

183 Leader Heights Road
P.O. Box 2726, York, PA 17405
800.233.1957 | Fax: 717.747.7021
glatfelterhealthcare.com

Return completed application to
submissions@glatfelterhealthcare.com



Underwritten by: National Union Fire Insurance
Company of Pittsburgh, Pa. (for admitted business)

HOME HEALTH CARE AIDE (Non-Medical) APPLICATION

In addition to this Application, please submit the following supplemental applications if applicable:

- 5 years of currently valued carrier loss run reports
- Resume of Administrator, CEO, COO, Owner or Other Key Employee (if in business less than three years)

New Business Application is required for first year only.

A pre-filled Renewal Questionnaire will be provided for subsequent renewals.

Please note: If your services consist of other than providing unskilled domestic services, do not complete this application.

GENERAL INFORMATION

Date Proposal Needed By:

Policy Effective Date:

Professional Liability: Claims-made – Current Retroactive date:

Occurrence

General Liability: Claims-made – Current Retroactive date:

Occurrence

Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.

Deductible:

No Deductible

Current Carrier:

Number of years in operation:

Legal Name of Organization:

Additional Named Insureds and a brief description of their operations (attach additional schedule as needed):

Address:

Street or PO Box	City	County	State	Zip Code
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Mailing Address:

Street or PO Box	City	County	State	Zip Code
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FEIN:

Website:

Contact Information:

Primary:

Name	Phone	Email
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Inspection:

Name	Phone	Email
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Legal Status	Non-profit	For-profit	Governmental
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Organization Structure	Corporation Joint Venture	Partnership Limited Liability Company	Privately/Individually-owned Other:
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Home Health Care Services	Do you engage in any business other than home health care services? If yes, please explain:	Yes	No
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Operations	Total annual operating budget: \$ If revenue exceeds \$5,000,000 please attach a copy of your last audited financial statement.					
	Are you accredited by?	CHAP	ACHC	NCQA	COA	
	Are you Medicare certified?					Yes No
	Has there been any mergers, acquisitions or consolidations within the last 10 years? If yes, please provide the name(s) of the organization(s) and the date of acquisition:					Yes No
	Has the applicant or any of its subsidiary organizations ever filed for bankruptcy?					Yes No
	Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions:					

Employee Information	Number of Employees - Full-time:		Number of Employees - Part-time:			
	Number of Volunteers:					
	What percentage of staff is composed of temporarily assigned personnel acquired through staffing agencies?					%
	Which of the following background check methods do you use?		<u>Employees</u>		<u>Volunteers (if any)</u>	
	Social Security number verification:		Yes	No	Yes	No
	Criminal background checks:		Yes	No	Yes	No
	Residency verification:		Yes	No	Yes	No
	Professional licensing verification:		Yes	No	Yes	No
	Prior employment:		Yes	No	Yes	No
	Driver's license information (MVR): Only required if the employee/volunteer operates a company vehicle or their personal vehicle on the organization's behalf.		Yes	No	Yes	No
Is annual training provided and attendance documented for all employees and volunteers? If yes, briefly describe your in-service training program:					Yes No	

Risk Management and Loss Control	Does your organization have a formal written Quality Assurance/Performance Improvement or Risk Management program? If yes, name and title of person responsible for program:				Yes	No
	Do you have an active Safety Committee? If yes, how often does the Safety Committee meet?				Yes	No

Loss History	In the past 5 years, has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake? If yes, please explain:				Yes	No
	Are there any claims, suits, legal proceedings, or investigations against you or your subsidiaries that have <u>not</u> yet been reported to your former insurance carrier? If yes, please provide details on a separate document.				Yes	No
	Is the applicant aware of any recent circumstance which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? If yes, please explain:				Yes	No
	In the past 5 years, has any insurance carrier cancelled or refused coverage? (Missouri applicants are not required to reply) If yes, please provide the reason for cancellation:				Yes	No
	Within the last 3 years has your organization been a part of any civil or criminal litigation or arbitration proceeding? If yes, please provide details on a separate document.				Yes	No
	If current coverage is claims made, are there any interruptions of continuous claims made coverage from the proposed effective date?				Yes	No

