# MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR HEALTHCARE PROFESSIONALS

This application for Claims Made or Occurrence Coverage is subject to review and approval by Positive Physicians and does not bind coverage.

| AGENCY/PRODUCER INFORMATION |
|---|
| Agency Name: |
| Agency Location: |
| Producer Name: |
| Producer License # (NPN): |

**Please answer all questions completely (state "n/a" if not applicable) as they pertain to the coverage requested, using REMARKS section as needed.** Alternatively, you may attach a credentialing or other company application dated within the past year, along with this application beginning with SECTION VII Claims Information.

## Application Checklist: Please attach current versions of the following:

☐ Curriculum Vitae (CV)

☐ Loss Runs for 10 years or from start of practice if less than 10 years

☐ Declarations Page or Certificate of Insurance "COI"

☐ Please download and print the Positive Physicians Business Associate Agreement at https://positivephysicians.com/hipaa and file with your other HIPAA compliance documents. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Positive Physicians Insurance Company to enter into a Business Associate Agreement with all business associates who manage or distribute protected health information.

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## SECTION I: APPLICANT INFORMATION

| First Name | Middle Name | Last Name | ☐ MD ☐ DO ☐ _____ |
|---|---|---|---|
| Date of Birth | NPI # | DEA License # | ☐ M ☐ F (at birth) |
| Primary Office Phone | Home Phone | Cell Phone | Website |
| Authorized Representative | Title | Email | |

| Office | Mailing Address | City | State | Zip | Preferred |
|---|---|---|---|---|---|
| Primary | | | | | ☐ |
| Billing | | | | | ☐ |
| Home | | | | | ☐ |
| Other | | | | | ☐ |

## SECTION II: EDUCATION & TRAINING

Please attach a CV or describe your medical education and training and explain any gaps in REMARKS.

☐ Check here if you have attached a current CV containing this information.

| | Full Name | City/State | Specialty | Started (mm/yyyy) | Completed (mm/yyyy) |
|---|---|---|---|---|---|
| Medical School | | | | | |
| Internship | | | | | |
| Residency | | | | | |
| Fellowship | | | | | |
| Additional | | | | | |

1. Are you entering private practice for the first time? ☐ Yes ☐ No

2. Have you completed a risk management or patient safety course or seminar in the past 12 months, OR do you employ or contract with a professional Healthcare Risk Manager, OR do you participate in the AHRQ Patient Safety Organization (PSO) program? ☐ Yes ☐ No

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## SECTION III: COVERAGE INFORMATION

**COVERAGE REQUESTED (select one)**

☐ **Are you requesting coverage as an ADDITION to an existing Positive Physicians insurance policy?** If yes, please provide: Policyholder: _____Policy #: _____

☐ **Claims Made WITHOUT Prior Acts Coverage.** No coverage is desired for acts/omissions occurring prior to this policy.

☐ Tail has been or will be purchased.

☐ Tail has not and will not be purchased.

I will not purchase tail coverage from my current insurer and realize failure to do so will result in uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current policy. I understand that the policy for which I am applying, if offered, will not provide Prior Acts Coverage. Initial Here: _____

☐ **Claims Made INCLUDING Prior Acts Coverage**.

☐ A Declarations Page, Schedule, Endorsement or Certificate is attached showing the requested retroactive date.

☐ **Occurrence Coverage**

Please complete the following with respect to your requested coverage:

| Requested Effective Date (12:01 AM) | Retroactive Date | Limits of Liability Requested: | Limit Type: | Hours* per week: | Patients per week: |
|---|---|---|---|---|---|
| | | _____ Per Occurrence/Claim<br>_____ Annual Aggregate | ☐ Shared<br>☐ Separate | | |

* Please note that "Hours per week" include patient care, office hours and record-keeping.

Are you part-time? ☐Yes ☐No If yes, when did you begin? _____

1. Have the following changed in the past five (5) years? If yes, please identify and explain change(s), dates and whether or not tail was purchased in the Remarks Section.

| | |
|---|---|
| Limits of liability | ☐Yes ☐No |
| Specialty | ☐Yes ☐No |
| Surgery: No/Minor/Major | ☐Yes ☐No |
| Procedures | ☐Yes ☐No |
| Locations | ☐Yes ☐No |

2. Will you be performing activities covered by another professional liability policy? ☐Yes ☐No
If yes, please explain in the Remarks section.

