THE HARTFORD

_____

Name of Insurance Company to which application is made

APPLICATION FOR
PRIVATE CHOICE ENCORE® FOR HEALTHCARE ORGANIZATIONS

NOTICE: THE LIABILITY COVERAGE PARTS SCHEDULED IN ITEM 5 OF THE DECLARATIONS PROVIDE CLAIMS MADE COVERAGE. EXCEPT AS OTHERWISE SPECIFIED HEREIN, COVERAGE APPLIES ONLY TO A CLAIM FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD AND PAYMENT OF DEFENSE COSTS REDUCE THE LIMIT OF LIABILITY. NOTICE OF A CLAIM MUST BE GIVEN TO THE INSURER AS SOON AS PRACTICABLE, AFTER A NOTICE MANAGER BECOMES AWARE OF SUCH CLAIM, BUT IN NO EVENT LATER THAN SIXTY (60) CALENDAR DAYS AFTER THE TERMINATION OF THE POLICY PERIOD, OR ANY EXTENDED REPORTING PERIOD. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

1. GENERAL INFORMATION

a) Name of Applicant Organization: _____

b) Address:

c) Nature of Business: (Check all that may apply)

☐ Adult Day Care	☐ HMO	☐ Psychiatric Hospital
☐ Affiliate Health System	☐ Home Healthcare	☐ Rehabilitation Facility
☐ Ambulatory Surgery Center	☐ Hospice Care	☐ Respite Care
☐ Assisted Living Facility/CCRC	☐ Hospital	☐ Skilled Nursing Facility
☐ Behavioral & Mental Health	☐ Integrated Delivery System	☐ Surgical Center
☐ Blood/Organ Collection Center	☐ IPA, PHO, MSO	☐ Other _____
☐ Clinical Research Facility	☐ Laboratory	_____
☐ Dependency Rehab	☐ Network Provider	_____
☐ Eye Care Center	☐ Non profit clinic	_____
☐ Faculty Practice Group	☐ Physician Group	_____
☐ Health System	☐ PPO	_____

d) Date of Incorporation/Formation:

e) State of Incorporation/Formation:

f) Internet Address:

g) NAIC Code:

h) Entity Type:

☐ For-Profit Corp. ☐ Limited Liability Company ☐ Not-For-Profit Tax Exempt Corp.
☐ Not-For-Profit Taxable Corp. ☐ Partnership
☐ Other _____

i) Number of Years in Business: _____

2. COVERAGE REQUESTED

Proposed Effective Date: _____

a) Liability Coverage Requested with desired Limit (Indicate with 'x')

- ❑ Directors & Officers — Limit:_____
- ❑ Entity Liability (Included in D&O Coverage Part Limit)
- ❑ Employment Practices Liability — Limit:_____
- ❑ 3rd Party Liability (Included in EPL Coverage Part Limit) — Limit:_____
- ❑ Fiduciary Liability — Limit:_____
- ❑ HIPAA Coverage Sublimit — Limit_____
- ❑ Settlement Program Coverage (Sub-limit of $100,000 in Fiduciary Liability Coverage Part) — Limit: $100,000

b) ❑ Defense Outside the Limit is desired __ Yes __ No

c) Please indicate if an Aggregate Limit for all purchased Liability Coverage Parts is desired __Yes __ No

d) Non Liability Coverage Requested with desired Limit (Indicate with 'x')

- ❑ Kidnap and Ransom/Extortion — Limit:_____
- ❑ Crime:
  - ❑ 1. Employee Theft — Limit:_____Retention:_____
  - ❑ 2. Depositors Forgery Or Alteration — Limit:_____Retention:_____
  - ❑ 3. Inside The Premises — Limit:_____Retention:_____
  - ❑ 4. Outside The Premises — Limit:_____Retention:_____
  - ❑ 5. Computer And Funds Transfer Fraud — Limit:_____Retention:_____
  - ❑ 6. Money Orders/Counterfeit Currency — Limit:_____Retention:_____