Contracted Services	Do you engage the use of independent contractors to provide any services?		Yes	No
	If yes, complete the following questions:			
	What percentage of revenue is provided by independent contractors?		%	
	Do you require a written contract with hold harmless and indemnification language in your favor?		Yes	No
	Do you require independent contractors list you as an additional insured on their liability policy?		Yes	No
	Do you require that all independent contractors maintain liability insurance and provide you with a copy of their Certificate of Insurance each year?		Yes	No
	Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements?		Yes	No
	<u>Service</u>	<u>Limit of Liability</u>	<u>Service</u>	<u>Limit of Liability</u>
	Dental:	Yes No \$	Mental Health:	Yes No \$
	Pharmaceutical:	Yes No \$	Physical Therapy:	Yes No \$
Occupational Therapy:	Yes No \$	Speech Therapy:	Yes No \$	
Dietary:	Yes No \$	X-Ray:	Yes No \$	
Medical Records:	Yes No \$	Laboratory:	Yes No \$	
Recreational Services:	Yes No \$	Social Services:	Yes No \$	
Barber/Beautician:	Yes No \$	Transportation:	Yes No \$	
Food:	Yes No \$	Laundry:	Yes No \$	
Other:	\$	Other:	\$	

Home Aide (Non-Medical) Services (Please check all that apply.)													
Home Aide services	Number of clients: Last 12 months: _____ Next 12 months: _____												
	Number of clients provided with 24-hour "live in" care:												
	Number of clients that are children (18 years of age or under):												
	Locations where services are provided: Private Homes Hospitals Clinics Nursing Homes /ALFs Other:												
	Do you provide medical equipment to your patients other than Class I and II items (e.g. crutches, wheel chairs, walkers, etc.)? If yes, please contact us for a Durable Medical Equipment Supplement.	Yes No											
	Are you a franchise owner? If yes, what is the franchise?	Yes No											
	Additional Services	<table border="1"> <tr> <td>Activities of Daily Living (ADL)</td> <td>Hospice Support</td> </tr> <tr> <td>Bathing/Dressing</td> <td>Medication Reminders</td> </tr> <tr> <td>Doctor Visits</td> <td>Respite for Family Caregivers</td> </tr> <tr> <td>Errands</td> <td>Supplemental Staffing</td> </tr> <tr> <td>Bill Paying</td> <td></td> </tr> <tr> <td>Other:</td> <td></td> </tr> </table>	Activities of Daily Living (ADL)	Hospice Support	Bathing/Dressing	Medication Reminders	Doctor Visits	Respite for Family Caregivers	Errands	Supplemental Staffing	Bill Paying		Other:
Activities of Daily Living (ADL)	Hospice Support												
Bathing/Dressing	Medication Reminders												
Doctor Visits	Respite for Family Caregivers												
Errands	Supplemental Staffing												
Bill Paying													
Other:													

Hired and Non-owned Auto Liability	Are you requesting this coverage? If yes, complete the questions in this section.	Yes	No
	If company-owned or leased vehicles are insured by another carrier, Non-owned Auto Liability coverage will be excluded from this policy and must be secured under your owned Auto policy.		
	Does your organization have positions where driving personal vehicles is a job function essential to the position?	Yes	No
	Do you have a policy in place which addresses driving requirements for employees and volunteers?	Yes	No
	Does this policy include specific hiring criteria applicable to new drivers who operate their personal vehicles on your behalf?	Yes	No
	Does your pre-employment hiring process include driver screening?	Yes	No
	Does this process include ordering Motor Vehicle Reports prior to hire?	Yes	No
	Does your policy include a process for removing drivers with unsatisfactory driving records from their driving duties?	Yes	No
	Does this process include verification of the state's minimum financial responsibility limits?	Yes	No
	Does your policy permit patient/client transport in personal vehicles? If yes, what personal auto liability limits do you require? \$ _____ / \$ _____ or \$ _____	Yes	No CSL
	Does your policy permit use of the patient or client's vehicles? If yes, is the caregiver required to verify the client maintains auto liability insurance?	Yes	No Yes No
	Does your organization offer training on safe driving practices?	Yes	No

Sexual Abuse Liability	Are you requesting this coverage? If yes, complete the questions in this section.	Yes	No
	Retroactive Date: _____	<i>Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.</i>	
	Do you order Criminal Background Checks including Sexual Abuse Registry on the following?		
	Employees:	Yes	No
	Volunteers:	Yes	No
	Agency personnel:	Yes	No
	Does your organization have a written "zero tolerance" sexual abuse and molestation policy?	Yes	No
	If yes, does your written policy include the following?		
	A zero tolerance statement:	Yes	No
	Definition of sexual abuse/molestation:	Yes	No
Reporting procedures with at least two persons to report to internally:	Yes	No	
Investigation and follow-up procedures:	Yes	No	
Anti-retaliation warning:	Yes	No	
Are all employees/volunteers required to acknowledge having read and comprehended the policy?	Yes	No	
Is annual training on the policy completed and acknowledged?	Yes	No	
Have you ever had any prior incidents, allegations or claims involving sexual abuse? If yes, please provide details:	Yes	No	