**COVERAGE HISTORY**

Please list all prior medical professional liability insurers for the past 10 years, or, if the retroactive date is more than 10 years old, back to that date. Please explain any gaps in Remarks section.

| Coverage Period Mm/dd/yyyy | Insurer | Coverage Type | Limits | Premium | Bought Tail? |
|---|---|---|---|---|---|
| From:<br>To: | | ☐Occurrence<br>☐Claims-made<br>Retro: | ☐Shared<br>☐Separate | $ | ☐ Yes<br>☐ No |
| From:<br>To: | | ☐Occurrence<br>☐Claims-made<br>Retro: | ☐Shared<br>☐Separate | $ | ☐ Yes<br>☐ No |
| From:<br>To: | | ☐Occurrence<br>☐Claims-made<br>Retro: | ☐Shared<br>☐Separate | $ | ☐ Yes<br>☐ No |
| From:<br>To: | | ☐Occurrence<br>☐Claims-made<br>Retro: | ☐Shared<br>☐Separate | $ | ☐ Yes<br>☐ No |

## SECTION IV: ENTITY/ORGANIZATION

1. Indicate which practice organization applies to you:
   ☐ Solo Unincorporated ☐ Independent Contractor ☐ Government Employee
   ☐ Solo Corporation ☐ Corporate Shareholder ☐ Employee
   ☐ Partner or Partnership ☐ Other

2. Name of Entity/Organization: _____

3. Is coverage desired for this Entity/Organization? ☐ Yes ☐ No

   If yes: Limit Type: ☐ Shared ☐Separate

   If Separate, an Entity/Organization application is required. Note: Separate entity limits are not available in all states.

4. Is there any other name under which you practice (DBA, unincorporated or trade name)? ☐ Yes ☐ No

   If yes, please provide all names: _____

5. Do you currently employ, independently contract or otherwise maintain an association with any other healthcare providers? ☐ Yes ☐ No

   If yes, please provide the number of each below. If coverage is desired, a separate application is required for each provider.

☐ Check this box if you have included a current roster in place of completing the table below.

| Name | # Employed | # Contracted | # Supervise Only | Coverage Requested |
|---|---|---|---|---|
| Physicians and Surgeons | | | | ☐ Yes ☐ No |
| Podiatrists | | | | ☐ Yes ☐ No |
| Dentists | | | | ☐ Yes ☐ No |
| Interns/Residents/Fellows | | | | ☐ Yes ☐ No |
| CRNAs | | | | ☐ Yes ☐ No |
| Certified Nurse Midwives | | | | ☐ Yes ☐ No |
| Nurse Practitioners | | | | ☐ Yes ☐ No |
| Physician Assistants | | | | ☐ Yes ☐ No |
| Chiropractors | | | | ☐ Yes ☐ No |

6. Please provide the coverage information below for all healthcare providers you employ, contract or otherwise associate with, for which coverage is NOT desired OR attach a copy of their current Declarations page or Certificate of Insurance.

| Name | Specialty | Insurer | License # | Association | Start Date |
|---|---|---|---|---|---|
| | | | | ☐ Employed<br>☐ Supervise<br>☐ Contracted<br>☐ Other | |
| | | | | ☐ Employed<br>☐ Supervise<br>☐ Contracted<br>☐ Other | |
| | | | | ☐ Employed<br>☐ Supervise<br>☐ Contracted<br>☐ Other | |

## SECTION V: PRACTICE INFORMATION

**SPECIALTY/CERTIFICATION**

| | | | | |
|---|---|---|---|---|
| Primary Specialty | % of practice | ☐ Board Certified<br>☐ Board Eligible<br>☐ Neither | Certifying Board | Date |
| Subspecialty 1 | % of practice | ☐ Board Certified<br>☐ Board Eligible<br>☐ Neither | Certifying Board | Date |

| Subspecialty 2 | % of practice | ☐ Board Certified<br>☐ Board Eligible<br>☐ Neither | Certifying Board | Date |
|---|---|---|---|---|

Have you ever failed a board examination? ☐Yes ☐No
If yes, how many times? Please explain in the Remarks section.

