Aspen American Insurance Company
499 Washington Blvd, 8th Floor
Jersey City, NJ 07310

Dentists Choice

LIABILITY INSURANCE APPLICATION FOR INDIVIDUAL DENTISTS

THIS IS AN APPLICATION FOR OCCURRENCE AND/OR CLAIMS-MADE INSURANCE, NOT AN INSURANCE BINDER. COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED. PLEASE CONTACT YOUR AGENT IF YOU HAVE ANY QUESTIONS REGARDING THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE AS WELL AS FOR DETAILED INFORMATION REGARDING EXTENDED REPORTING PERIODS AS IT RELATES TO CLAIMS-MADE COVERAGE.

PLEASE ANSWER ALL QUESTIONS UNLESS OTHERWISE INSTRUCTED. APPLICATION MUST BE SIGNED BY THE APPLICANT.

REQUESTED EFFECTIVE DATE: _____

PRIMARY INFORMATION

Full Name _____ ☐ DDS ☐ DMD ☐ MD ☐ BDS ☐ MS
Office Telephone _____Mobile Number _____
Mailing Address _____
Primary Practice State _____
Practice Website(s)_____
NPI Number _____ Date Of Birth _____
Email _____
Opt-in for quarterly risk management newsletter (email) ☐ YES ☐ NO

FORMAL TRAINING AND RECENT PRACTICE HISTORY

Did you complete a formal residency program? ☐ YES ☐ NO

Specialty (please indicate your specialty below, check any that apply):

☐ GENERAL DENTISTRY	☐ ORTHODONTICS	☐ ENDODONTICS	☐ PEDIATRIC DENTISTRY
☐ PERIODONTICS	☐ PROSTHODONTICS	☐ ORAL PATHOLOGY	☐ ORAL RADIOLOGY
☐ ORAL MEDICINE	☐ OROFACIAL PAIN	☐ PUBLIC HEALTH	☐ FORENSIC DENTISTRY
☐ DENTAL ANESTHESIOLOGY	☐ ORAL SURGERY		

In the **past three years**, did any of the following apply to you:

☐ Entered practice for the **first time** after completion of formal training (dental school or residency program)*
*If you are **now** entering practice for the **first time** after completion of formal training (dental school or residency program) do you wish to purchase a two-year occurrence professional liability insurance policy for $250? ☐ YES ☐ NO

☐ Received honorable military discharge and entered private practice for the **first time**

☐ A foreign dental school graduate who established U.S. based practice for the **first time**

☐ A public service sector dentist who entered private practice for the **first time**

If any of the above were selected, indicate the year such **first time** practice began: _____

PRACTICE PROFILE

☐ PRACTICE OWNER ☐ EMPLOYEE DENTIST ☐ INDEPENDENT CONTRACTOR DENTIST
☐ VOLUNTEER ONLY ☐ FULL-TIME FACULTY (NON-INTRAMURAL)

If "volunteer only", do you receive any remuneration? ☐ YES ☐ NO
If "volunteer only", describe your volunteer services: _____
_____

PLEASE LIST YOUR PRACTICE LOCATIONS (PLEASE USE A SEPARATE SHEET IF NEEDED)

List your practice addresses **starting with** your primary practice location:

STREET	CITY	STATE	ZIP CODE
STREET	CITY	STATE	ZIP CODE
STREET	CITY	STATE	ZIP CODE

PRACTICE HOURS

Indicate the practice hours for which you are applying for coverage. Please note that practice hours include **all** administrative duties, record keeping, lab work, patient visitations and consultations.

PRACTICE HOURS TYPE	DESCRIPTION	
FULL TIME	MORE THAN 20 HOURS PER WEEK.	☐ YES ☐ NO
PART TIME*	20 HOURS OR LESS PER WEEK	☐ YES ☐ NO
MOONLIGHTING*	10 HOURS OR LESS PER WEEK **AND** MUST BE FOR A SECOND JOB.	☐ YES ☐ NO

***If** Part-Time or Moonlighting types were selected above, do you agree to make your work schedule, office schedule (or other documentation necessary to confirm your practice hours) available to us in the event we perform a verification of your part-time or moonlighting status? ☐ YES ☐ NO ☐ N/A

