Copic Application for Medical Professional Liability Insurance

Allied Health Provider Application

Individual Limit of Liability

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

With your completed application, you are required to submit the following information:

- Current declarations page which provides a retroactive date and indicates limits of liability for which you are requesting coverage.
- A list of all organizations you would like listed as certificate holders for your coverage.
- Current business letterhead and advertisements (including website material).
- Curriculum Vitae (C.V.) – Please provide an explanation for any gap in practice greater than 90 days in length.
- A loss run report. To obtain this information, please call your prior carrier(s) and request a currently-valued loss run for the past ten (10) years.

Additional information may be requested.

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DISCLOSURE FORM CLAIMS-MADE POLICY
IMPORTANT NOTICE TO POLICYHOLDER

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT DESCRIBES SOME OF THE MAJOR FEATURES OF OUR CLAIMS-MADE POLICY FORM. READ YOUR POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

YOUR POLICY

Your policy is a claims-made policy. It provides coverage only for injury or damage occurring after the policy retroactive date (if any) shown on your policy and the incident is reported to your insurer prior to the end of the policy period. Upon termination of your claims-made policy an extended reporting period option is available from your insurer.

There is no difference in the kind of injury or damage covered by occurrence or claims-made policies. Claims for damages may be assigned to different policy periods, depending on which type of policy you have.

If you make a claim under your claims-made policy, the claim must be a demand for damages by an injured party and does not have to be in writing. Under most circumstances, a claim is considered made when it is received and recorded by you or by us. Sometimes, a claim may be deemed made at an earlier time. This can happen when another claim for the same injury or damage has already been made, or when the claim is received and recorded during an extended reporting period.

PRINCIPAL BENEFITS

This policy provides for defense and indemnification of covered claims arising from medical incidents and for defense costs only for covered proceedings up to the maximum dollar limit specified in the policy. This policy provides for unlimited defense costs only for covered peer review incidents.

The principal benefits and coverages are explained in detail in your claims-made policy. Please read it carefully and consult your insurance producer about any questions you might have.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS

Your claims-made policy contains certain exceptions, reductions and limitations. Please read them carefully and consult your insurance producer about any questions you might have.

RENEWALS AND EXTENDED REPORTING PERIODS

Your claims-made policy has some unique features relating to renewal, extended reporting periods and coverage for events with long periods of potential liability exposure. If there is a retroactive date in your policy, no event or occurrence prior to that date will be covered under the policy even if reported during the policy period. It is therefore important for you to be certain that there are no gaps in your insurance coverage. These gaps can occur in several ways. Among the most common are:

1. If you switch from an occurrence policy to a claims-made policy, the retroactive date in your claims-made policy should be no later than the expiration date of the occurrence policy.

2. When replacing a claims-made policy with a claims-made policy, you should consider the following:

    a. The retroactive date in the replacement policy should extend far enough back in time to cover any events with long periods of liability exposure, or
    b. If the retroactive date in the replacement policy does not extend far enough back in time to cover events with long periods of liability exposure, you should consider purchasing extended reporting period coverage under the old claims-made policy.

3. If you replace this claims-made policy with an occurrence policy, you may not have insurance coverage for a claim

    arising during the period of claims-made coverage unless you have purchased an extended reporting period under the claims-made policy. Extended reporting period coverage must be offered to you by law for at least one year after the expiration of the claims-made policy at a premium not to exceed 200% of your last policy premium.

CAREFULLY REVIEW YOUR POLICY REGARDING THE AVAILABLE EXTENDED REPORTING PERIOD COVERAGE, INCLUDING THE LENGTH OF COVERAGE, THE PRICE AND THE TIME PERIOD DURING WHICH YOU MUST PURCHASE OR ACCEPT ANY OFFER FOR EXTENDED REPORTING PERIOD COVERAGE.

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APPLICANT DATA

1. Last Name: ______________________ First Name: _____________________ Middle Initial: _________ Gender: __________

2. Date of Birth: ________/________/________ **3.** National Provider Identifier (NPI): ________________________________

4. Personal/Confidential Email Address (required for online access): ____

5. Legal Residence:

Physical Street/Home Address: ____

City: _____________________ State: _________ ZIP: ____________ Cell Phone Number: ___________________________

6. Primary Practice Location:

Address: ____

City: _____________________ State: _________ ZIP: ____________ Office Phone Number: __________________________

Website Address: ________________________ Primary Contact Name: ____

Primary Contact Email Address: ________________________________ Primary Contact Phone Number: ________________

7. Billing Address (if different from practice location)

Firm Name: ____

Address: ____

City: _________________ County: ________________ State: _______ ZIP: ________ Phone Number: __________________

8. Preferred Mailing Address (Confidential)

Choose one: ☐ Office ☐ Residence ☐ Billing

Preferred Mailing Address for Policy-Related Documents

Choose one: ☐ Office ☐ Residence ☐ Billing

If you have a PO Box you would prefer to use as your preferred mailing address, please indicate this as part of your submission.