3. ORGANIZATION INFORMATION

a) Total Revenues as of current fiscal year end: $_____
b) Total Assets as of current fiscal year end: $_____
c) Total Employees current fiscal yr. end: _____
d) Total number of locations: _____
e) Has an Organization experienced, within the past 2 years, any of the following events (or does an Organization expect any of the following events within the next 2 years):

- · acquisition of any other entity larger than 25% of the total assets of the Organizations? ___Yes___No
- · merger with any other entity? ___Yes___No
- · restructuring or legal or financial reorganization or filing for bankruptcy? ___Yes___No
- · write-downs, restatement(s) of financial reports, charges, or sale, distribution or divestiture of any assets? ___Yes___No
- · downsizing, layoffs, reduction in force, plant or office closings? ___Yes___No

f) Has an Organization, or anyone for whom insurance is intended, been involved in any:

- · anti-trust, restraint of trade, discrimination, or intellectual property-related proceeding(s)? ___Yes___No
- · civil or criminal action or administrative proceeding alleging a violation of any federal or state security law or regulation? ___Yes___No
- · representative actions, class actions, or derivative suits? ___Yes___No

If the answer is "Yes" to any of the above questions in e) or f), please provide complete details (attach separate sheet)

g) Please list all additional Organizations (e.g. Subsidiaries) on behalf of which coverage is being applied (attach separate sheet if necessary):

NAME	NATURE OF BUSINESS	DATE ACQ. OR CREATED	PERCENTAGE OWNED	STATE/COUNTRY OF INCORPORATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

- Latest CPA letter to management and any written response thereto
- Most recent audited Financial Statement or Annual Report and CPA opinion
- Other Information deemed necessary by the Underwriter

4. DIRECTORS, OFFICERS AND ENTITY COVERAGE PART (Complete Only if this Coverage Part is requested)

4.1 GENERAL

a) Total number of common shares outstanding:_____

b) Total number of common shareholders: _____

c) Total number of common shares held directly or beneficially by directors and officers (and functional equivalents): _____

d) Describe fully any other securities convertible to common shares: _____

e) Give names and percent owned of any shareholders who hold, directly or beneficially, 5% or more of the common shares outstanding: _____

f) Have there been any changes in executive directors or officers (or functional equivalents) during the past year or do they expect any within the next year? ___Yes ___No

g) Have the Organizations retained, or do they currently plan on retaining, an investment banker or financial advisor to increase or maximize shareholder value? ___Yes ___No

h) Is an Organization currently considering a private or public offering of any securities within the next year? ___Yes ___No

i) Do the Organizations, including the directors and officers (and functional equivalents) thereof, presently act or plan to act in the capacity of General Partner in any Limited or General Partnership? ___Yes ___No

j) Is an Organization currently, or has it at any time over the last year been, in breach or violation of any debt covenant or loan agreement or any other material contractual obligation? ___Yes ___No

k) Has an Organization changed auditors in the past year? ___Yes ___No

l) Have the Organizations' auditors informed an Organization of any disagreements or weaknesses with accounting practices? ___Yes ___No

m) Do the Organizations currently have tax exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code of 1986, as amended? ___Yes ___No

If "yes," is any challenge to an Organization's tax exempt status pending or anticipated by any party, private or governmental? ___Yes ___No

If the answer is "Yes" to any of the above questions, please provide complete details (attach separate sheet)

PLEASE PROVIDE THE FOLLOWING INFORMATION:

- Complete List of directors and officers (and functional equivalents) to include their name, position and affiliation with any other outside organizations
- Any Prospectus or Private Placement Memorandum

4.2 HEALTHCARE ORGANIZATION BUSINESS OPERATIONS

a) Are the Organizations JCAHO and/or NCQA accredited? ___ N/A ___Yes___No

If "yes," provide the accrediting body's name	Expiration Date	Last Overall Score

b) During the last 3 years, has any regulatory or accrediting body denied, suspended, revoked or granted, or subjected to contingency or recommendation, any license, certification or accreditation of any operation, department or facility of an Organization? ___ N/A ___Yes___No
If "yes," please provide complete details (attach separate sheet)

c) Does an Organization perform peer review or credentialing activities for medical staff or faculty? ___Yes___No

i) Do the Organizations have formal written policies and procedures in effect that address peer review, credentialing, re-credentialing and related activities, including, without limitation, decisions that could adversely affect medical staff or faculty membership, privileges or licensing? ___Yes___No
If "no," please provide complete details (attach separate sheet)
If "yes:"
Do such written policies and procedures meet:
- National Committee for Quality Assurance (NCQA) standards? ___Yes___No
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards? ___Yes___No
- applicable law according to the Organization's legal counsel? ___Yes___No

