

Please return completed application to: ***submissions@glatfelters.com***

## SENIOR LIVING PROGRAM

### Healthcare Application Supplement

1. Applicant Name: \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_
3. Website: \_\_\_\_\_
4. FEIN: \_\_\_\_\_
5. Phone Number: \_\_\_\_\_
6. Inspection and Insurance Contact Name: \_\_\_\_\_
7. Phone Number: \_\_\_\_\_
8. Email: \_\_\_\_\_

**PLEASE INCLUDE THE FOLLOWING ITEMS WITH THIS SUBMISSION**

(✓)

- |  |                          |
|--|--------------------------|
| 1. This Senior Living Program Application Supplement   | <input type="checkbox"/> |
| 2. ACORD Applications: (✓)   |                          |
| <input type="checkbox"/> General Liability <input type="checkbox"/> Umbrella <input type="checkbox"/> Property <input type="checkbox"/> Crime <input type="checkbox"/> Auto <input type="checkbox"/> Inland Marine |                          |
| 3. Currently valued carrier loss run reports – 5 years   | <input type="checkbox"/> |
| 4. Copy of Facility License  | <input type="checkbox"/> |
| 5. State Survey Report, Plan of Correction and Acknowledgement   | <input type="checkbox"/> |
| 6. Most recent financial statements  | <input type="checkbox"/> |
| 7. Resume of Administrator and Director of Nursing (if at the facility less than three years)  | <input type="checkbox"/> |

## I. APPLICANT INFORMATION

1. Applicant is: ☐ For-Profit ☐ Not-for-Profit ☐ Religious-Affiliated
2. Type of organizational structure: ☐ Corporation ☐ Partnership ☐ Individually-Owned ☐ Joint-Venture ☐ LLC  
☐ Other, please describe: \_\_\_\_\_
3. Total Number of facilities owned by the applicant: \_\_\_\_\_
4. Any plans for mergers/acquisitions/sale of assets/change in services during the next twelve months? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
5. Please list all Entities/Subsidiaries **and** their business operations that are to be included as Insureds (if any):  
a. \_\_\_\_\_  
b. \_\_\_\_\_  
c. \_\_\_\_\_
6. Has the applicant or any of its subsidiary organizations ever filed for bankruptcy? ☐ Yes ☐ No
7. Has the applicant/any subsidiaries ever been arrested/charged/convicted of any civil/criminal violations? ☐ Yes ☐ No

## II. FACILITY INFORMATION

1. Facility Name: \_\_\_\_\_
2. Facility Address: \_\_\_\_\_  
\_\_\_\_\_
3. The facility is best described as which **one** of the following?  
☐ Skilled nursing facility  
☐ Assisted living facility (with or without Independent living)  
☐ Independent living ONLY  
☐ CCRC (Continuing Care Retirement Community)  
☐ Rehabilitation facility  
☐ Senior housing apartments (Please note the number of HUD-financed units: \_\_\_\_\_)
4. Number of years under present ownership: \_\_\_\_\_
5. Is this facility managed by a management company? ☐ Yes ☐ No  
If yes, name of management company: \_\_\_\_\_  
Number of years managed by this management company: \_\_\_\_\_  
Does this management company manage other facilities? ☐ Yes ☐ No  
If yes, name and addresses of other facilities: \_\_\_\_\_  
\_\_\_\_\_
6. Date of licensure: \_\_\_\_/\_\_\_\_/\_\_\_\_
7. Date of last inspection/survey: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Number of deficiencies: \_\_\_\_\_
8. How many resident complaints, if any, were investigated within the last three years? \_\_\_\_\_
9. Has this facility had its license suspended/revoked/been placed on probation within the last five years? ☐ Yes ☐ No
10. Has a state or federal agency investigated or fined this facility within the last five years? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
- 11: Name of administrator: \_\_\_\_\_  
Length of time at this facility: \_\_\_\_\_
12. Is the administrator a full-time employee? ☐ Yes ☐ No
13. Is the facility certified for Medicare and Medicaid? ☐ Yes ☐ No
14. Is the facility CARF-accredited? ☐ Yes ☐ No

### III. COVERAGE

1. Requested coverage form:

General Liability ☐ Occurrence ☐ Claims-Made If claims-made, provide retroactive date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Prof. Liability ☐ Occurrence ☐ Claims-Made If claims-made, provide retroactive date: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. If current coverage is claims made, are there any interruptions of continuous claims made coverage from the proposed effective date? ☐ Yes ☐ No

3. Proposed policy effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Deductible: \_\_\_\_\_ or ☐ no deductible

### IV. LOSS HISTORY

*Please attach loss run reports.*

1. In the past five years, has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake? ☐ Yes ☐ No

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

2. Have all claims, suits, legal proceedings, and investigations against you or your subsidiaries during the past five years been reported to your former insurance carrier? ☐ Yes ☐ No

