

General Information

Named Insured: _____

1. Is your nonprofit required to be licensed? Yes No
 License expiration date: _____ Licensed capacity (number of children, students, and so on): _____
 ■ Has your nonprofit's license ever been suspended or revoked? Yes No
 If "Yes", attach an explanation, and describe what was done to prevent a similar occurrence and be re-licensed.

I. Insureds Operations

Please provide a brief description of operations: _____

By checking here, I am confirming that the insured's operations do not involve any of the following **ineligible** operations:

- | | |
|---|---|
| Adoption or Foster care placement | Funeral Homes or Chapels |
| Adult Day Care-Alzheimer/dementia- non ambulatory | Home Care, Home nursing, or similar type |
| Condo or homeowners association | Hospitals, including mental institutions |
| Confidence courses | Labor Unions |
| Contracting or construction risks | One on One Mentoring |
| Governmental Agencies | Political Organizations |
| Correction or Penal Facilities | Radical Advocacy Groups |
| Contact sports | Residential Facilities for the mentally ill |
| Convalescent, assisted living or hospice care | Substance Abuse- Medical Detoxification |
| Employment Agencies- as primary operation of risk | Suicide Hotline |

This organization does have one or more ineligible operations but I would like consideration regardless based on the following:

II. Activities

N/A

Check all activities that apply to your operations:

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Archery | <input type="checkbox"/> Fishing | <input type="checkbox"/> Rock Climbing | <input type="checkbox"/> White Water Rafting |
| <input type="checkbox"/> Fire arms | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Rope Course | <input type="checkbox"/> Horseback Riding |
| <input type="checkbox"/> Overnight camp | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Water Skiing | <input type="checkbox"/> Martial Arts (contact) |
| <input type="checkbox"/> Boating** | <input type="checkbox"/> Swimming*** | <input type="checkbox"/> Tackle Football | <input type="checkbox"/> Confidence Course |
| <input type="checkbox"/> Other, describe: _____ | | | |

**Provide the number of canoes _____, rowboats _____, and motorboats _____

***Is the swimming in a lake or a pool? _____

III. Facilities

- Is there a housekeeping and maintenance program in effect? Yes No
- Are all exits marked with lighted "Exit" signs? Yes No
- Is the building equipped with emergency lighting? Yes No
- Is the building equipped with hard-wired smoke detectors? Yes No
- Are fire drills conducted at least semi-annually? Yes No
- Do you require subcontractors to name your nonprofit as an additional insured on their general liability insurance policies? Yes No
- If the facility has a kitchen:
 - Is cooking equipment covered by an automatic suppression system? