
Name of Insurance Company to which Application is made

# APPLICATION FOR EMPLOYERS PREMIER CHOICE POLICY

**NOTICE:** THIS IS A PROPOSAL FOR A CLAIMS-MADE AND REPORTED POLICY. THE POLICY FOR WHICH THIS PROPOSAL IS MADE IS LIMITED TO LIABILITY FOR **WRONGFUL ACTS** FOR WHICH **CLAIMS** ARE FIRST MADE WHILE THE POLICY IS IN FORCE, AND WHICH ARE REPORTED TO THE INSURER NO LATER THAN SIXTY (60) DAYS AFTER THE TERMINATION OF THE POLICY. THE LIMIT OF LIABILITY AVAILABLE TO PAY **LOSS**, INCLUDING JUDGEMENT OR SETTLEMENT AMOUNTS, SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE AND OTHER **CLAIM** EXPENSES. FURTHER NOTE, THE AMOUNTS INCURRED FOR DEFENSE AND OTHER **CLAIM** EXPENSES SHALL BE APPLIED AGAINST THE APPLICABLE RETENTION AMOUNT. THE POLICY DOES NOT PROVIDE FOR ANY DUTY OR OBLIGATION ON THE PART OF THE INSURER TO DEFEND THE **INSURED PERSONS** AND THE **COMPANY**.

Instructions:

A. Answer all questions. If the answer to any question is NONE, please state NONE.
B. Terms appearing in bold face in this Application are defined in the Policy and have the same meaning in this Application as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker.
C. If the space to answer any question fully is insufficient, please attach a separate sheet.
D. The Application must be signed and dated by the owner, partner, or officer, and by a human resources or personnel officer.
E. PLEASE READ CAREFULLY THE STATEMENT AT THE END OF THIS APPLICATION.

## 1. GENERAL INFORMATION

Applicant Name : _____
(Please include the names of all **Companies** and **Subsidiaries** which are to be covered if the policy is issued. Include the nature of business, date acquired or formed, number of **Employees**, and percentage of ownership)
Address: _____
State of Incorporation: _____
The **Insured** has been in continuous operation since: _____ mm/dd/yyyy
Description of All Operations: _____
SIC Code: _____ Type of **Company**: ☐ Private ☐ Public Stock Symbol _____
Type of Organization: ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other_____
Website Address: _____
Designated representative to receive all notices from the Insurer on behalf of **Insureds** and **Insured Persons** proposed for this insurance:
Name: _____ Title: _____
Address: _____
Telephone: _____ Fax: _____ Email: _____

## 2. COVERAGE REQUESTED

Limit of Liability: _____ Self Insured Retention: _____ Continuity Date: _____
Proposed **Policy Period**: From: _____ To: _____
Pending and Prior Litigation Date: _____

**3. PRIOR INSURANCE**

a. Does the **Insured** currently have Employment Practices Liability Insurance? ☐ Yes ☐ No
If yes, please provide the following details:
Insurance Carrier:
_____
Limit of Liability: $_____ Self Insured Retention: $_____ Premium:$_____
**Policy Period** _____ **-** _____Continuity Date _____

b. Have any of the **Insured's** current or previous Employment Practices Liability insurers refused to offer renewal terms? ☐ Yes ☐ No
If yes, please provide details: _____

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**4. THIRD PARTY CLAIM COVERAGE**

Is the **Insured** requesting Third Party Claim coverage? ☐ Yes ☐ No
If yes, please complete *Supplement I, Third Party Claim Questionnaire.*

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**5. PUNITIVE DAMAGE COVERAGE**

Is the **Insured** requesting punitive damages coverage? ☐ Yes ☐ No

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**6. OTHER INSURANCE**

Does the **Insured** currently carry the following insurance?

a. Directors and Officers Liability ☐ Yes ☐ No
Insurance Carrier:_____
Limit of Liability: $_____ Premium: $_____ **Policy Period** _____ **-** _____

b. General Liability ☐ Yes ☐ No
Insurance Carrier:_____
Limit of Liability: $_____ Premium: $_____ **Policy Period** _____ **-** _____

c. Umbrella Liability ☐ Yes ☐ No
Insurance Carrier:_____
Limit of Liability: $_____ Premium: $_____ **Policy Period** _____ **-** _____

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**7. EMPLOYEE INFORMATION**

a. Does the **Insured** have any foreign operations? ☐ Yes ☐ No
If coverage for foreign operations is desired, please complete *Supplement II, Foreign Exposure Questionnaire*.

b. Please provide the total number of **Employees** in the **Parent Company** and all **Subsidiaries** that are to be covered if a Policy is issued :
_____Full-Time _____Leased _____Independent Contractors
_____Part-Time _____Volunteers
_____Unionized Workers
_____Temporary/Seasonal _____Outside the United States

c. Please provide a breakdown of the total number of **Employees** or **Insured Persons** in the following geographical locations:
_____CA _____FL _____LA _____MI _____NY _____WA
_____D.C _____IL _____MA _____NJ _____TX

d. Please provide a breakdown of the total number of other workers, **Employees** or **Insured Persons** with the following salaries: $ 50,000 or less per year _____

$ 50,001 - $100,000 per year _____
$100,001 - $150,000 per year _____
$150,001 - $250,000 per year _____
Over $250,000 per year _____

e. What is the percentage of **Employees** over 40 (forty) years of age: _____%

f. Does the **Insured** have a tracking system that monitors the overtime, vacation and sick pay hours of non-exempt **Employees**? ☐ Yes ☐ No

Please provide **Employee** turnover for the most recent 3 (three) years:

Year _____ _____% Year _____ _____% Year _____ _____%

h. For each of the last three (3) years, indicate the number of officers and other **Employees** that have been involuntarily terminated: Year _____ _____ Year _____ _____ Year _____ _____

i. Does the **Insured** have a written employment contract with any **Employee** or **Insured Person**? ☐ Yes ☐ No

If yes, are the employment contracts created and reviewed by outside employment/labor counsel? ☐ Yes ☐ No

Total number of employment contracts: _____
Total value of all contracts: $_____
Total value of largest contract: $_____

Please provide a specimen contract.

## 8. PAST ACTIVITIES

Please state below whether any **Insured** has been involved in any of the following and provide details for any "yes" response:

a. Qui tam action? ☐Yes ☐ No

b. Civil or criminal action or administrative proceeding charging a violation of a federal, state, local, or foreign employment law or regulation? ☐ Yes ☐ No

c. Any other criminal actions? ☐ Yes ☐ No

d. Representative actions, class actions or derivative suits in connection with employment issues? ☐ Yes ☐ No

e. Investigation by the Equal Employment Opportunity Commission (EEOC) or similar state, local or foreign agency? ☐ Yes ☐ No

f. Is any **Insured** presently subject to any judicial or administrative order, decree, judgment or conciliation agreement that is employment-related? ☐ Yes ☐ No

## 9. CLAIM HISTORY

a. Regardless of whether or not such **Claim(s)** may have been covered by any insurance policy, please provide a list of all employment-related complaints, grievances, arbitrations, charges, litigation, investigations and administrative proceedings (including Equal Employment Opportunity Commission (EEOC) or other federal, state and local agency proceedings, such as proceedings involving the National Labor Relations Board (NLRB), U.S. Department of Labor (DOL), U.S. Department of Justice (DOJ), or the Office of Federal Contract Compliance Programs (OFCCP) commenced against any **Insured** during the past five (5) years. The list should include: (a) date of **Claim(s)**, (b) a description of the allegation, (c) the court or agency involved, (d) description of any decision, determination or judgment rendered, (e) total **Claim(s) Expenses** incurred to date, (f) any judgment or settlement amount, (g) whether the **Claim(s)** remains pending or closed, (h) if pending, provide demand amount, and (i) what corrective action has been taken to mitigate or prevent such **Claim(s)** from occurring or recurring.

b. Are you aware of actual or alleged **Wrongful Acts** or other acts, errors, omissions, facts, situations or circumstances that may result in a **Claim(s)** within the scope of the proposed insurance being made against you? ☐ Yes ☐ No

c. Has any **Insured** given written notice under the provisions of any prior or current Employment Practices Liability policy or similar insurance policy of specific facts or circumstances that might give rise to a **Claim** being made against the Applicant? ☐ Yes ☐ No

d. Have any **Loss** payments been made on behalf of any proposed **Insured** under any liability policy or similar insurance? ☐ Yes ☐ No

If answered yes to any of the above, please complete *Supplement III, Supplemental Claim Form*.

It is agreed that with respects to the questions 8 and 9, if such facts or circumstances exist, any **Claim(s)** arising therefrom are excluded from the proposed insurance for all **Insureds**.

## 10. PRIOR EXPERIENCE

No **Claim(s)** have been made against any entity(ies) or person(s) proposed for this insurance in a capacity that would be insured under this policy (including **Loss** payments and **Claim Expenses**).

If there are any exceptions, please attach complete details. ☐ None

It is agreed that with respects to question 10 above, any **Claim** based upon, arising from, or in any way related to any act, error, omission, fact or circumstance of which any **Insured** has any knowledge or information will be excluded from coverage under the proposed insurance.

## 11. EMPLOYMENT POLICIES AND PROCEDURES

a. Does the **Insured** have a Human Resources or Personnel Department? ☐ Yes ☐ No
If no, please provide details on the handling of this function on a separate page.

b. How many **Employees** are in this department? _____
Is it centralized? ☐ Yes ☐ No

c. Does the **Insured** require that all employment terminations be reviewed prior to discharge by (check all that apply):

| | | |
|---|---|---|
| Human Resources Department? | ☐ Yes | ☐ No |
| Legal Department? | ☐ Yes | ☐ No |
| Outside Employment Counsel? | ☐ Yes | ☐ No |

d. What outside legal counsel does the **Insured** use for employment and/or labor advice and/or representation?
_____

e. Does the **Insured** use an employment application for all applicants for employment? ☐ Yes ☐ No
If no, which applicants are not required to complete an application and how is the screening/hiring process conducted?
_____

f. Does the **Insured** utilize a standardized written employment offer to all applicants? ☐ Yes ☐ No
If no, which applicants are not provided with written employment offer letters and why not?
_____

g. Does the **Insured** test for any of the following:

| | | |
|---|---|---|
| Drug/alcohol screening | ☐ Yes | ☐ No |
| Physical examinations | ☐ Yes | ☐ No |
| Psychological examinations | ☐ Yes | ☐ No |
| Skills Testing | ☐ Yes | ☐ No |
| Polygraph Testing | ☐ Yes | ☐ No |

If answered yes to any of the above, please attach a copy of any written policies and procedures.
Who conducts the testing? _____
Are the above tests and examinations conducted pre-employment or post-offer of employment? _____
Are all **Employees** subject to these tests? ☐ Yes ☐ No
If no, which **Employees** are not subject to these tests and/or examinations and explain why they are not subject.
_____

h. Does the **Insured** have a formal orientation program for all new **Employees**? ☐ Yes ☐ No
If yes, is an orientation checklist maintained for all new **Employees**? ☐ Yes ☐ No

i. Does the **Insured** have an **Employee** handbook? ☐ Yes ☐ No
If yes, is the handbook distributed to all **Employees**? ☐ Yes ☐ No
Do all **Employees** provide a written acknowledgement that they have received the handbook? ☐ Yes ☐ No
Is the **Employee** handbook uniform at all locations and subsidiaries? ☐ Yes ☐ No

Has an employment attorney reviewed the **Employee** handbook? ☐ Yes ☐ No
When was the **Employee** handbook last reviewed by an employment attorney? _____

j. Does the **Insured** provide annual written performance evaluations to all **Employees**? ☐ Yes ☐ No
If no, please explain_____

k. Is the **Insured** required to file an affirmative action plan with the Office of Federal Contract Compliance Programs (OFCCP)? ☐ Yes ☐ No
Has the **Insured** ever been subject of an OFCCP audit or investigation, that resulted in a finding of a violation? ☐ Yes ☐ No
If yes, please attach a copy of the audit or investigation report, the **Insured's** response to the report and any documentation disclosing actions the **Insured** has taken to remedy the violation.

