



**WILDLAND FIRE FIGHTING CONTRACTORS
INSURANCE APPLICATION**

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: _____
(Include all organizations that are to be included as insureds)

FEIN: _____
Mailing Address: _____ County: _____
Physical Address: _____ County: _____
Telephone: _____ Fax: _____
Contact Name: _____ Contact Title: _____
Website Address: _____ E-Mail Address: _____

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: _____

Coverage Information

Please indicate the Coverage(s) you are applying for:

☐ Property ☐ General Liability ☐ Auto ☐ Crime ☐ Inland Marine.

Business Information

The business is a (please check one):

☐ Corporation ☐ Limited Liability Company ☐ Partnership ☐ Sole Proprietorship ☐ Joint Venture
☐ Other: _____

Business Information (continued)

Type of business (please check all that apply):

- ☐ **Fire Suppression Contractors** – these are contractors who provide various size fire engines and a crew of personnel with the engine. Also included would be contractors that provide water tenders (tankers), bulldozers and related heavy equipment, or provided fire suppression standby.
- ☐ **Crew Contractor** – these are contractors who provide personnel using crews of approximately 20 persons. Crews are used for constructing fire line using hand tools. Crews are also used for mop-up operations after the fire is contained within a fire line. The contractor provides transportation, generally using 12-15 passenger vans.
- ☐ **Support Contractor** – these contractors provide support services to the fire management team and are generally located at the centralized “fire camp”. Support functions include shower facilities; laundry facilities, cooking/food services. These facilities are usually provided using large tractor-trailers type units and/or tents. The contractor provides transportation and staffing.
- ☐ **Fuel Management** – these provide non-fire emergency fuel reduction on natural cover lands to include cutting and stacking of brush/timber, controlled burning.
- ☐ **Other:** _____

Years in operation: _____ (*Minimum Requirement: 3 Years in Operation*)

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

Provide a brief, specific description of your planned scope of work under this entity: _____

Governmental Entity you plan to work for: _____

Do you own any other entities performing work that would share equipment/vehicles?

☐ Yes ☐ No

Years' experience in industry (please provide details of experience): _____

In the past 10 years, did the insured operate under a different name?

☐ Yes ☐ No

If yes, please explain: _____

In which states does the insured perform services? _____

Please describe all duties of Executives/Officers (*do they have occasion to work out in the field?*): _____

Number of Employees: _____ Number of Executives/Officers/Owners: _____ Number of Active Owners: _____

Does the insured have a formal written safety program in effect?

☐ Yes ☐ No

If yes, please include a copy with this application.

Please describe the level of experience or formal training programs in place for employees: _____

Do you provide training to any outside organization?

☐ Yes ☐ No

If yes, please describe: _____

Does this insured perform controlled burns?

☐ Yes ☐ No

If yes, do you have a RXB2 Certification?

☐ Yes ☐ No

If yes, please provide a copy of your certification

Real and Personal Property

☐ N/A

Please complete the schedule below. All Property will be covered on a Replacement Cost basis. If the coverage is blanket, be sure to show the individual building and contents values at each location. If more than 5 locations please complete Property Acord form.

Loc. No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Heat Detection			Coinsurance: <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%
Own/Lease: <input type="checkbox"/> Own <input type="checkbox"/> Lease	Building Info: Number of Stories: _____ Building Sq. Ft.: _____ Sq. Ft. You Occupy: _____ Year Built: _____	Year: _____ Updated/Inspected Roof: _____ / _____ Plumbing: _____ / _____ Wiring: _____ / _____ HVAC: _____ / _____	Additional Occupancies _____ _____ _____ _____		

Loc. No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Heat Detection			Coinsurance: <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%
Own/Lease: <input type="checkbox"/> Own <input type="checkbox"/> Lease	Building Info: Number of Stories: _____ Building Sq. Ft.: _____ Sq. Ft. You Occupy: _____ Year Built: _____	Year: _____ Updated/Inspected Roof: _____ / _____ Plumbing: _____ / _____ Wiring: _____ / _____ HVAC: _____ / _____	Additional Occupancies _____ _____ _____ _____		

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 complete and attach a separate Property Supplement.