3. 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? ☐ Yes ☐ No

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

4. In the past three years, has any insurance carrier cancelled or refused coverage? ☐ Yes ☐ No

### V. HEALTHCARE SERVICES

1. This facility offers:

- ☐ Skilled nursing (skilled, sub-acute, intermediate care)
- ☐ Assisted living/personal care
- ☐ Short-term rehabilitation services
- ☐ Memory care (Dementia/Alzheimer's)
- ☐ Independent living (no healthcare services offered; residents living independently but may have common dining)
- ☐ Senior housing (residential housing for seniors; no healthcare services; no common dining)

	Loc. # _____	Bldg. # _____	Loc. # _____	Bldg. # _____	Loc. # _____	Bldg. # _____
<b>Skilled Nursing - # of Beds</b>	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
# Memory Care Beds included in Bed Count						
<b>Total</b>						

<b>Assisted Living - # of Beds</b>			
# Memory Care Beds included in Bed Count			
<b>Total</b>			

<b>Short-Term Rehab - # of Beds</b>	Occupied Beds:	Occupied Beds:	Occupied Beds:
# Memory Care Beds included in Bed Count			
<b>Total</b>			
<b>Hospice - # of Beds</b>			

<b>Independent Living - # of Units</b>	
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Is there common dining?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there emergency call buttons or pull chords in each unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a daily mechanism to monitor residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is a visitor log maintained?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Senior Apartments – # of Apartment Units</b>	
Is the building HUD-subsidized?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what percentage of funding is provided by HUD?	_____ %

2. Number of residents being cared for or receiving the following types of services:

_____ IV Infusion therapy	_____ Developmentally disabled
_____ Ventilation therapy	_____ Chemical dependency
_____ Traumatic brain injury	_____ Psychiatric care

3. How many residents are under the age of 65? \_\_\_\_\_

If any, please explain services provided: \_\_\_\_\_

## VI. CONTRACTED SERVICES

1. Please indicate which of the following services are (1) contracted to you at this facility (2) if a contract is in place and (3) limits of liability:

Services	Is service provided?	Is a contract in place?	Limits of liability
Physicians	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Pharmaceutical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Speech Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dietary	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Medical Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Social Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Recreational Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Barber/Beautician	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

2. Are contractors required to provide professional liability coverage limits of at least \$1,000,000? ☐ Yes ☐ No
3. Are current Certificates of Insurance obtained for all contracted services? ☐ Yes ☐ No
4. Is there a contract review process in place for all contracts with third parties? ☐ Yes ☐ No

## VII. NON-RESIDENT SERVICES

1. Please indicate if the following services are provided to non-residents:

- ☐ Home healthcare; Annual revenue \$ \_\_\_\_\_
- ☐ Hospice; Number of outpatient visits: \_\_\_\_\_
- ☐ Rehabilitation services; Annual revenue: \$ \_\_\_\_\_
- ☐ Pharmacy; Revenue from non-resident services: \$ \_\_\_\_\_
- ☐ Adult day care; Licensed capacity: \_\_\_\_\_ Annual revenue: \$ \_\_\_\_\_
- ☐ Child day care; Licensed capacity: \_\_\_\_\_ Annual revenue: \$ \_\_\_\_\_
- ☐ Meals on Wheels; Estimated receipts: \$ \_\_\_\_\_
- ☐ Transportation; Annual revenue: \$ \_\_\_\_\_

## VIII. STAFFING

1. Total number of employees: \_\_\_\_\_
2. Who serves as the Director of Nursing? \_\_\_\_\_  
Length of time at this facility: \_\_\_\_\_ years
3. Total number of nurse employees: \_\_\_\_\_

### GENERAL STAFFING

Total number of nursing/caregiver (whether employed or independent contractor) positions, by staff category:

Category	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Turnover Percentage - Prior 12 Months
RN	# _____	# _____	# _____	# _____
LPN/LVN	# _____	# _____	# _____	# _____
CNA/Personal Caregiver	# _____	# _____	# _____	# _____

4. If agency nurses are used is a:  
Certificate of insurance obtained from the agency for professional liability coverage? ☐ Yes ☐ No ☐ NA
5. Which of the following background checks are performed on new employees?  
☐ Employment history ☐ Drug testing  
☐ Education ☐ Sexual abuse registry  
☐ Licensure ☐ Driving record (Motor Vehicle Report), if job duties include driving  
☐ Criminal background check
6. Are background checks completed for agency personnel? ☐ Yes ☐ No ☐ NA
7. Is an orientation conducted for all employees and agency personnel? ☐ Yes ☐ No
8. Are there regularly scheduled in-service trainings for all employees and agency personnel? ☐ Yes ☐ No
9. Does training include Sexual Abuse Prevention, identification, and reporting? ☐ Yes ☐ No
10. Total number of volunteers: \_\_\_\_\_  
Is there formal screening/orientation process for volunteers? ☐ Yes ☐ No  
Are background checks/sexual abuse registry checks conducted on all volunteers? ☐ Yes ☐ No