l. Does the **Insured** utilize arbitration for employment-related **Claims**? ☐ Yes ☐ No
If yes, is it mandatory? ☐ Yes ☐ No
If yes, please provide a copy of the arbitration policy

m. Does the **Insured** conduct standardized exit interviews when an **Employee** resigns or is terminated (voluntary and involuntary)? ☐ Yes ☐ No
Are exit interviews documented? ☐ Yes ☐ No
Does the **Insured** have a formal out-placement program that assists terminated or laid-off **Employees** in finding other jobs? ☐ Yes ☐ No

n. Does the **Insured** conduct training on sexual harassment, harassment and discrimination prevention? ☐ Yes ☐ No
Who is required to attend?_____
Who conducts the training?_____
How often is training conducted? _____
Is the training documented? ☐ Yes ☐ No

o. Does the **Insured** conduct other management training? ☐ Yes ☐ No
If yes, please describe: _____

p. Does the **Insured** have formal written policies or procedures regarding:
1) the handling of **Employee** complaints of discrimination or harassment ☐ Yes ☐ No
2) the investigation of **Employee** complaints of discrimination or harassment ☐ Yes ☐ No
3) AIDS or assisting an **Employee** with life threatening or communicable diseases ☐ Yes ☐ No
4) **Employee** discipline and/or progressive discipline ☐ Yes ☐ No
5) The Family and Medical Leave Act ☐ Yes ☐ No
6) Americans with Disabilities Act / reasonable accommodation(s) ☐ Yes ☐ No
7) Military Leave / USERRA ☐ Yes ☐ No
8) Sexual Harassment and all other forms of harassment ☐ Yes ☐ No
9) Discrimination and all forms of discrimination ☐ Yes ☐ No
10) **Employee** hotline to report discrimination, harassment or other workplace issues ☐ Yes ☐ No
11) At-Will Employment ☐ Yes ☐ No
12) Equal Employment Opportunity ☐ Yes ☐ No

If you answered yes to any of the above, please provide copies of all such policies or details regarding such procedures.

q. Does the Applicant have a formal job posting policy? ☐ Yes ☐ No
Are all jobs posted internally? ☐ Yes ☐ No
If no, please explain _____

## 12. CORPORATE HISTORY

a. Has the **Insured** in the past 36 months completed, agreed to, or contemplated the occurrence within the next 18 months of, any of the following:
1) Merger, acquisition or consolidation with another entity? If yes, please provide details. ☐ Yes ☐ No
2) Sale, distribution or divestiture of any assets resulting in a reduction of the total number of **Employees** of the **Insured**? ☐ Yes ☐ No
3) Anticipated any plant, facility, branch or office closing, consolidation or layoff? ☐ Yes ☐ No
If yes to questions 12 a. 1) or 2) above, please complete *Supplement IV: Reduction in Workforce Questionnaire*

b. Has the **Insured** been involved in any bankruptcy proceeding, or is it contemplating the filing of a petition for protection under the bankruptcy code? If yes, please provide details. ☐ Yes ☐ No

c. Has the **Insured** converted or does the **Insured** plan to convert its traditional pension plan to a cash balance plan? ☐ Yes ☐ No

d. Has your business name changed? If yes, list all former names on a separate sheet. ☐ Yes ☐ No

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**13. CLAIMS HANDLING PROCEDURES**

a. Who in the **Insured's** organization will be responsible for the reporting of **Claims** to the insurer under any Policy that may be issued pursuant to this Application?

Name: _____ Title: _____

Address: _____

Telephone Number (include area code): _____Email Address: _____

b. Who in the **Insured's** organization will be responsible for handling **Claims** in conjunction with the insurer under any Policy that may be issued pursuant to this Application?