Are such written policies and procedures evaluated, implemented and provided to all members of the medical staff or faculty for review? ___Yes___No

ii) Is legal counsel always consulted before any recommendation or decision is finalized that could adversely affect medical staff or faculty membership, privileges or licensing? ___Yes___No
If "no," please provide complete details (attach separate sheet)

iii) During the last five (5) years, has an Organization been subject to legal recourse due to the restriction or suspension of any license or privilege of any member of the medical staff or faculty? ___Yes___No
If "yes," please provide complete details (attach separate sheet)

d) Do the Organizations have a formal committee of independent Directors, Managers or Trustees that reviews executive compensation? ___Yes___No
If "no," please provide complete details (attach separate sheet)

e) Is the legal advice of outside counsel always sought on matters of non-compete clauses, exclusive contracts, preferred pricing contracts (including Most Favored Nations or Most Favored Nations Plus clauses) ___Yes___No
If "no," please provide complete details (attach separate sheet)

f) Does an Organization render any standard setting, accrediting, peer review, credentialing, re-credentialing, licensing, or similar services to any third party? ___Yes___No

g) Does an Organization provide any non-clinical management or administrative services to any third party under any contract or agreement? ___Yes___No

h) Is an Organization managed or administered by any third party under contract or agreement? ___Yes___No

i). Does the market share of the Organizations' (including whether providers, healthcare services provided, membership in a network or hospital beds) exceed 25% in any geographical service areas? ___Yes___No

j) Are the Organizations' medical malpractice (Med. Mal.)/healthcare Professional Liability or other liability coverage self-insured or insured by means of a self-insured trust, captive, risk sharing arrangement or pool? ___Yes___No
If "yes:"
Please describe that insurance program by separate attachment (referenced below), including the most recent actuarial study and method of administration. Also include information regarding the funding of such program (e.g. whether it is in accordance with annually determined actuarial requirements).
Does the program provide insurance other than to the Organizations? ___Yes___No

If the answer is "Yes" to any of the above questions in f) though j), please provide complete details (attach separate sheet)

4.3 HEALTHCARE ORGANIZATION COMPLIANCE POLICIES AND PROCEDURES

a) Do the Organizations:

i) have formal written regulatory compliance policies and procedures (for example, The Federal False Claims Act , HIPAA, or HITECH Act) addressing the responsibilities of the Organization, its business partners, vendors and employees? ___Yes___No

If "Yes": Date(s) Implemented:_____ Date(s) Last Revised_____

ii) implement regular compliance education and training? ___Yes___No

iii) use audits or other evaluation techniques to monitor compliance/implementation? ___Yes___No

iv) use outside counsel to provide an opinion as to whether there could be a violation of law? ___Yes___No

b) Has an Organization:

i) Been subject to any regulatory investigation or indictment involving patient billing, business referral(s) or any anti-kickback law? ___Yes___No

ii) Been subject to any type of federal or state mandate or regulatory compliance oversight (for example, a corporate integrity agreement) ___Yes___No

iii) Been subject to any type of regulatory monetary settlement, fine or penalty? ___Yes___No