Real and Personal Property (Continued)

☐ Please indicate if Blanket Coverage is desired

Indicate the desired Property Deductible: ☐ \$1000 ☐ \$2500 ☐ \$5000 ☐ Other _____

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

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

General Liability

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

Damage to Rented Premises: ☐ \$100,000 ☐ \$300,000 ☐ \$500,000 ☐ \$1 million

Payroll and Receipts:

Please indicate the payroll and receipts projected for this year, and for each of the past two years:

Exclude executive officer's payroll and clerical payroll. Include leased employee payroll.

	PAYROLL			RECEIPTS		
	This Year - Projected	Last Year - Actual / Audit Results	Previous Year - Actual / Audit Results	This Year - Projected	Last Year - Actual / Audit Results	Previous Year - Actual / Audit Results
Fire Suppression	\$	\$	\$	\$	\$	\$
Crew Contractors	\$	\$	\$	\$	\$	\$
Support Services	\$	\$	\$	\$	\$	\$
Fuel Management	\$	\$	\$	\$	\$	\$

Percent of Government Operations: _____%

Percent of Privatized work: _____%

Does the insured perform any other services not reflected in the payroll/receipts shown above? ☐ Yes ☐ No

If yes, please describe and provide projected payroll / receipts: _____

Does the insured hire subcontractors? ☐ Yes ☐ No

If yes, are certificates of insurance obtained/maintained from all subcontractors? ☐ Yes ☐ No

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

Please describe how the insured makes sure that its subcontractors maintain their insurance: _____

Please describe the work **performed by subcontractors** and indicate the annual receipts for this work:

Description: _____

Annual Receipts: \$ _____

General Liability (Continued)

Does the insured utilize leased employees? ☐ Yes ☐ No

If yes, how many? _____ Payroll \$ _____

Have any of the insured's prior losses resulted from work performed by subcontractors? ☐ Yes ☐ No

If yes, please describe: _____

Does the insured provide any Emergency Medical Services, Medical Services, Incidental Medical Services, or Medical Transportation Services?

☐ Yes ☐ No

Does the insured perform any of the following types of work?

Logging Operations ☐ Yes ☐ No

Nursery Operations ☐ Yes ☐ No

Excavation Operations ☐ Yes ☐ No

Chemical Spraying ☐ Yes ☐ No

Potable Water Delivery Operations ☐ Yes ☐ No

Public Livery Service Operations ☐ Yes ☐ No

Restoration Operations ☐ Yes ☐ No

Land Clearing ☐ Yes ☐ No

Mastication Operations ☐ Yes ☐ No

Planning/Drafting/Engineering Operations ☐ Yes ☐ No

Fire Trail Development Operations ☐ Yes ☐ No

Farming Operations ☐ Yes ☐ No

Other: _____ ☐ Yes ☐ No

If yes to any of the above, provide an explanation of the work? _____

What percentage of your operation is this activity? _____ %

If you answered Yes to any of the above, please be advised that these operations will be excluded for coverage under your policy. Separate insurance coverage should be maintained elsewhere for these exposures.

Watercraft/Aircraft

Does the organization own any watercraft more than 26' in length? ☐ Yes ☐ No

If yes, please indicate type, length, horsepower, number of seats, type of use, and where used. _____

If watercraft hull coverage is desired, schedule the watercraft under the Portable Equipment section of this survey.

Does the insured own, lease or utilize aircraft in any way? ☐ Yes ☐ No

If yes, please explain: _____

Automobile Liability

Do you lease your autos to others?

☐ Yes ☐ No

Indicate the desired coverage below:

\$ _____ Auto Liability

\$ _____ Medical Payments

\$ _____ PIP / No-Fault

\$ _____ Additional PIP

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

\$ _____ Uninsured Motorists/ Underinsured Motorists P.D.

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 _____

Physical Damage Coverage

Please indicate the desired deductible for all vehicles with Physical Damage Coverage:

Comprehensive (ACV) ☐ \$1000 ☐ \$2000 ☐ \$3000 ☐ \$5000

Collision (ACV) ☐ \$1000 ☐ \$2000 ☐ \$3000 ☐ \$5000

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

- If more than 10 vehicles, please attach Auto Acord Schedule.
- A complete drivers list with drivers' names, license numbers, dates of birth and dates of hire.
- Copies of motor vehicle reports for all drivers.