## IX. Physicians

1. Number of physicians:  
Employed: \_\_\_\_\_  
Contracted: \_\_\_\_\_  
Affiliated: \_\_\_\_\_

2. Are physicians credentialed by this applicant? ☐ Yes ☐ No
3. Is a physician on-site or on-call on a 24-hour basis? ☐ Yes ☐ No
4. Does the medical director also act as the attending physician for any residents? ☐ Yes ☐ No
- If yes, how many employees? \_\_\_\_\_

## X. RISK MANAGEMENT

1. Is there a risk management program implemented at this facility? ☐ Yes ☐ No
2. Is there a designated risk manager at this facility? ☐ Yes ☐ No
3. Is there a formal safety program, and does it include the following: ☐ Yes ☐ No
- Life Safety? ☐ Yes ☐ No
- Employee Safety? ☐ Yes ☐ No
- Hazardous materials? ☐ Yes ☐ No
- Environment? ☐ Yes ☐ No
4. What security measures are in place to control unauthorized entrances and exits from the facility? \_\_\_\_\_
- 
5. Is a visitor log maintained? ☐ Yes ☐ No
6. Are Wander Guards or similar devices in place in memory units (for Dementia and Alzheimer's residents)? ☐ Yes ☐ No
7. How many elopements have occurred in the past three years? \_\_\_\_\_
8. Are nursing assessment protocols in place to identify residents at risk for:
- Elopement? ☐ Yes ☐ No
- Falls? ☐ Yes ☐ No
- Skin breakdowns/ulcers? ☐ Yes ☐ No
- Cognitive impairment? ☐ Yes ☐ No
- Nutrition deficiency? ☐ Yes ☐ No
9. Are admission, discharge, and transfer criteria established? ☐ Yes ☐ No
10. Is there a written procedure in place for reporting resident abuse? ☐ Yes ☐ No
11. Is there a formal grievance procedure in place to address resident/family complaints? ☐ Yes ☐ No
12. Does the facility use electronic health records? ☐ Yes ☐ No
13. Does the facility use ACTUM? ☐ Yes ☐ No
14. Is all advertising material, including website information, reviewed by legal counsel? ☐ Yes ☐ No

## XI. PROPERTY INFORMATION

1. Year of construction: \_\_\_\_\_
2. Were all buildings constructed for their current occupancy? ☐ Yes ☐ No
- If no, please note original occupancy: \_\_\_\_\_
3. Are all resident buildings 100% sprinklered? ☐ Yes ☐ No
- If no, what areas are not sprinklered? \_\_\_\_\_
4. Is there a facility 'no smoking' policy in effect? ☐ Yes ☐ No
5. Are smoking residents supervised and/or in designated areas? ☐ Yes ☐ No
6. Is there a documented emergency evacuation plan in effect? ☐ Yes ☐ No
7. Are evacuation drills conducted regularly? ☐ Yes ☐ No
8. In cooking areas (other than independent living units) is there a fire suppression system? ☐ Yes ☐ No
9. In multi-story buildings, are non-ambulatory residents on levels above the first and second floors? ☐ Yes ☐ No

10. Are emergency call buttons or resident pull chords in each room/unit? ☐ Yes ☐ No
11. Is there a community center? ☐ Yes ☐ No
12. Is there an exercise/weight room? ☐ Yes ☐ No  
Is it open to the public? ☐ Yes ☐ No
13. Is there a swimming pool on the premise? ☐ Yes ☐ No
14. Are there any other bodies of water present or within three miles of the facility? ☐ Yes ☐ No
15. Are pets allowed on the premise, including residents' pets? ☐ Yes ☐ No
16. Is there a restaurant open to the public on the premise? ☐ Yes ☐ No  
Is alcohol served? ☐ Yes ☐ No

## XII. CORPORATE IDENTITY COVERAGE

Corporate Identity Coverage is available as an optional coverage. This coverage includes Personal Identity Liability and Expense Reimbursement for administrative expenses, notification costs, crisis expense and post event services.

If you are interested in this coverage, please indicate the desired limit:

☐ \$50,000 ☐ \$100,000 ☐ \$150,000 ☐ \$500,000 ☐ \$1,000,000

1. Is Firewall technology used at all internal points of presence to prevent unauthorized access to internal networks? ☐ Yes ☐ No
2. Do you use antivirus software on all desktops, portable computers and mission critical servers? ☐ Yes ☐ No
3. Are antivirus applications updated in accordance with the software provider's requirements? ☐ Yes ☐ No  
How often? \_\_\_\_\_
4. Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access? ☐ Yes ☐ No
5. 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? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
6. Do you have a written information security and privacy policy? ☐ Yes ☐ No
7. Do you back up your computer data and store it off site? ☐ Yes ☐ No

## XIII. DISCLOSURE/AUTHORIZATION/DECLARATIONS

**WARNING NOTICE:** 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.

The undersigned Applicant authorizes the Company, its agents, and representatives to secure claims information from my current and previous insurance carriers.

THE UNDERSIGNED DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE INSURANCE, NOR DOES REVIEW OF THE APPLICATION BIND THE INSURER TO ISSUE A POLICY. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

(PLEASE SIGN ALL ACCOMPANYING "ACORD" APPLICATIONS AS WELL.)

## 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.

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