**PRACTICE LOCATIONS**

| Primary Practice/Hospital Name | | % of practice | Specialty | | Start Date |
|---|---|---|---|---|---|
| Street Address | City | | County | State | Zip |
| Practice/Hospital Name | | % of practice | Specialty | | Start Date |
| Street Address | City | | County | State | Zip |
| Practice/Hospital Name | | % of practice | Specialty | | Start Date |
| Street Address | City | | County | State | Zip |

Do you practice at any other locations for which you request coverage under this application?
☐Yes ☐No If yes, please provide name, % of practice, start date and address in Remarks.

Do you practice at any other locations that are insured elsewhere? ☐Yes ☐No
If yes, please provide name, % of practice, start date and address in Remarks.

Please indicate the state(s) in which you hold a license to practice medicine:

| State | Location | % of Practice | Status |
|---|---|---|---|
| | | | ☐Active ☐Inactive ☐Temporary ☐ Pending |
| | | | ☐Active ☐Inactive ☐Temporary ☐ Pending |
| | | | ☐Active ☐Inactive ☐Temporary ☐ Pending |
| | | | ☐Active ☐Inactive ☐Temporary ☐ Pending |

Do you perform consultations, render medical services or opinions, or give medical advice outside the state of your primary location, including but not limited to Telemedicine? If yes, list state(s): _____

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**PROCEDURES**

Please check the box indicating the extent of surgery you perform:

☐ **No Surgery** except incisions of boils, cysts, circumcisions (newborns) or other superficial abscesses or suturing minor lacerations

☐ **Minor Surgery** includes most procedures performed under local anesthesia; or assisting in major surgery on your own patients

☐ **Major Surgery** includes major surgical procedures done under general, spinal or caudal anesthesia; or assisting in major surgery on other than your own patients

If you assist in surgery, please indicate the number of procedures performed annually:
Assisting in major surgery on own patients: # per year: _____
Assisting in major surgery on other than own patients: # per year: _____

Please check the procedures which you perform for which you are requesting coverage or that you have performed in the last 5 years.

☐ Abdominoplasty
☐ Abortion
Trimester: ☐ 1st ☐ 2nd ☐ 3rd
☐ Elective % of practice: ____
☐ Therapeutic % of practice: ____
☐ Acupuncture
☐ Addiction Medicine
☐ Suboxone Therapy
☐ Anesthesia (General/Spinal/Caudal)
☐ Angiography/Arteriography
☐ Angioplasty
☐ Appendectomy
☐ Arthroscopy
☐ Bariatric Surgery
☐ Gastric Bands # Per Year ____
☐ Bypass or Staples # Per Year ____
☐ Gastric Sleeve # Per Year ____
☐ Other # Per Year ____
☐ Botox # Per Year ____
☐ Bronchoscopy
☐ Cardiac Catheterization
☐ Left Heart
☐ Right Heart (other than Swan Ganz/CVP lines)
☐ Chelation Therapy
☐ Cryosurgery (non-external lesions)
☐ D&C
☐ Dermatology
☐ Cool Sculpting
☐ Chemabrasion/Dermabrasion
☐ Chemical Peels
☐ Deep ☐ Superficial
☐ Hair Transplants
☐ Liposuction/Lipoinjection
☐ Silicone Injections
☐ Skin Flaps/Grafts
☐ Endoscopic Procedures
☐ Sigmoidoscopy only
☐ Other than Sigmoidoscopy
☐Laser Therapy
☐ Fertility/Infertility Treatment
☐ Fracture Reductions
☐ Open
☐ Closed
☐ General Surgery
☐ Hysterectomy
☐ IV Hydration Therapy (Mobile)
☐ Laparoscopy
☐ Lithotripsy
☐ Medical Marijuana
☐ Morcellation, Power
☐ Needle Biopsy
Type: _____

Continues on next page

☐ Obstetrics ☐ Performing ☐ Assist only
- ☐ C-Sections # per year ____
- ☐ Vaginal Births # per year ____
- ☐ VBACs # per year ____
- ☐ Prenatal Care
  - ☐ Including 1st Trimester only
  - ☐ Including 1st and 2nd Trimesters
  - ☐ Prenatal to term, no delivery
  - ☐ Prenatal to term, and delivery