If "Yes" to any of b (i)-(iii) above, please provide complete details (attach separate sheet)

c) Do the Organizations have a formal written conflict of interest policy? ___Yes___No

d) Do the Organizations have a formal charity care policy that meets or exceeds applicable minimum state and federal requirements? ___Yes___No

e) Do the Organizations have any exclusive contracts with any providers? ___Yes___No
If "yes," please provide complete details (attach separate sheet)

f) Are all persons for whom this insurance is intended required to annually disclose financial and other conflicts of interest? ___Yes___No

g) Are all compensation arrangement s and business transactions evaluated annually for compliance with Excess Benefit Transaction rules as defined in Section 4958 of the Internal Revenue Code of 1986? ___Yes___No
If "no," please provide complete details (attach separate sheet)

h) Has an Organization or persons for whom this insurance is intended been subject to an investigation or paid a fine for an Excess Benefit Transaction Violation?. ___Yes___No
If "yes," please provide complete details (attach separate sheet)

i) Has an Organization been subject to an investigation or paid a fine for a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA)? ___Yes___No
If "yes," please provide complete details (attach separate sheet)

j) Do the Organizations have a formal code of ethics and business conduct policy? ___Yes___No
If "yes," does the Organization have an annual certification requirement? ___Yes___No

m) Do the Organizations have a program for continuous training and education as respects HIPAA/HITECH and other privacy laws and regulations? ___Yes___No

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5. EMPLOYMENT PRACTICES LIABILITY COVERAGE PART (Complete Only if this Coverage Part is Requested)

a) For the current and previous years, please list the following Employee and related information:

Year	_____	_____
Total Employees	_____	_____
Full Time	_____	_____
Part Time	_____	_____
Seasonal	_____	_____
Leased	_____	_____
Temporary	_____	_____
Union	_____	_____

Approximately what percent of the above are Employee Physicians?
_____% _____%

****

Non-Employee Physicians/Staff	_____	_____
Independent Contractors	_____	_____

b) Please also list the following for the current and previous years:

Year	_____	_____
Involuntary Terminations:	_____	_____
Resignations:	_____	_____
Retirees:	_____	_____
Layoffs:	_____	_____

c) Please list the total number of employees in the following jurisdiction.

MICHIGAN	_____
TEXAS	_____
CALIFORNIA	_____
OTHER	_____
FOREIGN	_____

d) Please list the number of employees in the following salary ranges (including any bonus and commissions):

$50,000 or less	$50,000 - $100,000	$100,000 - $250,000	Over $250,000

e) Are the following policies or procedures contained in the employee handbook? If no handbook, are they distributed to each employee and/or posted?

Sexual Harassment	___Yes ___No
Discrimination	___Yes ___No
Equal Employment Opportunity	___Yes ___No
Americans with Disabilities Act	___Yes ___No
"Employment-At-Will" wording?	___Yes ___No

f) Does each employee sign acknowledgement of these procedures? ___Yes ___No

g) Do the Organizations have written procedures for:

Discipline	___Yes ___No
Termination	___Yes ___No
Performance Evaluations	___Yes ___No
Employment Related Disputes	___Yes ___No

h) Has legal counsel approved the aforementioned policies? ___Yes ___No

i) Are employee performance evaluations conducted on an annual basis? ___Yes ___No

j) Are exit interviews mandatory? ___Yes ___No

k) Do the Organizations Maintain Personnel Files for all Employees? ___Yes ___No

l) Has an Organization experienced any complaints charges or hearings involving any of the following:

Title VII of the Civil Rights Act of 1964	___Yes ___No
Age Discrimination in Employment Act	___Yes ___No
The Americans with Disabilities Act	___Yes ___No
The Equal Employment Opportunity Commission	___Yes ___No
The Family and Medical Leave Act	___Yes ___No
Any State or Local Government agency as respects Employment Practices Liability.	___Yes ___No

If "yes" to any part of question l), please provide complete details (attach separate sheet)

m) Do the Organizations have a Human Resources Department? ___Yes ___No
If "no," who handles Human Resource functions? _____
Who handles Human Resource functions at locations other than your principal place of business?
_____
Who has the authority to hire and terminate employees? _____

n) If an Organization had any downsizing, layoffs, reduction in force, plant or office closings, please answer the following questions:

Was/is severance available to all employees? ____Yes ____No **If "no,"** please provide details_____

Were/are the employees required to sign a release for the severance package? ____Yes ____No

Did any employees refuse to sign the release? ____Yes ____No **If "yes,"** how many? ___

Complete Only if Third Party Liability is Requested:

a) Do the Organizations have written procedures describing conduct when working with patients, visitors and third parties including anti-discrimination and/or anti-harassment statements? ____Yes ____No

b) Do the Organizations have written procedures for responding to complaints, discrimination or harassment by third parties? ____Yes ____No

c) What percentage of the Organization's employees deal with patients, visitors, the general public, work at customer locations or perform a majority of their functions off-site? _____%

d) Has there been any loss history from an Organization receiving any complaints from a non-employee? ____Yes ____No
If "yes," please provide complete listing, with number, defense and/or settlement costs.