COVERAGE REQUESTED

9. Requested Effective Date: ________/________/________ Retroactive Date: ________/________/________

10. Limits of Liability Per Incident: $_________ Per Aggregate: $_________ (For example, $1M/$3M)

11. Practicing as: ☐ Individual ☐ Joining Group ☐ Forming Group ☐ Joining Hospital

Name of Group(s) or Employer(s): ____

Is your current employer insured with Copic? .... ☐ Yes ☐ No

12. Professional Designation: ☐ Physician Assistant ☐ Surgical Assistant/Tech ☐ Nurse Practitioner ☐ Certified Nurse Midwife ☐ Certified Nurse Anesthetist ☐ Other: ____

PROFESSIONAL LIABILITY INSURANCE HISTORY

13. Policy Information

Name of Company: ____ Policy Limits: $_________ / $________

Period of Coverage: (MM/YY) to (MM/YY) Retroactive Date: (MM/YY) to (MM/YY) ☐ Claims-Made ☐ Occurrence

Name of Company: ____ Policy Limits: $_________ / $________

Period of Coverage: (MM/YY) to (MM/YY) Retroactive Date: (MM/YY) to (MM/YY) ☐ Claims-Made ☐ Occurrence

Name of Company: ____ Policy Limits: $_________ / $________

Period of Coverage: (MM/YY) to (MM/YY) Retroactive Date: (MM/YY) to (MM/YY) ☐ Claims-Made ☐ Occurrence

14. Type of Coverage Desired:

☐ Claims made coverage *with* Prior Acts coverage (If this option is chosen, move to Question 16.)

☐ Claims made coverage *without* Prior Acts coverage (If this option is chosen, please complete the following:)

If claims-made coverage without prior acts coverage was selected and your most recent policy was issued on a claims-made basis, please indicate one of the following:

☐ An extended reporting endorsement (tail coverage) has been or will be purchased.

☐ An extended reporting endorsement (tail coverage) has not and will not be purchased. I understand that my failure to purchase such coverage from my current insurer could result in an uninsured claim which may arise as a result of professional services prior to joining Copic. I understand that the policy for which I am applying with Copic Insurance Company, if offered, will not provide coverage for incidents prior to my effective date of coverage.

Initial here to confirm your understanding: ___________

15. Has any professional liability insurer ever canceled, declined to issue, refused to renew, offered renewal with a surcharged rate, required that you accept a deductible, or issued coverage with any restrictions or exclusions? .... ☐ Yes ☐ No

(Missouri applicants do not answer this question.)

16. Have you ever practiced without professional liability insurance? .... ☐ Yes ☐ No

LICENSES

17. List all states in which you have ever been licensed to practice medicine, the license number for that state, the date the license was issued, and the number of hours you will work in each state as of the requested effective date of coverage.

State: ________________ License #: ________________ Date Issued: _________________ # Hours/Week: _________________

State: ________________ License #: ________________ Date Issued: _________________ # Hours/Week: _________________

State: ________________ License #: ________________ Date Issued: _________________ # Hours/Week: _________________

PRACTICE CHARACTERISTICS

18. Average hours per week

When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations; all on-call time which results in actual patient contact; and all time spent making hospital rounds.

☐ 1-15 ☐ 16-20 ☐ 21-25 ☐ ≥26

19. After your effective date, will you maintain professional liability coverage with another carrier for activities or exposures not covered by Copic? .... ☐ Yes ☐ No

If "Yes," please explain: ____

20. Will you be scheduled to work at a separate location from your supervising or collaborating physician? .... ☐ Yes ☐ No

If "Yes," please provide additional information: ____

21. Do you work outside of the control and supervision of your employer ("moonlight")? .... ☐ Yes ☐ No

If "Yes," where? ____

What percentage of your practice is devoted to moonlighting? ___________%

PROCEDURES PERFORMED

22. Do you perform or supervise anyone who performs aesthetic or cosmetic procedures? ……………...…………………….. ☐ Yes ☐ No

    If "Yes," please provide an Elective Aesthetic & Cosmetic Procedures Supplemental Application.