☐ Orthopedics
- ☐ Including Spine % of practice ____
- ☐ No Spine % of practice ____

☐ Pain Management
- ☐ Medication only
- ☐ Nerve Block (Spinal, Paraspinal, Paravertebral, Epidural)
- ☐ Nerve Block (Other)
- ☐ Pain TEQ
- ☐ Spinal Cord Stimulators
- ☐ X-stop | ☐ Superion Procedures
- ☐ Verteflex Spinal Implants
- ☐ Implants (including Intrathecal Pumps)
- ☐ Lumbar Fusion
- ☐ SI Joint Fusion | ☐ SI Fusion

☐ Permanent Pacemakers

☐ Plastic Surgery
- ☐ Cosmetic % of practice ____
- ☐ Reconstructive % of practice ____

☐ Prolotherapy

☐ Radiology
- ☐ Interventional
- ☐ Radiopaque Dye
- ☐ Radiation/X-Ray Therapy

☐ Renal Dialysis

☐ Sclerotherapy

☐ Spinal Surgery

☐ Telemedicine % of practice ____

☐ Tonsillectomy/Adenoidectomy

☐ Transgender Surgery

☐ Trauma Surgery % of practice ____

☐ Tubal Ligations

☐ Weight Control Medication % of practice ____

☐ Weight Control Surgery % of practice ____

☐ Vasectomies

☐ Wound Care
- ☐ Hyperbaric Medicine
- ☐ Surgical Debridement

☐ Other Medical/Procedural Techniques not listed above (please describe in REMARKS and provide %) ____

Do you perform any procedures that are covered by other insurance? ☐Yes ☐No

Do you participate in clinical trials that are not FDA or IRB approved? ☐Yes ☐No

Please provide descriptions of any Yes answer(s) above, along with any comments that will help us to better understand your practice:

## SECTION VI: CLAIMS INFORMATION

1. Within the past 10 years, has any claim or suit for alleged malpractice been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No
   If yes, complete the following and a Claim Supplement Form for each claim, suit or incident and provide loss runs for the past 10 years or from the date you began practicing medicine if less than 10 years ago.

| Total # of Claims and Suits | # Open | # Closed |
|---|---|---|
| Total # of Incidents: | # Open | # Closed |

2. Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you? ☐Yes ☐No

   If yes, has it been reported to your current insurer? ☐Yes ☐No
   If not report it immediately to your current insurer. Our policy will not provide coverage for this incident.

   If you answered Yes to #1 or #2 above, please complete the Claim Supplement for each such circumstance, attaching additional sheets as necessary.

3. Have you made any changes to your practice as a result of any claims, suits or incidents? ☐ Yes ☐ No

   If yes, please explain:

## SECTION VII: ADDITIONAL INFORMATION

1. Has your medical professional liability insurance ever been declined, non-renewed or cancelled, including cancellation for nonpayment of premium? (Not applicable to Missouri applicants) ☐ Yes ☐ No

2. Has your medical professional liability insurance ever been surcharged, reduced or issued with a deductible or other special terms? ☐ Yes ☐ No

3. Have you been charged or convicted of any crime other than minor traffic violations? ☐ Yes ☐ No

4. Have you ever had your medical or DEA license revoked, limited, refused, suspended or denied? ☐ Yes ☐ No

5. Have your hospital privileges ever been surrendered, limited or revoked, whether voluntarily or involuntarily? ☐ Yes ☐ No

6. Have your hospital privileges been expanded or reduced in the last 12 months? ☐ Yes ☐ No

7. Has membership of any Professional Association or Society ever been refused, revoked or limited in any way? ☐ Yes ☐ No

8. Have you ever had a complaint filed, been censured, or had a private reprimand with a County or State Medical Society? ☐ Yes ☐ No

9. During the past year, have you incurred or become aware of having an illness or physical disability that impairs, or could impair, your ability to practice medicine? ☐ Yes ☐ No
   If yes, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.

10. Have you ever been treated for alcoholism, narcotic addiction or mental impairment? ☐ Yes ☐ No
    If yes, provide the details and dates of the treatment/ rehabilitation program.

