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PROGRAM UNDERWRITERS

Amwins Program Underwriters

Home Health Care Insurance Program – New Business Application

Coverage provided by: Liberty

INSTRUCTIONS:

1. Answer all questions completely for desired coverages.

2. This form must be completed, signed and dated by a Principal or Officer of the firm.

Click here to apply for the following coverages:

☐ Professional Liability ☐ General Liability

☐ Non-owned Auto Liability ☐ Products Liability

I. APPLICANT INFORMATION

a) Client Name: _____

(if more than one entity/subsidiary, please attach description and % owned for each)

☐ For Profit ☐ Not for Profit ☐ Partnership ☐ Other (specify) _____

b) Address: _____

Street PO Box

_____

City State Zip

Phone: _____ Fax: _____

Website: _____ Email: _____

c) Total Annual Gross Receipts: $ _____

d) Date Business Established: _____
(Required: Attach Principal's resume if in business less than 3 years)

e) Type of Firm (check all that apply):

☐ Home Health Care Provider ☐ Infusion Therapy Provider ☐ Companion Agency

☐ Visiting Nurse Agency ☐ Nurse Registry ☐ Closed Pharmacy

☐ Supplemental Staffing ☐ Medical Equipment Supplier ☐ Hospice

☐ Other (describe):_____

f) Total Number of Employees: _____

II. HIRING/SCREENING AND CREDENTIALING PROCEDURES

a) Are employees/contractors' references contacted before hired/placed? ☐ Yes ☐ No

b) Does the applicant conduct criminal background screening for all clinical employees/contractors prior to hire/placement? ☐ Yes ☐ No

If yes, at what level are criminal searches conducted? ☐ State ☐ Federal

c) Does the applicant verify certification and/or professional licensure status of employees and independent contractors? ☐ Yes ☐ No

d) Has the applicant formalized a drug and alcohol screening program requiring all employees/contractors to satisfy drug and alcohol testing prior to hire/placement and is there a procedure for screening suspect employees/contractors when drug or alcohol abuse is alleged? ☐ Yes ☐ No

III. RISK MANAGEMENT/QUALITY IMPROVEMENT

a) Is the applicant licensed in all states in which it is operating? ☐ Yes ☐ No

b) Has the applicant's license ever been suspended, revoked, voluntarily surrendered, or subject to probate in any state? ☐ Yes ☐ No

If yes, please explain:_____

c) Does the applicant utilize a formal written Quality Improvement and Risk Management Program? ☐ Yes ☐ No

If yes, please explain:_____

d) Is the overall responsibility for risk management assigned to one individual in your firm? ☐ Yes ☐ No

If yes, please give name and title:_____

If no, please describe how risk management is monitored:_____

e) Does the applicant have a formalized training and education program? ☐ Yes ☐ No

IV. CLAIMS HISTORY

a) Have any claims/suits been made within the last five (5) years against the applicant? ☐ Yes ☐ No
If yes, please attach a copy of insurance company loss reports for each claim or suit. Specify date, description, amount paid and amount outstanding for each claim.

b) Is the applicant aware of any circumstances which may result in any claim or suit being made (including requests for medical records)? ☐ Yes ☐ No

If yes, please explain: _____

c) Has any insurance company or Lloyd's declined, canceled or refused to renew any of the applicant's insurance?
Note: Missouri applicants do not reply ☐ Yes ☐ No

If yes, please explain: _____

d) Please attach five years of currently valued loss runs for all desired lines of coverage.