PLEASE TELL US ABOUT YOUR PROFESSIONAL SERVICES

1. **IMPORTANT:** Please identify the procedures you perform **and** the corresponding informed consent type(s) and training specific to any procedure you perform:

PROCEDURE	DO YOU PERFORM?	INFORMED CONSENT TYPE	TRAINING
MOLAR ENDODONTICS ON PERMANENT TEETH	☐ YES ☐ NO	☐ WRITTEN ☐ ORAL ☐ NONE	☐ CE ☐ POST GRAD ☐ DENTAL SCHOOL
IMPACTED THIRD MOLAR EXTRACTIONS (FULL OR PARTIAL)	☐ YES ☐ NO	☐ WRITTEN ☐ ORAL ☐ NONE	☐ CE ☐ POST GRAD ☐ DENTAL SCHOOL
SURGICAL PLACEMENT OF FULL-ARCH IMPLANTS	☐ YES ☐ NO	☐ WRITTEN ☐ ORAL ☐ NONE	☐ CE ☐ POST GRAD ☐ DENTAL SCHOOL
SURGICAL PLACEMENT OF IMPLANTS (OTHER THAN FULL-ARCH)	☐ YES ☐ NO	☐ WRITTEN ☐ ORAL ☐ NONE	☐ CE ☐ POST GRAD ☐ DENTAL SCHOOL
TREATMENT OF TMJ DISORDERS	☐ YES ☐ NO	☐ WRITTEN ☐ ORAL ☐ NONE	☐ CE ☐ POST GRAD ☐ DENTAL SCHOOL

2. If “oral” informed consent is indicated above for any procedure, is the patient record noted/charted accordingly? ☐ YES ☐ NO ☐ N/A

3. Do you obtain a complete medical/dental health history for all new patients in your practice? ☐ YES ☐ NO

4. Do you now (or have you in the past **five years**) provide professional services in any of the following settings?

MEDI-SPA	☐ YES ☐ NO	K – 12 SCHOOL	☐ YES ☐ NO
CORRECTIONAL FACILITY	☐ YES ☐ NO	NURSING HOME FACILITY	☐ YES ☐ NO
HOSPITAL/URGENT CARE CENTER	☐ YES ☐ NO	MOBILE DENTISTRY	☐ YES ☐ NO

For any setting identified above, please describe specific services rendered: _____
_____
_____

5. Do your professional services include:

Holistic or alternative dental services? If **"Yes",** complete a Holistic Dental Services Questionnaire.	☐ YES ☐ NO
Elective cosmetic dermal procedures? If **"Yes",** complete an Elective Cosmetic Dermal Questionnaire.	☐ YES ☐ NO
Treatment of sleep apnea without a physician referral? If **"Yes",** please provide an explanation _____ _____	☐ YES ☐ NO
Treatment of patients under oral conscious sedation in your office?	☐ YES ☐ NO
Treatment of patients under IV or IM conscious sedation in your office?	☐ YES ☐ NO
Treatment of patients under general anesthesia or deep sedation in your office? If **"Yes",** who administers the anesthesia: ☐ YOURSELF ☐ ANOTHER LICENSED PROFESSIONAL	☐ YES ☐ NO
Use of dental cone-beam computed tomography (CBCT) imaging?	☐ YES ☐ NO
Teledentistry?	☐ YES ☐ NO
Services you render on behalf of a temporary staffing agency?	☐ YES ☐ NO
Services you render as a locum tenens?	☐ YES ☐ NO

PLEASE TELL US ABOUT YOUR PROFESSIONAL PROFILE, INSURANCE AND CLAIMS HISTORY

6. Are you a board-certified member in your specialty and in good standing? ☐ YES ☐ NO

7. Are you a member of your state dental association or society? ☐ YES ☐ NO

8. Have you completed a risk management course or seminar given by an ADA CERP or PACE Provider within the past 3 years? ☐ YES ☐ NO
if **"Yes",** provide the year of completion: _____