11. Have you ever been accused of sexual misconduct? ☐ Yes ☐ No

12. Have you treated on a regular basis, or will you regularly treat, celebrities or collegiate/semi-professional/professional athletes? ☐ Yes ☐ No

13. Have you practiced or will you practice at a prison, correctional facility, or other similar facility, or have you or will you provide professional healthcare services to prisoners or inmates? ☐ Yes ☐ No

14. Do you use any non-FDA approved devices, drugs or procedures? ☐ Yes ☐ No

15. Do you provide healthcare professional services at any skilled nursing or long-term care facility to patients other than your own? ☐ Yes ☐ No

16. Do you have any medical director, management or similar responsibilities at or on behalf of any entity(ies)/organization(s) that are not an insured under this policy? ☐ Yes ☐ No

## SECTION VIII: REMARKS

Please provide any additional information/explanations for your application, below.

## AGREEMENT AND NOTICES

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.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any Attachments, shall be the basis of the contract with Positive Physicians Insurance Company (the "Company"). I have also made a reasonable inquiry, where appropriate, to ensure the responses here are as complete and accurate as possible. I agree to notify the Company if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

All information requested in this application is considered material and important. I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

To the fullest extent permitted by law, I extend absolute immunity to and release the Company, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

☐ If this box is checked, I do not wish to receive notices or policy documents in an electronic format and prefer to receive physical policies and documents through the U.S. mail.

Name (printed): _____

Applicant's Signature: _____ Date: _____

*This application is not valid without your complete signature.*

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## CLAIM / SUIT / INCIDENT SUPPLEMENT

Complete this form or attach a detailed narrative with the following information for each claim or suit brought against you, and each incident that you have reported within the past 10 years. Additional information may be requested.

| Patient Name | Age | ☐Male ☐Female |
|---|---|---|
| Relationship to patient (ex: attending, consulting, primary or assisting surgeon): | | |
| Incident Date (mm/dd/yy) | Incident Location | |
| Insurer: | Date Reported to Insurer (mm/dd/yy) | |
| ☐Suit ☐Notice of Intent to Sue ☐Demand for Money ☐Records Request<br>☐Incident Only ☐Other, please identify: | | |

Conditions and diagnosis at time of incident:

Description of treatment rendered, including dates:

Condition of patient subsequent to professional services:

Allegations:

Other persons and entities involved:

Status/Disposition:

☐ Open Indemnity and Expenses Reserved:

☐ Closed Date Closed:

- ☐ Closed without payment
- ☐ Settled
- ☐ Judgment/Verdict for Defense Loss Paid: Expenses Paid:
- ☐ Judgment/Verdict for Plaintiff Loss Paid: Expenses Paid:

Has there been a change in practice as a result of this claim, suit or incident? ☐ Yes ☐ No If yes, please explain:

I understand this information is part of my application:

Signature Printed Name Date

# MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FRAUD NOTIFICATIONS

*This Supplement forms a part of the application for medical professional liability insurance coverage with Positive Physicians Insurance Company.*

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.

Fraud Warning by State:

**Notice to Alabama Residents:** 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 restitution fines or confinement in prison, or any combination thereof.

**Notice to Alaska Residents:** 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 Residents:** For your protection Arizona law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

**Notice to Arkansas Residents:** Any person who knowingly presents a false or fraudulent claim for payment for 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 Residents:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Notice to Colorado Residents:** 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 Residents:** 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 Residents:** 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 Residents:** 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 Residents:** 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 Residents:** Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or missing information commits a felony.

**Notice to Kansas Residents:** Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

**Notice to Kentucky Residents:** 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 Louisiana Residents:** 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 Maine Residents:** 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 denial of insurance benefits.

**Notice to Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to Minnesota Residents:** A person who files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.

**Notice to Missouri Residents:** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

**Notice to New Hampshire Residents:** 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 Residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Notice to New Mexico Residents:** 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 Residents:** 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 Residents:** Any person who, with intent to defraud or knowing that he or she 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 Residents:** 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. The absence of such a statement shall not constitute a defense in any prosecution.

**Notice to Oregon Residents:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**Notice to Pennsylvania Residents:** 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 Rhode Island Residents:** 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 Tennessee Residents:** 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 Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Notice to Virginia Residents:** 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, denial of insurance benefits, and civil damages.

**Notice to Washington Residents:** 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 West Virginia Residents:** 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.