Name: _____ Title: _____

Address: _____

Telephone Number (include area code): _____Email Address: _____

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THIS APPLICATION WILL ONLY BE PROCESSED IF THE FOLLOWING APPLICABLE INFORMATION IS INCLUDED. FAILURE TO INCLUDE THE APPLICABLE INFORMATION FOR ANY **COMPANY** TO BE COVERED BY THIS INSURANCE WILL DELAY THE ISSUANCE OF A QUOTE UNTIL THE INFORMATION IS RECEIVED OR WILL RESULT IN A QUOTE EXCLUDING THE **COMPANY(IES)** FOR WHICH THE INFORMATION HAS NOT BEEN RECEIVED.

Indicate attachments by an (X):

a. ☐ most recent annual report
b. ☐ latest **Employee** handbook and copies of any written employment at will, open door, discrimination, harassment/sexual harassment, ADA /reasonable accommodation, Family and Medical Leave, severance, progressive discipline, grievance policies and procedures including termination and/or exit interview forms
c. ☐ copies of all employment application forms currently utilized as well as specimen offer letters
d. ☐ copies of **Employee** reduction in workforce, termination and out-placement procedures
e. ☐ organizational chart that depicts where the Human Resource function exists
f. ☐ details on any performance appraisal or interview training
g. ☐ supervisory manual(s)
h. ☐ **Employee** performance form(s)
i. ☐ EEO-1 reports for the past three (3) years
j. ☐ resume/biography of the Director of Human Resources

*In addition, any and all information filed with the Securities and Exchange Commission or public records may be obtained by the Insurer via the Internet, utilized in the underwriting process, and form a part of the Application. Additional information may be required as part of the Application process.*

THE UNDERSIGNED DECLARES ON BEHALF OF THE APPLICANT THAT HE/SHE IS AUTHORIZED BY THE APPLICANT TO SIGN THE APPLICATION, AND THAT STATEMENTS SET FORTH IN THIS APPLICATION AND IN ALL ATTACHMENTS HERETO, ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE UNDERSIGNED WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE. THE "EFFECTIVE DATE" IS THE DATE THE COVERAGE IS BOUND, OR THE FIRST DAY OF THE CURRENT **POLICY PERIOD**, WHICHEVER IS LATER.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE CONTRACT, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.
ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

The undersigned authorized officer of the Applicant hereby acknowledges that:

1. This policy applies to **Claims** first made or deemed made, during the **Policy Period** or extending reporting period, if purchased, and
2. The Limit of Liability available to pay damages or settlements will be reduced, and may be completely exhausted, by the payment of **Claim Expenses**, and in such event, the Insurer shall not be responsible for the continued **Claim Expenses** or for the amount of any judgment or settlement to the extent that any of the foregoing exceed any applicable Limit of Liability.

## FRAUD WARNINGS

**ARKANSAS 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.**

**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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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 APPLICANTS: 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 APPLICANTS: 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.**

**HAWAII APPLICANTS: FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.**

**KENTUCKY 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.**

**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.**

**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.**

**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.**

**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.**

**NEW YORK 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 MATERIAL FACT THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL BE ALSO SUBJECT**

**TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.**

**OHIO APPLICANTS: 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 APPLICANTS: 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 APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION OR; (2) FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT MAYBE VIOLATING STATE LAW.**

**PENNSYLVANIA 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, FOR THE PURPOSE OF MISLEADING, CONCEALS INFORMATION CONCERNING ANY FACT FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**TENNESSEE 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.**

**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.**

**WEST VIRGINIA 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.**

**NOTE: BOTH SIGNATURE LINES MUST BE COMPLETED.**

| Date | Applicant's Authorized Signature of Chairperson, President, or Chief Executive Officer | Title |
|---|---|---|
| | Please Print Name | |
| Date | Applicant's Authorized Signature of the **Executive Officer** in Charge of the Human Resources Department (or equivalent position) | Title |
| | Please Print Name | |

Name of Broker: _____

Name of Agency: _____

Address: _____

_____

Signed: _____

_____

PLEASE SUBMIT THIS PROPOSAL AND APPROPRIATE MATERIALS TO:

Hartford Financial Products
2 Park Avenue, 5th Fl.
New York, NY 10016

**Save a copy as ...**

**Print**

**Submit by Email**