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V. PREVIOUS PROFESSIONAL LIABILITY INSURANCE (PAST 3 YEARS)

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

VI. PREVIOUS GENERAL LIABILITY INSURANCE (PAST 3 YEARS)

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

PROFESSIONAL LIABILITY SECTION

I. EMPLOYEES – ANNUAL STAFFING:

Employee Type	# Full Time	# Part Time	Annual Hours	Annual Payroll
Nurse (RN)				
LPN/LVN				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Speech Therapist				
Occupational Therapist				
Social Worker				
Pharmacist				
Home Health Aide/CNA				
Homemakers				
Sitter/Companion				
Physician				
X-Ray Technicians				
Medical Directors				
Pharmacy Ass't/Techs				
Doula				
Other (specify)				

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II. INDEPENDENT CONTRACTORS – ANNUAL STAFFING:

Contractor Type	# 1099s	Annual Hours	Amount Paid per 1099s
Nurse (RN)			
LPN/LVN			
Nurse Practitioner			
Physical Therapist			
Respiratory Therapist			
Speech Therapist			
Occupational Therapist			
Social Worker			
Pharmacist			
Home Health Aide/CNA			
Homemakers			
Sitter/Companion			
Physician			
X-Ray Technicians			
Medical Directors			
Pharmacy Ass't/Techs			
Doula			
Other (specify)			

III. TYPES OF LOCATIONS WHERE SERVICES ARE PROVIDED (TOTAL MUST EQUAL 100%)

☐ Private Homes _____%

☐ Nursing Homes/Assisted/
Independent Living _____%

☐ Hospitals _____%

☐ Schools _____%

☐ Clinics _____%

☐ Doctor's Offices _____%

☐ Laboratories _____%

☐ Prison Facilities _____%

☐ Other (specify) _____%
_____

IV. TYPES OF SERVICES PROVIDED (TOTAL MUST EQUAL 100%)

☐ Personal Care/Companion _____%

☐ Rehabilitation _____%

☐ Infusion Therapy _____%

☐ Blood Transfusion _____%

☐ Pain Management _____ %

☐ Chemotherapy _____%

☐ Surgical Nursing/Operating Techs _____%
Describe Services _____

☐ Obstetrical Services _____%

☐ Adult Day Care* _____%

☐ Child Day Care* _____%

☐ Respiratory Therapy _____%

☐ Training/Certification Program
Open to the General Public _____%

☐ Hospice _____%

☐ Supplemental Staffing (Medical) ____%

☐ Supplemental Staffing (Non-Med) ___%

☐ Respite Care _____%

☐ Social Services _____%

☐ Meals on Wheels _____%

☐ Medical Equipment Supplier _____%

☐ Infant/Pediatric Care _____%

☐ Retail Pharmacy _____%

☐ Closed Pharmacy _____%

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☐ Clinical Trials_____%
☐ Radiation Therapy_____%
☐ Laboratory Services_____%
☐ Doula_____%
☐ Compounding**_____%
☐ Mail Order Pharmacy_____%
☐ Clinics Owned/Operated_____%
☐ Other (describe)_____%
_____

*Firms providing day care may be required to complete a supplemental application
**Compounding questionnaire required

GENERAL UNDERWRITING SECTION
(Please complete for ALL lines of coverage)

I. OWNED OR LEASED PREMISES
Please attach a separate list of all other locations owned, rented and operated with occupancy of each. List: address of each location, state if you own or lease the location, and describe the occupancy of each building.

a) Are any services provided on your premises (i.e. clinics, day care, infusion, etc.)? ☐ Yes ☐ No

If yes, please explain: _____
_____

b) Does the applicant own or operate any bed/board facilities? ☐ Yes ☐ No

If yes, please explain: _____
_____

c) List all entities to be name as Additional Insureds with names and insurable interest:

1. Name		2. Name	
Address		Address	
Interest		Interest	

d) Has applicant sold, acquired, or discontinued any operations in the past five years? ☐ Yes ☐ No

If yes, please explain: _____

PRODUCTS LIABILITY SECTION

I. MEDICAL EQUIPMENT/SUPPLIERS (Attach product listing for all products sold, leased or rented and website address if applicable) **Note:** If applicant has locations in more than one state, please provide information on a per state basis.

a) Does the applicant SELL any medical supplies and/or equipment? ☐ Yes ☐ No
Total Annual Sales: $ _____

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b) Does the applicant provide pharmaceutical products? ☐ Yes ☐ No
Total Annual Sales: $_____

c) Does the applicant RENT or LEASE any medical supplies and/or equipment? ☐ Yes ☐ No
Total Annual Rental/Leased Receipts: $_____

d) Does the applicant REPAIR or DO MAINTENANCE on any medical supplies or equipment? ☐ Yes ☐ No
1. Total Annual Repair/Maintenance Receipts: $_____
2. Total Annual Repair/Maintenance Payroll: $_____

If you have answered "NO" to a) thru d), please skip the remainder of this section. If you have answered "YES" to a) thru d), please complete the remainder of this section.