9. In the last **five** years:

Have your hospital privileges been involuntarily revoked, suspended or otherwise terminated?	☐ YES ☐ NO
Has a government agency, including a state licensing board, investigated or taken action against your dental and/or narcotics license, including suspension, revocation, probation, restriction, denial and/or other sanction?	☐ YES ☐ NO
Have you been charged with or convicted of any criminal charges (including a DUI, OWI, etc.) **Not** including minor traffic violations?	☐ YES ☐ NO
Have you been treated for alcoholism, drug addiction, mental illness or physical impairment?	☐ YES ☐ NO
Have you or your legal entity had any allegations, convictions or fines for Medicaid fraud?	☐ YES ☐ NO
Have you practiced without professional liability coverage?	☐ YES ☐ NO
Has your professional liability insurance been refused, canceled or non-renewed? (N/A in MO)	☐ YES ☐ NO

Please provide an explanation to any **"yes"** response above: _____
_____

10. Are you re-entering clinical practice now after a gap or absence from active clinical practice that has lasted **two or more** years? If **"yes",** please complete the gap in practice questionnaire. ☐ YES ☐ NO

11. Will you provide dental services that will be covered by another professional liability policy? ☐ YES ☐ NO
If **"Yes",** please explain: _____
_____

12. Have you maintained continuous professional liability insurance coverage for **at least five years** prior to the requested effective date of this policy? (Used to determine eligibility for claims free credit) ☐ YES ☐ NO

A. If **"No",** how many years of continuous professional liability insurance coverage do you have prior to the requested effective date of this policy? _____

B. Please list your current professional liability insurance company. If **none,** then state "none":
_____

13. In the past **five years**, has a dental malpractice claim or suit been filed against you? ☐ YES ☐ NO
If **"Yes",** please complete a claim supplement.

14. Are you currently aware of any circumstance, act or omission that could reasonably lead to a malpractice claim or suit (hereinafter referred to as a **"known incident"**) against you, your legal entity or anyone for whom you are legally responsible? ☐ YES ☐ NO
If **"Yes",** please complete a claim supplement.
If **"Yes",** have you reported such "known incident" to your current insurer? ☐ YES ☐ NO ☐ N/A

NOTICE: Without prejudice to any other rights and remedies of the company, you understand and agree that if a "known incident" exists, whether or not disclosed above, any claim or suit arising from such "known incident" is excluded under any policy issued by the company.

Report all "known incidents" to your current professional liability insurer.

PRACTICE OWNER SECTION

Only complete this section if you are a practice owner. If you are not a practice owner, please proceed to Question 21.

15. Will all dentists with ownership in your practice be insured with us? ☐ YES ☐ NO
If **"No",** please list the names and ownership percentages of those practice owners who will not be insured with us:

NAME	OWNERSHIP PERCENTAGE

16. Do you employ (W2) dentists to provide services for your practice? ☐ YES ☐ NO

A. If **"Yes",** will all employee dentists be insured with us? ☐ YES ☐ NO

B. If **"No"** to **16a.**, please indicate the number of your employee dentists (by provider type) who will maintain professional liability insurance with a different company:

Please note that additional vicarious liability charges will apply to you for the vicarious liability exposure you have for any employee dentist in your practice not insured with us.

EMPLOYEE DENTISTS NOT INSURED WITH US	# FULL-TIME	# PART-TIME*
DENTISTS (OTHER THAN ORAL SURGEONS AND ANESTHESIOLOGISTS)		
ORAL SURGEONS		
DENTAL ANESTHESIOLOGISTS		

*Part-time is considered an average of 20 hours or less per week.

C. Do you collect and keep on file **current proof of professional liability insurance** for all employee dentists in your practice? ☐ YES ☐ NO

17. Do you contract with (1099) independent contractor dentists and/or anesthesia providers to render professional services **in your office(s)**? ☐ YES ☐ NO

A. If **"Yes",** estimate the average number of hours per week such independent contractor (IC) dentists and/or anesthesia providers render services **in your office(s)**: _____

B. If **"Yes",** do you have written contracts with such dentists and/or anesthesia providers? ☐ YES ☐ NO

C. If **"Yes"** to **17b**., do your contracts include hold harmless clauses that indemnify you for the actions of such dentists and providers? ☐ YES ☐ NO ☐ I DON'T KNOW

D. Do you collect and keep on file **current proof of professional liability insurance** for all IC dentists and anesthesia providers rendering professional services in **your office(s)?** ☐ YES ☐ NO

18. Do you operate a dental laboratory? ☐ YES ☐ NO
If **"Yes",** are referrals from patients outside your practice accepted? ☐ YES ☐ NO