    If "Yes," is any of this practice on behalf of a medical spa? …………………………………………...…………………. ☐ Yes ☐ No

23. Do you perform procedures or use equipment not used by a majority of practitioners in your specialty or perform "invasive" procedures for which you were not formally trained or for which you do not hold hospital privileges? …………………….………….. ☐ Yes ☐ No

    If applicable, please list all such procedures: ____

24. Do you perform or assist in surgery? ………………………………………………………………………………………. ☐ Yes ☐ No

    If "Yes," are any of these surgeries office-based surgeries which require sedation? ………………………………………. ☐ Yes ☐ No

25. Do you provide gender-affirming care/services? ………………………………………………………………………...…….. ☐ Yes ☐ No

    If "Yes," do you offer/provide gender-affirming services, medical or surgical, to patients under 19 years of age? ………... ☐ Yes ☐ No

26. Do you maintain hospital privileges? ………………………………………………………………………………………. ☐ Yes ☐ No

27. For CRNAs only, do you perform cervical epidural injections (CEI)? …………………….………………………………. ☐ Yes ☐ No

CERTIFIED NURSE MIDWIVES ONLY

28. Do you offer obstetric ultrasound images or videos created solely for non-medical reasons or without an ultrasound report for the medical record or any non-medical use of ultrasound imaging, such as "keepsake ultrasounds"? ………..………………….. ☐ Yes ☐ No

29. Do you hold a current certification in Advanced Life Support in Obstetrics (ALSO)? ……………………………..……….. ☐ Yes ☐ No

30. Do you perform obstetrical procedures in a surgical suite more than one hour or 50 miles from a hospital? ………...….. ☐ Yes ☐ No

31. Do you perform elective home delivery? ……………………………………………………………………...……………...…. ☐ Yes ☐ No

32. Do you perform water births? ………………...……………………………………………………………………………….…. ☐ Yes ☐ No

33. Do you perform Vaginal Birth after Cesarean (VBAC)? ………………...…………………………………...…………...…. ☐ Yes ☐ No

    If "Yes," is a physician physically on premises and immediately available for the entire course of care? ………………….. ☐ Yes ☐ No

34. Average number of deliveries performed per year: ___________

IF YOU PRACTICE IN A STATE WITH A PATIENT COMPENSATION FUND

35. If approved for Copic coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under a patient compensation fund? ………………………………………………………………. ☐ Yes ☐ No ☐ N/A

36. Have you been a qualified health care provider under the fund at all times subsequent to the retroactive date requested above and as shown on the insurance declarations page(s) attached to the application? ……………………………..………. ☐ Yes ☐ No ☐ N/A*

    (*"N/A" means that you do not practice within a fund state and, therefore, this question is not applicable.)

    Note: Examples of states with patient compensation funds include Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, and Wisconsin. It is advisable to investigate specific regulations in each state where you practice to determine whether participation in the fund is voluntary.

OTHER INFORMATION

ALL 'YES' ANSWERS REQUIRE AN EXPLANATION. PLEASE ATTACH ADDITIONAL SHEETS, IF NECESSARY

37. Has any disciplinary action ever been taken regarding any healing arts license which you hold or have ever held? (Include any disciplinary actions by the U.S. military, U.S. Public Health Service, or other U.S. federal governmental entity. Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations which are currently pending.) ………………………………………………………………………….………….. ☐ Yes ☐ No

38. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ……………………………………...………………………… ☐ Yes ☐ No

39. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? ………………………………… ☐ Yes ☐ No

40. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? (Note: You must answer "Yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned, or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.) ……………………………….. ☐ Yes ☐ No

41. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, healthcare facility, or any other healthcare entity? ………...…...………………… ☐ Yes ☐ No

42. Within the past 5 years, have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (i.e. serious neurologic illness or injury, uncontrolled seizure disorder, mental health diagnosis, sexual addiction, alcohol, opioid, or other substance use disorder, serious physical illness or injury, etc.) ……………………………………...……… ☐ Yes ☐ No

If "Yes," state the condition(s) and date(s), and identify your treating physician(s) below. A statement from your physician attesting to your fitness to practice your specialty is required to be submitted with this application.