CATEGORY I. EXPENDALE ITEMS – Intended for one time usage and disposed (ie. adhesive tape, bandages, hypodermic needles, etc.) DO NOT INCLUDE PHARMACEUTICAL SALES.
Annual Sales: $_____

CATEGORY II. NON-EXPENDABLE ITEMS – Excluding diagnostic treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids (ie. walkers, strollers, canes, crutches, wheelchairs, etc.), prosthetic devices and I.V. stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.
Annual Sales: $_____ Annual Lease/Rental Receipts: $_____

CATEGORY III. DIAGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life of perform critical life monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines or sending devices.
Annual Sales: $_____ Annual Lease/Rental Receipts: $_____

CATEGORY IV LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment/devices that malfunction/fail or improperly function of which could result in death or serious deterioration in health condition. (Please attach list of Category IV equipment/devices).
Annual Sales: $_____ Annual Lease/Rental Receipts: $_____

Note: Total amount of Annual Sales in Categories I-IV must equal amount in Section I. a) above.
Total amount of Annual Lease/Rental Receipts in Categories II-IV must equal amount in Section I. c) above.

e) Does the applicant manufacture any products? ☐ Yes ☐ No

f) Is the applicant named as an additional insured/vendor on the manufacturer's policy for any/all products? ☐ Yes ☐ No

Note: required for any Category IV products. Provide copies of Certificates for Category IV.

g) Does the applicant obtain certificates of insurance from their products suppliers? ☐ Yes ☐ No

h) Does or has the applicant ever distributed or directly imported products from a foreign manufacturer? ☐ Yes ☐ No

1. If yes, please explain: _____

2. If yes, does the foreign manufacturer have a United States location? ☐ Yes ☐ No

i) Does the applicant modify any product in any way from its intended use? ☐ Yes ☐ No

If yes, please explain: _____

j) Does the applicant do any repackaging or re-labeling of items obtained from suppliers? ☐ Yes ☐ No

If yes, please explain: _____

k) Does the manufacturer's label remain on the equipment? ☐ Yes ☐ No

l) Does the applicant perform preventative maintenance on all equipment according to a written schedule? ☐ Yes ☐ No

m) Is all equipment checked and its condition documented prior to their release? ☐ Yes ☐ No

n) Does the applicant use the services of EPA approved contractors for disposal of hazardous waste materials? ☐ Yes ☐ No

If yes, please explain: _____

o) Does the applicant have any exposure to nuclear or radioactive materials? ☐ Yes ☐ No

If yes, please explains: _____

p) For oxygen, oxygen related equipment, life sustaining or critical life monitoring equipment or devices describe the 24 hour service, 365 day/year program that exists:

_____

_____

q) Does the applicant distribute oxygen cylinders? ☐ Yes ☐ No

If yes, are they pre-filled or do you fill them at your premises? _____

r) ***When the applicant has oxygen transfilling exposure:***

Applicant has indicated an exposure with filling oxygen on premises. For this exposure, confirm the following:

1. Confirm the applicant is FDA approved for filling oxygen tanks. ☐ Yes ☐ No
2. Certificates of Analysis are required & purity test is conducted upon every delivery at risk's site? ☐ Yes ☐ No
3. Lot numbers are received and/or created for both the received product and during filling so that it can be traced back to the supplier at any time? ☐ Yes ☐ No
4. Are the employees that are performing filling properly trained and certified? ☐ Yes ☐ No
5. Do oxygen operations take place in a separate room? ☐ Yes ☐ No
   a. If yes, is this room restricted only to the applicant's employees and not the general public? ☐ Yes ☐ No
   b. Is this room clearly marked as restricted to only employees and also marked "NO SMOKING"? ☐ Yes ☐ No