PLEASE PROVIDE THE FOLLOWING INFORMATION:
Employee Handbook
Employment Application

EEO-1 Report if the total number of employees is over 100.

6. FIDUCIARY LIABILITY COVERAGE PART (Complete Only if this Coverage Part is Requested)

a) For Each Plan to be covered, please list the following:

PLAN NAME	PLAN TYPE*	# OF PARTICIPANTS	PLAN ASSETS (CURRENT YEAR)	PLAN STATUS**
			$	
			$	
			$	

* Plan Type: Defined Benefit (DB), Defined Contribution (DC), Welfare (W), Employee Stock Ownership (ESOP) or Other (O).

** Plan Status: Active (A), Merged (M), Terminated (T) or Frozen (F).

b) Does the plan conform to ERISA? ___Yes ___No

c) Has an Organization, plan, or plan fiduciary been accused or found guilty of a breach of fiduciary duty or violation of ERISA? ___Yes ___No

d) Does any plan hold or provide the option to invest in the securities of an Organization or any subsidiary? **If "yes,"** please list the percentage that the securities comprise that plan's total assets. ___Yes ___No

e) During the past 2 years have there been, or during the next year do you anticipate any reduction in benefits? ___Yes ___No

f) Have any plan been investigated by the DOL, IRS or any other regulatory agency in the past 2 years? ___Yes ___No

g) Has the IRS threatened to withdraw the tax-exempt status of a plan? ___Yes ___No

If there is an adverse response to any question above, please provide complete details (attach separate sheet)

PLEASE PROVIDE THE FOLLOWING INFORMATION:
Plan Audit or Form 5500 for all Pension and Welfare plans to be covered by this policy when Plan Participants exceed 100.

7. CRIME COVERAGE PART (Complete Only if this Coverage Part is Requested)

LOSS EXPERIENCE		
List all fidelity and crime losses discovered or sustained in the last three years. Check here if none: ☐		
DATE OF LOSS	**TYPE OF LOSS (Employee Dishonesty, Forgery, etc.)**	**AMOUNT OF LOSS**
Please attach details of all losses including description, corrective action taken and amount covered by insurance.		

a) FOREIGN EXPOSURE:
- Total Number of Foreign Employees (excl. Canada): _____
- Total Number of Foreign Locations: _____
- Countries where foreign locations exist: _____

b) Do you prohibit any employee who reconciles bank statements from also:
- Signing checks? ___Yes ___No
- Handling bank deposits? ___Yes ___No
- Making withdrawals? ___Yes ___No
- Having access to check signing machines or signature plates? ___Yes ___No

c) Is an authorized vendor list used to assist in detecting payments to fictitious suppliers ___Yes ___No

d) Is the responsibility for authorizing vendors, approving invoices and processing payments

segregated among different individuals ___Yes ___No
If "no," and one person has complete responsibility, does this person also have authority to sign checks and reconcile bank accounts? ___Yes ___No

e) Is your purchasing department separated from receiving responsibilities and supervised by someone who is not authorized to pay bills? ___Yes ___No

f) Are perpetual inventories maintained, including a physical check of stock and equipment? ___Yes ___No
If "yes," by whom? _____How often? _____

g) Are the duties of computer programmers and operators separated? ___Yes ___No

h) Are two or more employees involved in the wire transfer process? ___Yes ___No

i) If wire transfers are done via telephone, does your bank process the transfer only after making a return phone call to an employee other than the one who requested the transfer? ___Yes ___No

j) Is there a process whereby completion of wire transfers are confirmed? ___Yes ___No
If "yes," are the wire transfers reconciled on the same day the confirmation is received? ___Yes ___No