Employee Benefits Liability	\$25,000 each employee/\$25,000 aggregate is automatically provided. If you are requesting higher limits, please indicate:		
	\$50,000/\$50,000	\$100,000/\$100,000	\$250,000/\$250,000
	\$500,000/\$500,000	\$750,000/\$750,000	\$1,000,000/\$1,000,000

Employer's Liability Coverage	If your Workers Compensation coverage does <u>not</u> provide Employer's Liability (ND, OH, WA, WY), do you want Employer's Liability coverage? Yes No If yes, provide total annual payroll: \$ _____		
	Limits desired: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">"Bodily Injury" by accident each accident</td> <td style="width: 33%; border: none;">"Bodily injury" by disease policy limit</td> <td style="width: 33%; border: none;">"Bodily injury" by disease each "employee" or volunteer</td> </tr> </table>	"Bodily Injury" by accident each accident	"Bodily injury" by disease policy limit
"Bodily Injury" by accident each accident	"Bodily injury" by disease policy limit	"Bodily injury" by disease each "employee" or volunteer	

Cyber Liability and Privacy Crisis Management Expense	Are you requesting this coverage? If yes, complete the questions in this section.	Yes	No
	Retroactive Date:	<i>Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.</i>	
	Cyber Liability protects you when claims are made against you for monetary damages arising out of an electronic information security event:		
	\$1,000,000	Each Electronic Information Security Event, subject to	
	\$3,000,000	Annual Aggregate	
	Privacy Crisis Management Expense reimburses for expenses you incur as a result of a privacy crisis management event first discovered during the policy period. This first party coverage is intended to provide professional expertise in the identification and mitigation of a privacy breach while satisfying Federal and State statutory requirements.		
	\$50,000	Each Privacy Event / \$50,000 Aggregate (automatically included)	
	\$100,000	Each Privacy Event / \$100,000 Aggregate	
	\$250,000	Each Privacy Event / \$250,000 Aggregate	
	\$500,000	Each Privacy Event / \$500,000 Aggregate	
Cyber Extortion Expense reimburses for expenses you incur as a result of a cyber extortion threat first made against you during the policy period. A \$20,000 limit applies to Each Cyber Extortion Threat, subject to the Privacy Crisis Management Expense Aggregate.			
Is Firewall technology used at all internet points of presence to prevent unauthorized access to internal networks?	Yes	No	
Do you use antivirus software on all desktops, portable computers and mission critical servers?	Yes	No	
Are antivirus applications updated in accordance with the software provide's requirements? How often?	Yes	No	
Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access?	Yes	No	
Has your organization suffered a computer attack, such as a hacking attack, breach of personal information, denial of service attack, virus or malware infection or ransomware attack in the last 12 months? If yes, please explain:	Yes	No	
Do you have a written information security and privacy policy?	Yes	No	

REAL & PERSONAL PROPERTY Yes No

Complete this section or you may submit a Property ACORD application.

Coverage desired: Scheduled Property (Non-Blanket) Blanket Per Premises (Property and Contents) Policy Blanket
 Deductible desired: \$500 \$1,000 \$2,500 \$5,000 \$10,000 \$15,000 \$25,000 \$50,000 Other:

Loss of Income: \$250,000 is automatically included. If a higher limit is being requested, please indicate: \$	Extra Expense: \$250,000 is automatically included. If higher limit is being requested, please indicate: \$
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CONSTRUCTION CODES

- | | | | | |
|--------------------------|----------------------------------|----------------------------------|-------------------|-----------------------------|
| 1 Frame | 3 Non-combustible | 5 Modified Fire Resistant | 7 Concrete | 9 Reinforced Masonry |
| 2 Joisted Masonry | 4 Masonry Non-combustible | 6 Fire Resistant | 8 Steel | |

ROOF CODES (0 = Unknown)

Covering	1 Metal sheathing with exposed fasteners 2 Metal sheathing with CONCEALED fasteners	3 Built-up roof or single-ply membrane WITH gutters 4 Built-up roof or single-ply membrane WITHOUT gutters	5 Concrete/clay tiles 6 Wood shakes	7 Shingle - 55 mph wind rating 8 Shingle - 55 mph wind rating/Secondary Water Resistance (SWR)	9 Shingle - 110 mph wind rating 10 Shingle - 110 mph wind rating/Secondary Water Resistance (SWR)
Geometry	1 Flat Roof WITH Parapets 2 Flat Roof WITHOUT Parapets	3 Hip Roof with Slope <= 6:12 (26.5°) 4 Hip Roof with Slope > 6:12 (26.5°)	5 Gable Roof with Slope <= 6:12 (26.5°) 6 Gable Roof with Slope > 6:12 (26.5°)	7 Braced Gable Roof with Slope <= 6:12 (26.5°) 8 Braced Gable Roof with Slope > 6:12 (26.5°)	
Anchors	1 Toe Nailing/No Anchorage	2 Clips	3 Single Wraps	4 Double Wraps	5 Structural