6. Is a home assessment conducted prior to delivery and set up of any oxygen and its related equipment in a patient's home? ☐ Yes ☐ No

7. When oxygen is provided in the home are "NO SMOKING" signs provided to the patient? ☐ Yes ☐ No

8. Is the proper use of oxygen reviewed with the patient and the caregiver and sign-off required by all parties (patient, caregiver and employee)? ☐ Yes ☐ No

s) ***When applicant has oxygen exposure but tanks are prefilled:***
Applicant has indicated an exposure with pre-filled oxygen on premises. For this exposure, confirm the following:

1. Do oxygen operations take place in a separate room? ☐ Yes ☐ No
   a. If yes, is this room restricted only to the applicant's employees and not the general public? ☐ Yes ☐ No
   b. Is this room clearly marked as restricted to only employees and also marked "NO SMOKING"? ☐ Yes ☐ No
2. Is a home assessment conducted prior to delivery and set up of any oxygen and its related equipment in a patient's home? ☐ Yes ☐ No
3. When oxygen is provided in the home, are "NO SMOKING" signs provided to the patient? ☐ Yes ☐ No
4. Is the proper use of oxygen reviewed with the patient and the caregiver and sign-off required by all parties (patient, caregiver and employee)? ☐ Yes ☐ No

II. MAINTENANCE AND/OR REPAIR OF EQUIPMENT

a) Does the applicant SELL used equipment? ☐ Yes ☐ No
If yes, please list the gross revenue derived from this operation: $_____

b) Does the applicant REPAIR used equipment? ☐ Yes ☐ No
If yes, please list the gross revenue derived from this operation: $_____

c) Please list all types of equipment you repair:

_____

_____

d) Are manufacturer's recommendations followed for all repair of equipment? ☐ Yes ☐ No

NON-OWNED AUTOMOBILE SECTION

a) How many of the applicant's staff (employees and/or I.C.'s) drive their own vehicles during the course of business, other than driving to and from a single work site? _____

b) Does the applicant require ***Employees*** and **Independent Contractors** to carry their own automobile liability insurance coverage? ☐ Yes ☐ No

c) Does the applicant review Motor Vehicle Reports as a condition of employment? (Please attach MVR's) ☐ Yes ☐ No

If yes, is this done annually for all staff including Independent Contractors?_____

d) Do any of the applicant's employees or Independent Contractors provide client transportation services? ☐ Yes ☐ No

e) Has the applicant ever been notified of a claim arising from an automobile incident involving an employee driver who was driving during the course of providing services for your business? ☐ Yes ☐ No

If yes, provide details on a separate sheet including incurred claim cost.

THIS SECTION TO BE COMPLETED BY ALL APPLICANTS

I/WE hereby declare the above statements and particulars are true to the best of my/our knowledge, and that I/we have not concealed or misstated any material facts, and I/we agree this application shall be the basis of the contract with the Company. If a policy is issued, this application will be attached to and become part of the policy.

FRAUD WARNINGS

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ALABAMA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

NOTICE TO ARKANSAS, NEW MEXICO AND 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.

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 FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

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.

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NOTICE TO 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.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWEDLGE 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 FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO 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.

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 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 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.

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 (365:15-1-10, 36 §3613.1).

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NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO 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 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 TENNESSEE, VIRGINIA AND WASHINGTON 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.

It is understood and agreed that the completion of this application does not bind the company to issue, nor the applicant to purchase the insurance.

Applicant Firm Name: _____

Signed By: _____
(Please type or print name and title)

Signature: _____ Date: _____
(Must be signed and dated by Principal or Officer of Firm)

Please **submit /** send application to**:**

Amwins Program Underwriters | 121 Connor Way, Suite 250, Williston, VT 05495

or email to:

Marie Gaudette**, CIC, CPIW, AINS**
Vice President, Program Manager
Phone: (802) 391-2195
Email: marie.gaudette@amwins.com