Description of condition: ____

Date(s) of treatment(s): From ______/_______ To: _______/_________ ☐ Currently in treatment

Name of treating physician(s): ____

43. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended, revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action? ……………………..………………………….……. ☐ Yes ☐ No

44. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing board, Board of Medical Examiners, health plan, managed care organization, or other medical review committee? ……………………..…… ☐ Yes ☐ No

45. Are you personally registered as a patient or recipient on any state's medical marijuana registry, or are you personally a frequent or habitual user of marijuana? ……………………………………………………………………………………………...……….. ☐ Yes ☐ No

46. Have you ever been accused of sexual misconduct or harassment by one of your employees, an associate's employee, or an employee of a hospital or surgery center; or have you been accused by a patient or been investigated by any state regulatory authority for boundary violations of a sexual nature? ……………………………………………………………………………….. ☐ Yes ☐ No

47. Have you ever been reported to the National Practitioners Data Bank? ……………………………………...………………….. ☐ Yes ☐ No

CLAIMS INFORMATION

Important information regarding questions 48 and 49 (including sub-questions):

1. The word "claim" as used in questions 48 and 49 below refers to:

- **(a) Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or**
- **(b) Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.**

2. If you answer "Yes" to question 48 and 49 (including sub-questions), please complete the attached Supplementary Claims Information Form.

48. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? ………………………………….. ☐ Yes ☐ No

49. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

- **a.** A request for records from a patient and/or attorney related to an adverse outcome? ………………………………….. ☐ Yes ☐ No
- **b.** A letter from an attorney regarding your medical treatment of a patient? ………………………………………..……... ☐ Yes ☐ No
- **c.** Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ………...……… ☐ Yes ☐ No
- **d.** Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? …………………. ☐ Yes ☐ No
- **e.** Any other circumstances that might reasonably lead to a claim or suit? ……………………………………………….….. ☐ Yes ☐ No

50. If "Yes," to any of the above, have they been reported to your current or prior professional liability insurance carrier? ….. ☐ Yes ☐ No

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SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Initials: _______________

2. Date reported to insurance company: _______________

3. Name of insurance company: ____

4. Date of incident and your treatment: _______________

5. Allegations: ____
____
____

6. What is the present condition of the patient? ____
____
____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? .... ☐ Yes ☐ No

8. Status of claim (check applicable answer):

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ Summary judgment in your favor

☐ Suit settled out of court

a. Date claim paid:_______________

b. Amount paid: $_________________

c. Did you want to settle this claim? ☐ Yes ☐ No

☐ Court outcome in your favor

☐ Court outcome in favor of plaintiff:

Amount of Loss payment:
$____________________

☐ Awaiting mediation

☐ Awaiting court action:

Reserve Amount:
$__________

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?
....☐ Yes ☐ No
If "Yes," amount was $_______________

Signature: ____ **Date**: __________________________

Name (Printed): ____

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! As a condition of being insured, I understand and agree to the requirement to submit to a health and skills assessment by a physician of Copic's choice. This assessment may be required at Copic's discretion.

I hereby declare and represent that all answers and statements in this application are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. I understand that these answers and statements are material and, as such, will be relied upon by Copic to determine whether to issue my liability insurance, to determine the amount of limits available, or to specifically exclude a risk. If I or any other person making application or providing information on my behalf misstate(s) or fail(s) to disclose any material information, my application may be declined. If my application is approved and it includes any material misstatement or it fails to disclose material information, Copic has the right to rescind my insurance. Copic also has the right to decline coverage for a specific claim if Copic would have declined to issue insurance or would have limited my coverage if I had not made the material misstatement or omission.

I authorize any licensing board, hospital board or committee, hospital records department, insurance company, professional society or association, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to Copic or its assigns. This authorization applies regardless of whether I am currently affiliated with the above persons or entities, or have been in the past. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with Copic policy, I hereby consent to Copic's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations (including professional societies or associations), professional liability insurance carriers, and state and federal regulatory entities, including but not limited to any licensing board, the National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank. This release applies to the following information: my name, business address, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioners Data Bank and/or the Healthcare Integrity and Protection Data Bank. To the fullest extent permitted by law, I hereby release all providers of such information, including Copic, its employees and agents, from any and all liability therefore.

Allied health professional's signature ____ Date ________________________________

Please PRINT your name ____

RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

INSURANCE FRAUD WARNINGS

The following Insurance Fraud Warnings are required to be provided with all applications.

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 state prison.

ALABAMA

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.

ARKANSAS

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.

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.

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 denial of insurance benefits.

MARYLAND

Any person who knowingly and 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.

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 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 provides false, incomplete, or misleading material information to an insurance company with the intent to knowingly defraud may be found guilty of insurance fraud by a court of law.

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.

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.

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.