k) Are your financial statements audited by an independent CPA? ___Yes ___No

l) Does the independent CPA provide a Management Letter? **If "yes,"** please attach the most recent copy along with management's response to the letter. ___Yes ___No

m) Do you have an internal audit department or someone with internal audit responsibilities? ___Yes ___No
If "yes," what is the staff size? _____Are all locations audited? ___Yes ___No

n) For new employees, are background checks conducted? **If "yes,"** does it include: ___Yes ___No
- prior employment verification? ___Yes ___No
- criminal history? ___Yes ___No
- drug testing? ___Yes ___No

o) Please mark any of the following characteristics or exposures that apply to your company's operations:
___ Precious metals/gemstones ___ high unit value, portable inventory ___ Narcotics/pharmaceuticals
___ Art or other collectibles ___ warehouse/distribution operations ___ manufacturing operations

p) Do you take care and custody of clients' property? ___Yes ___No
If "yes," does care and custody occur; ___ On premises ___ On clients' premises (please check)

q) Please describe in detail the services you provide for clients:_____
_____

r) What is the maximum amount of money/securities at any one location?
Money:_____
Securities:_____ Negotiable Instruments:_____

If the answer is "No" to any of questions b) through n), please provide complete details.

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8. KIDNAP AND RANSOM/EXTORTION COVERAGE PART (Complete Only if this Coverage Part is Requested)

a) Has there ever been a prior kidnapping, extortion or detention incident? ___Yes ___No

b) Has there ever been any threat or attempt at a kidnapping, extortion or detention? ___Yes ___No

c) Are there any current threats or incidents regarding kidnapping, extortion or detention? ___Yes ___No

d) Are any of the persons for whom this insurance is intended likely kidnapping prospects because of business, outside interests or other activities? ___Yes ___No

e) Are any operations to be insured involved in the production of food, beverages or pharmaceuticals (including toothpaste, mouthwash, etc.)? ___Yes ___No

If "yes" to any of the above, please provide details:

_____

_____

_____

Please complete the following regarding the foreign travel of the Organizations' employees:

Country	Number of Trips/Year	Average Length of Stay	Number of Employees Traveling
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe the Organizations' security precautions taken for foreign travel:

_____

_____

_____

Please complete the following regarding foreign locations:

Country	Number of Employees	Number of Locations
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the security precautions taken at foreign locations:

_____

_____

_____

9. CURRENT INSURANCE PROGRAMS:

Please provide the following details regarding the Organizations' Current Insurance programs:

PRODUCT	INSURER	LIMIT	SIR	PERIOD FROM/TO	PREMIUM
D&O	_____	_____	_____	_____	_____
EPL	_____	_____	_____	_____	_____
Fiduciary	_____	_____	_____	_____	_____
MPL/E&O	_____	_____	_____	_____	_____
GL	_____	_____	_____	_____	_____
PL (including Med. Mal.)	_____	_____	_____	_____	_____
Work Comp	_____	_____	_____	_____	_____
Fidelity/Crime	_____	_____	_____	_____	_____
Kidnap and Ransom/Extortion	_____	_____	_____	_____	_____

10. PRIOR KNOWLEDGE (RENEWAL APPLICANTS: Question 10. need not be answered).

Does anyone for whom insurance is being applied have any knowledge or information of any error, misstatement, misleading statement, act, omission, neglect, breach of duty or other matter that may give rise to a claim that may fall within the scope of coverage of the proposed insurance? ___Yes ___No

If "yes," please provide complete details (attach separate sheet)

IT IS AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM BASED ON, ARISING FROM, OR IN ANY WAY RELATING TO SUCH ERROR, MISSTATEMENT, MISLEADING STATEMENT, ACT, OMISSION, NEGLECT, BREACH OF DUTY OR OTHER MATTER OF WHICH THERE IS KNOWLEDGE OR INFORMATION SHALL BE EXCLUDED FROM COVERAGE UNDER THE INSURANCE BEING APPLIED FOR.