19. Does your practice provide radiology / imaging services to patients outside your practice? ☐ YES ☐ NO
If **"Yes",** please explain: _____
_____

20. Indicate the percentage of your annual practice revenues in each of the following market segments:

MARKET SEGMENT	PRACTICE REVENUE PERCENTAGE
PRIVATE INSURANCE	
MEDICARE	
MEDICAID	
FEE-BASED (NO INSURANCE)	

PLEASE TELL US ABOUT YOUR LIABILITY COVERAGE NEEDS

PROFESSIONAL LIABILITY COVERAGE:

21. Select **one** of the claims-made **or** occurrence limits options below.

CLAIMS-MADE (STATE EXCEPTIONS MAY APPLY)	**OR**	**OCCURRENCE**
☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $3,000,000 ☐ $2,000,000 / $4,000,000 ☐ $2,000,000 / $6,000,000 ☐ $3,000,000 / $3,000,000 ☐ $3,000,000 / $6,000,000 ☐ $4,000,000 / $4,000,000 ☐ $5,000,000 / $5,000,000 ☐ $5,000,000 / $6,000,000 ☐ $5,000,000 / $8,000,000 ☐ OTHER: _____		☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $2,000,000 ☐ $2,000,000 / $6,000,000 ☐ OTHER: _____

22. If claims-made is desired, please indicate your desired prior acts date: _____
*If your prior acts date is earlier than the effective date of this application, then you must submit a current professional liability declarations page showing your prior acts date.

23. Do you work for, or contract with, an entity that requires you to name it as an "additional insured" on your professional liability insurance policy? ☐ YES ☐ NO
If **"Yes",** please enter name of entity to be listed as additional insured: _____
if **"Yes",** please provide a copy of your employment contract.

24. Please schedule below your practice entities for professional liability coverage. Do not include real estate or non-practice entities in this section who do not require malpractice coverage.
Mark **"N/A"** for "prior acts" if you have selected occurrence coverage. Please note that an additional charge applies for separate limits of insurance. Shared limits of insurance are **not** available in every state.

LEGAL ENTITY NAME	**STATE**	**FEIN**	**LIMITS OF LIABILITY**
			☐ SHARED OR ☐ SEPARATE **IF** SEPARATE, ENTER PRIOR ACTS DATE*: _____
			☐ SHARED OR ☐ SEPARATE **IF** SEPARATE, ENTER PRIOR ACTS DATE*: _____

*If prior acts coverage is desired, include a current professional liability dec page

A. Is every legal entity requesting **separate limits** professional coverage majority owned by a licensed dentist(s)? ☐ YES ☐ NO ☐ N/A
If **"No",** please explain: _____

B. Is the sole function/purpose of each legal entity listed in the schedule above, for the practice of dentistry? ☐ YES ☐ NO
If **"No",** please explain: _____

C. Do you desire that one of the legal entities listed above also be listed as the **First Named Insured** on this policy? ☐ YES ☐ NO

If **"Yes",** please list such entity here: _____

Please confirm entity type: ☐ PARTNERSHIP ☐ CORPORATION ☐ LLC ☐ LLP ☐ PC/PA ☐ OTHER _____

EMPLOYMENT PRACTICES LIABILITY COVERAGE:

25. Do you desire employment practices liability coverage?

☐ None Desired

☐ $25,000 Defense-Only Limit

☐ Higher defense and indemnity limit desired (separate application required)

COMMERCIAL GENERAL LIABILITY / ERISA FIDUCIARY & EMPLOYEE BENEFIT LIABILITY COVERAGE:

26. Do you desire commercial general liability coverage? ☐ YES ☐ NO

If **"Yes"**, please complete questions 27 - 34. If **"No"**, proceed to signature page.

Please note that ERISA Fiduciary & Employee Benefit Liability coverage is only available if Commercial General Liability coverage is purchased.

27. Please select a commercial general liability limit of insurance:

☐ $1,000,000 / $2,000,000 ☐ $2,000,000 / $4,000,000

☐ $1,000,000 / $3,000,000 ☐ OTHER: _____

28. Do you desire a separate aggregate General Liability limit of insurance per location? ☐ YES ☐ NO

29. Do you desire to increase the standard $500,000 limit for Fire / Water Legal Liability? ☐ YES ☐ NO

If **"Yes",** select the desired limit: ☐ $750,000 ☐ $1,000,000

30. Do you desire hired auto physical damage coverage with a limit of $75,000? ☐ YES ☐ NO

31. Have you had any commercial general liability claims in the past 5 years? ☐ YES ☐ NO

If **"Yes",** please complete a claim supplement.

