ☐ No

   If "Yes" to 1 through 5, attach a detailed explanation. For question 4, include details on reason(s) for change(s) or termination(s), and details on whether severance was paid or waivers signed.

C. Please complete the following information (for the current year):

Total Assets: _____ Total Liabilities: _____

If revenue > $1MM, provide most recent IRS Form 990 (or audited financial statements).

MANAGEMENT LIABILITY (CONTINUED)

EMPLOYMENT PRACTICES INFORMATION

A. Employee Count	Current Year	Previous Year
1. Full time employees:	_____	_____
2. Part time employees:	_____	_____
3. Employees located in CA:	_____	_____
4. Involuntary terminations (past 12 months):	_____	_____

B. Does the Applicant distribute and record the receipt of the below written procedures to all employees:

1. Equal Opportunity Employment? ☐ Yes ☐ No
2. Prohibition of Discrimination and Sexual Harassment? ☐ Yes ☐ No

LOSS/CLAIMS INFORMATION (DO NOT COMPLETE FOR RENEWALS)

A. Regarding the coverage(s) applied for, has the Applicant given notice of any claim, circumstance, potential claim, or loss to any insurer during the past 5 years? ☐ Yes ☐ No

If "Yes" attach detailed explanation of all such claims, circumstances, potential claims and losses.

B. Has the Applicant or any person or entity proposed for coverage been the subject of, or been involved in, any civil, criminal or administrative actions or proceedings during the past 5 years, including (but not limited to):

1. Anti-trust, membership denial, copyright or patent litigation? ☐ Yes ☐ No
2. Discrimination or harassment? ☐ Yes ☐ No
3. Any other civil, criminal or administrative actions or proceedings? ☐ Yes ☐ No

If "Yes" for 1 through 3 above, attach a detailed explanation.

C. Regarding the coverage(s) applied for, has any insurer cancelled or refused to renew any such coverage(s) within the past 3 years? ☐ Yes ☐ No

(MISSOURI RESIDENTS SHOULD NOT ANSWER THIS QUESTION)

D. Regarding the coverage(s) applied for, have there been any claims against any person or entity proposed for coverage that may fall within the scope of such coverages during the past 5 years? ***If "Yes" attach a detailed explanation.*** ☐ Yes ☐ No

PRIOR KNOWLEDGE – MANAGEMENT LIABILITY COVERAGE PARTS (DO NOT COMPLETE FOR RENEWALS)

Does any person or entity proposed for coverage have any knowledge of or information concerning any actual or alleged act, error, omission, fact or circumstance which may result in a claim that may fall within the scope of coverage applied for? If "Yes" attach a detailed explanation. ☐ Yes ☐ No

IT IS AGREED THAT ANY CLAIM ARISING FROM, BASED UPON, OR ATTRIBUTABLE TO ANY ACTUAL OR ALLEGED ACT, ERROR, OMISSION, FACT OR CIRCUMSTANCE OF WHICH ANY SUCH PERSON OR ORGANIZATION HAS ANY KNOWLEDGE OR INFORMATION WILL BE EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

The Applicant declares that the information in this Application and in the materials submitted herewith is true, accurate and complete. Signing this Application does not bind the Applicant to purchase insurance, but it is agreed that this Application shall be the basis of any insurance policy issued.

The information requested in this Application does not constitute notice under any policy of a claim or potential claim. All such notices must be submitted pursuant to the terms of the policy under which coverage is sought.

If there is any material change in the answers to the questions in this Application before the policy inception date, the Applicant must immediately notify the Insurer in writing. In such case, any outstanding quotation may be modified or withdrawn.

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution or confinement in prison, or any combination thereof.

NOTICE TO ARKANSAS, LOUISIANA, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an Insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

NOTICE TO KANSAS APPLICANTS: 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, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication 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.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

NOTICE TO OREGON APPLICANTS: Any person who, knowingly and with intent to defraud or facilitate a fraud against any insurance company or other person, submits an application, or files a claim for insurance containing any false, deceptive, or misleading material information may be guilty of insurance fraud.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with the 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.

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

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 Broker's Signature: _____ **Date:** _____

(To be signed by someone who does not have access to funds)