11. LOSS HISTORY (RENEWAL APPLICANTS: Question 11. need not be answered).

a) Provide details of any actual or potential claims reported under prior insurance for which this policy would provide coverage (if none, so state).

b) Has any Insurer cancelled or refused to renew any Directors and Officers, Employment Practices, Fiduciary, Crime, Kidnap Ransom or similar insurance within the past 3 years?

___Yes ___No

*** MISSOURI APPLICANTS NEED NOT REPLY.**

Applicable to Liability Coverage Parts Only:

c) Are there any pending claims or demands against an Organization or anyone for whom this insurance is intended that may fall within the scope of coverage afforded by any similar insurance presently or previously in effect? ___Yes ___No

d) Has anyone for whom this insurance is intended given notice under the provisions of any other previous or current similar insurance policy of any facts or circumstances, which may give, rise to a claim being made against an Organization and/or anyone for whom this insurance is intended? ___Yes ___No

If the answer is "Yes" to any of the above questions, please provide complete details (attach separate sheet)

REGARDING THESE QUESTIONS C & D, IT IS AGREED THAT IF ANY SUCH CLAIMS, DEMANDS OR NOTICES EXIST, ANY CLAIM BASED UPON, ARISING FROM OR IN ANY WAY RELATED TO SUCH MATTERS SHALL BE EXCLUDED FROM THE INSURANCE BEING APPLIED FOR. THE INFORMATION PROVIDED IN THIS APPLICATION IS FOR UNDERWRITING PURPOSES ONLY AND DOES NOT CONSTITUTE NOTICE TO THE COMPANY OF A CLAIM OR POTENTIAL CLAIM UNDER ANY POLICY. IF YOU INTEND TO NOTICE A CLAIM OR POTENTIAL CLAIM FOR POSSIBLE COVERAGE, PLEASE COMPLY WITH THE NOTICE OF CLAIM CONDITIONS/PROVISIONS FOUND IN YOUR POLICY, BY SENDING WRITTEN NOTICE OF SUCH TO: (Insert the address and phone number of the local The Hartford office.)

California Notice: The Hartford may charge a fee if this bond or policy is cancelled before the end of its term. The fee can range between 5% to 100% of the pro rata unearned premium. Please refer to the terms and conditions stated in the policy or bond. This notice does not apply to cancellations initiated by The Hartford.

FRAUD WARNING STATEMENTS

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.

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

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 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 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: 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 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 MAY BE 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 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.

PUERTO RICO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURANCE COMPANY PRESENTS FALSE INFORMATION IN AN INSURANCE APPLICATION, OR PRESENTS, HELPS, OR CAUSES THE PRESENTATION OF A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR ANY OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME DAMAGE OR LOSS, SHALL INCUR A FELONY AND, UPON CONVICTION, SHALL BE SANCTIONED FOR EACH VIOLATION WITH THE PENALTY OF A FINE OF NOT LESS THAN FIVE THOUSAND (5,000) DOLLARS AND NOT MORE THAN TEN THOUSAND (10,000) DOLLARS, OR A FIXED TERM OF IMPRISONMENT FOR THREE (3) YEARS, OR BOTH PENALTIES. IF AGGRAVATED CIRCUMSTANCES PREVAIL, THE FIXED ESTABLISHED IMPRISONMENT MAY BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS; IF EXTENUATING CIRCUMSTANCES PREVAIL, IT MAY BE REDUCED TO A MINIMUM OF TWO (2) YEARS.

RHODE ISLAND 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."

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.

VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE, OR A STATEMENT OF CLAIM CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME IN CERTAIN JURISDICTIONS.

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."

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.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (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, 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.

THIS APPLICATION MUST BE SIGNED BY THE CHAIRMAN OF THE BOARD, CHIEF EXECUTIVE OFFICER OR THE PRESIDENT OF THE APPLICANT ORGANIZATION.

SIGNATURE_____

TITLE:_____DATE_____

PLEASE SUBMIT THIS PROPOSAL AND APPROPRIATE MATERIALS TO:

(Enter the address and phone number of the local The Hartford office.)

Required applicants in **Florida, Iowa & New Hampshire**

NAME OF BROKER _____BROKER LICENSE NO._____

ADDRESS_____

BROKER SIGNATURE *(Required: New Hampshire only)*_____