32. Do you desire to increase ERISA Fiduciary / Employee Benefits Liability (EBL) coverage above the standard $25,000 limit? Coverage is recommended if you sponsor an employee benefit plan. Please note that this is **not** the bond for your pension plan. Coverage is written on a claims made basis. ☐ YES ☐ NO

IF **"YES",** PLEASE COMPLETE THE FOLLOWING:

A. Total Number of Employees In Your Practice: _____

B. ERISA Fiduciary / EBL Prior Acts Date: _____

C. ERISA Fiduciary / EBL Limit of Insurance:

☐ $100,000 ☐ $250,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000

D. Have you had any ERISA Fiduciary / EBL claims in the past 5 years? ☐ YES ☐ NO

If **"Yes",** please complete a claim supplement.

33. Do you have ownership in any real estate or non-practice entities for which Employment Practices Liability, General Liability or ERISA Fiduciary / Employee Benefits Liability coverage is desired? ☐ YES ☐ NO

If **"Yes",** please complete the schedule below. For business purpose, please describe the purpose of the entity:

LEGAL ENTITY NAME	STATE	FEIN	BUSINESS PURPOSE

34. If you have an agreement that requires you to name an entity as an additional insured for general liability purposes, please identify the type of agreement below as well as the name and address of the entity as it appears in your contract/agreement:

TYPE OF CONTRACT	ENTITY NAME/ADDRESS	INSURED LOCATION ADDRESS	DESCRIPTION
☐ LANDLORD ☐ EQUIPMENT LEASE ☐ LOSS PAYEE ☐ OTHER			
☐ LANDLORD ☐ EQUIPMENT LEASE ☐ LOSS PAYEE ☐ OTHER			

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

[**NOTICE TO APPLICANTS OF ALL U.S. JURISDICTIONS EXCEPT CALIFORNIA, COLORADO, DISTRICT OF COLUMBIA, FLORIDA, KANSAS, KENTUCKY, LOUISIANA, MAINE, MARYLAND, MINNESOTA, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE AND VERMONT, VIRGINIA**: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

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 FOR INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

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

NOTICE TO NOTICE TO FLORIDA APPLICANTS: 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 of the third degree.

NOTICE TO 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 statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy, or a claim for payment or other benefit pursuant to an insurance policy 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 crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

NOTICE TO KENTUCKY, OHIO AND PENNSYLVANIA 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 and subjects such person to criminal and civil penalties.

NOTICE TO LOUISIANA 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 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.

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 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 solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

NOTICE TO PUERTO RICO APPLICANTS: The Entity understands that according to the Insurance Code of Puerto Rico (Article 27.320): “Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, it will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with a pain of no smaller fine of five thousand ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or, both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2).

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 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.]

AUTHORIZATION AND REPRESENTATIONS

I hereby represent and acknowledge that the aforementioned statements and answers are correct and complete. I agree that any coverage issued will be contingent upon the truth of the preceding information. I further understand that any incorrect or incomplete statement could invalidate my coverage. I hereby authorize the company to release the information on this application and associated underwriting information.

_____ _____

APPLICANT SIGNATURE **DATE**

_____ _____

AGENT'S SIGNATURE **DATE**

If you apply your signature to this application electronically, you hereby consent and agree that your use of a keypad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

REMINDER TO INCLUDE:

- ☐ Copy of Prior Carrier Declarations Page, if applicable.
- ☐ Holistic Questionnaire, if applicable.
- ☐ Elective Cosmetic Dermal Questionnaire, if applicable.
- ☐ Gap In Practice / Gap in Coverage Questionnaire, if applicable.
- ☐ Employment practices liability (EPLI) supplemental application, if requesting higher limits for EPLI
- ☐ **"Yes"** responses to certain questions require attachment of additional documents/information.
- ☐ Claim supplement(s), if applicable.

PRE-FILL AGENCY INFORMATION

RETURN TO:

AGENT NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE #: _____ AGENT'S LICENSE NUMBER: _____