Premises #	Item #	Street Address City / State / Zip / County	Building Occupied as:	Amount of Insurance At 100% Replacement Cost Value (RCV). Include value of foundations.		Year Built	# Sq Feet	Building Area You Occupy	# of Stories	Protection Class	Construction Code	Sprinkler System Y/N	Vacant Y/N	Date of Last Inspection	Year of Mech System Updates	Year of Roof Updates	Roof Covering	Roof Geometry	Roof Anchors	Type of Fire or Other Alarms
				Building	Contents															
		/																		
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				Building	Contents															
		/																		
		/																		
		/																		
		/																		
		/																		

Other occupants?	Are there any other occupants in the buildings you occupy?			Yes	No
	Premises #	Item #	List of Other Occupants		

Mortgagee	Name:						
	Street:						
	City:			State:		Zip:	
Applies to Premises/Item #s:	/	/	/	/	/	/	/

Mortgagee	Name:						
	Street:						
	City:			State:		Zip:	
Applies to Premises/Item #s:	/	/	/	/	/	/	/

What Coverages and Limits do you require?	Accounts Receivable:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Debris Removal:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Outdoor Property	\$150,000 (automatically included)	Increase Limit \$
	Property in Transit or Off Premises:	\$100,000 (automatically included)	\$250,000
	Software:	\$500,000 (automatically included)	Increase Limit \$
Trees, Shrubs, Plants and Lawns:	\$25,000 (automatically included)	Increase Limit \$	
Valuable Papers and Records:	\$100,000 (automatically included)	\$250,000	
	\$500,000	\$1,000,000	

What Coverage Options do you want to purchase?	Scheduled Fine Arts:	Yes (attach schedule)	No
	Special Property Floater:	Yes (attach schedule)	No
	Equipment Breakdown including:		
	Spoilage:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Hazardous Substance:	\$250,000 (automatically included)	\$500,000
		\$1,000,000	
	Expediting Expense:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Flood Coverage:	Yes Limit \$	No
	Include Real Property/BPP/LOI/EE		
	Include BPP/LOI/EE		
Earthquake Coverage:	Yes Limit \$	No	
	Include Real Property/BPP/LOI/EE		
	Include BPP/LOI/EE		

CRIME Yes No

Limits Option requested? (Select one of the following)

Limits Option	Employee Theft	Forgery or Alteration	Temporary Increased Limits for Special Events			Computer & Funds Transfer Fraud	Money Orders	Fraudulent Impersonation
			Inside the Premises		Outside the Premises			
			Theft of Money & Securities	Robbery/Safe Burglary				
1	\$10,000	\$10,000	\$10,000	\$5,000	\$10,000	\$20,000	\$10,000	\$10,000
2	\$25,000	\$25,000	\$25,000	\$5,000	\$25,000	\$20,000	\$10,000	\$10,000
3	\$50,000	\$50,000	\$50,000	\$5,000	\$50,000	\$50,000	\$25,000	\$25,000
4	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000
5	\$250,000	\$250,000	\$250,000	\$100,000	\$250,000	\$250,000	\$250,000	\$250,000
6	\$400,000	\$400,000	\$400,000	\$100,000	\$400,000	\$400,000	\$250,000	\$250,000
7	\$500,000	\$500,000	\$500,000	\$100,000	\$500,000	\$500,000	\$250,000	\$250,000
8	\$1,000,000	\$1,000,000	\$1,000,000	\$100,000	\$1,000,000	\$500,000	\$250,000	\$250,000
9	\$2,000,000	\$1,000,000	\$1,000,000	\$100,000	\$1,000,000	\$500,000	\$250,000	\$250,000

Deductible requested? (Deductibles above \$1,000 are only available with Limits Options 5, 6, 7, 8 and 9.)

\$250	\$1,000	\$5,000	\$15,000
\$500	\$2,500	\$10,000	\$25,000

Indicate what security provisions apply and identify how often:

Audit	Reconciliations
Bank statements	Other
Countersignature	

Temporary Increased Limit for Special Events	Is temporary increased limit requested for inside and outside premises for special events?		Yes	No
	Limit Requested	Description of Event	# of days	

AUTO Yes No

Complete this section or you may submit an Auto ACORD application.