Driver Information

Do owners or employees take home company-owned vehicles, or use them for personal use?

☐ Yes

☐ No

If yes, please describe: _____

Does the insured review Motor Vehicle Reports (MVR's)?

☐ Yes

☐ No

If yes, how often?

☐ Annually

☐ Every 2-3 years

☐ More than 3 years

Does the insured have written criteria for acceptable MVR's?

☐ Yes

☐ No

Do all drivers have a license commensurate with applicable legal requirements (CDL, etc.)?

☐ Yes

☐ No

Number of drivers currently employed:

_____ Full Time

_____ Part Time

_____ Contract

Percent of driver turnover in the last 12 months?

_____ %

Crime

☐ N/A

Fidelity

Type of Bond:

☐ Commercial Blanket

Limit of Insurance

\$ _____

Number of Class I Employees (direct contact with funds)

Number of Class II Employees (all others)

☐ Position Schedule

Position

Limit of Insurance

\$ _____

\$ _____

\$ _____

\$ _____

☐ Faithful Performance

\$ _____

☐ Forgery or Alterations

\$ _____

☐ Money and Securities

\$ _____

General Crime Information

List all persons managing funds:

Name: _____ Title _____

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? \$ _____

During what months are the receipts the largest? _____

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 checks require 2 signatures?

☐ Yes

☐ No

If no, do checks over a certain amount require 2 signatures?

☐ Yes

☐ No

Crime (Continued)

To whom and how often is there a report of receipts and disbursements? _____

By whom and how often are the accounts examined? _____

The accounts were last examined when? _____

Inland Marine

☐ N/A

Contractors Scheduled Equipment

No.	Description (Year, Manufacturer, Model, Serial No.)	Limit of Insurance
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$
6.		\$
7.		\$
8.		\$

Please indicate desired Deductible for Contractors Scheduled Equipment Coverage: ☐ \$500 ☐ \$1000 ☐ \$2500 ☐ \$5000

Unscheduled Tools

Description	Limit of Insurance
Your Unscheduled Tools	Limit/item: <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 \$ _____ aggregate per occurrence
Please indicate Deductible for your Unscheduled Tools Coverage: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500	
Your Employees Unscheduled Tools	Limit/item: <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 \$ _____ aggregate per occurrence
Please indicate Deductible for your Employees Unscheduled Tools Coverage: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500	

Equipment rented, loaned to/from others with/without operators? ☐ Yes ☐ No

If yes, explain: _____

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 the insured's business. (**IF ADDRESS NOT INCLUDED, AI will not be added*)

Loc. No.	Additional Insured Information	Certificate of Insurance	Additional Insured
	Name: Address: Nature of interest/relationship: Job description: Job duration: Job location:	<input type="checkbox"/>	<input type="checkbox"/>
	Name: Address: Nature of interest/relationship: Job description: Job duration: Job location:	<input type="checkbox"/>	<input type="checkbox"/>
	Name: Address: Nature of interest/relationship: Job description: Job duration: Job location:	<input type="checkbox"/>	<input type="checkbox"/>

Umbrella and Excess Liability

Desired Limit of Insurance (maximum \$2 million): \$ _____ (These limits will apply to Excess Liability and Umbrella Liability)

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 \$500,000 bodily injury by accident/\$500,000 bodily injury by disease/\$500,000 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: _____

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.*

Prior Insurance Record

Coverage	Policy Term	Insurance Company	Policy Number	Premium
Property / IM				
Property / IM				
Property / IM				
General Liability				
General Liability				
General Liability				
Auto				
Auto				
Auto				

Claims History

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. *

DOL	DESCRIPTION	STATUS	AMOUNT

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

Attachments

Attachments to this application must include the following:

- Three years of currently valued, hard copy loss runs, including loss details and descriptions (for all lines requested).
- A quotation will not be offered if the attachments are not included with the application.

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 fines or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS: 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.

NOTICE TO ARIZONA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS, LOUISIANA, 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 CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 DELAWARE APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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 of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

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 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 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 may include imprisonment, fines or a 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 MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO 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 civil fines and criminal 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 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.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE TO TENNESSEE AND VIRGINIA 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 TEXAS APPLICANTS: 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.

NOTICE TO UTAH APPLICANTS: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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: _____