What Coverages and Limits do you desire?	Liability Limit (Combined Single Limit):	\$300,000	\$500,000	\$1,000,000	Deductibles:	
	Uninsured/Underinsured Motorists Limit:					Comprehensive: \$500 \$1,000 \$2,000 \$3,000 \$5,000
	PIP Limit:					Collision: \$500 \$1,000 \$2,000 \$3,000 \$5,000
	Hired and Non-owned Liability coverage desired?	Yes	No			

VEHICLE CLASSIFICATION				
Private Passenger	Truck – Service	Truck – Retail	Truck – Commercial	Van
Bus	Service/Utility Trailer	Mobile Equipment	Golf Cart	Other

Veh #	Year	Make	Description (Model / Type)	Vehicle Classification	Vans and Buses		Serial Number (VIN)	Cost New ACV	Garaged at Premises #
					Seating Capacity	Radius in Miles			
EX.	2020	Nissan	Altima	Private Passenger	1-5	0-50	1BAAGCSA9XF082111	\$24,000	1
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Do you have any Customized vehicles?	Have any vehicles been customized from a previous use? Yes No	Describe:
	If yes, indicate vehicle number(s):	

Add'l Insured Lessor Loss Payee	Name:	City:	State:	Zip:
Applies to Vehicle #'s:	Street:			

Add'l Insured Lessor Loss Payee	Name:	City:	State:	Zip:
Applies to Vehicle #'s:	Street:			

Auto Fleet Management Information	Do you pre-screen all drivers before they are permitted to drive your vehicles?	Yes	No	
	Do you have procedures in place to regularly check their Motor Vehicle Records?	Yes	No	
	Do you have specific criteria in place used to evaluate driver acceptability?	Yes	No	
	Do you provide driver training?	Yes	No	
	Do your drivers meet CDL requirements based on the vehicle's passenger capacity?	Yes	No	N/A
	Do you provide non-emergency patient transportation in your owned vehicles? If yes, please describe:	Yes	No	
	Do you have a formalized documented vehicle safety program which includes vehicle preventative maintenance and required safety inspections?	Yes	No	
	Do you own or use any 15 passenger vans? If yes: Have vans been modified with dual rear wheels or changed seating capacity? If yes, describe:	Yes	No	
	Are van models prior to 2009 equipped with Electronic Stability Controls?	Yes	No	N/A
	Is there a requirement that vans are not overloaded?	Yes	No	
Is there a requirement that no loads are placed on the roof of the vans?	Yes	No		

EXCESS LIABILITY		Yes	No
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What Coverages and Limits do you desire?	Limits desired: \$ _____ occurrence / \$ _____ aggregate
	<p>Note: Underlying liability limits of \$1,000,000 are required. All underlying coverage to be scheduled must be provided by the program. Exceptions are permitted for Employer's Liability coverage. For Employer's Liability Coverage insured elsewhere, provide the following:</p> <p>Policy Number: _____</p> <p>Effective Date: _____</p> <p>Policy Limits: _____</p> <p>Carrier Name: _____</p>

OCCUPATIONAL ACCIDENT / BUSINESS TRAVEL ACCIDENT	Yes	No
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If your organization is a non-profit organization and coverage is being requested, please **complete the Supplement on our website.**

WRAP-UP INFORMATION

Any significant changes to your organization during the policy year must be reported to Glatfelter Underwriting Services, Inc. to ensure coverage.

Name of Producing Agency:	_____
Agency's Address:	_____
Agency's Phone:	_____
If you are not licensed as a broker, are you a property/casualty agent?	Yes No
Producer or CSR (for contact purposes): Name:	_____
Email:	_____
If you have never placed business with us before, please provide the person responsible for agency/brokerage licensing and contracting:	
▪ Contact's Name:	_____
▪ Contact's Email:	_____
▪ Contact's Direct Phone:	_____

FRAUD WARNING NOTICE – PLEASE READ CAREFULLY

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 act, which is a crime, and may subject such person to criminal and civil penalties.

Alabama	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.
Arkansas	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.
California	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 prison.
Colorado	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.
District Of Columbia	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.
Florida	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.
Kansas	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 or 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 that 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.
Kentucky	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.
Louisiana	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.
Maine	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.
Maryland	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.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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.
New York	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.
Ohio	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.
Oklahoma	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.
Oregon	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, may be guilty of a fraudulent act, which may be a crime, and may subject such person to criminal and civil penalties.
Pennsylvania	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.
Rhode Island	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.
Tennessee	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.
Vermont	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.
Virginia	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.
Washington	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.
West Virginia	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.

Your signature below acknowledges that you have read the Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

Applicant's signature:

Title:

Date:

Agent's signature:

Date: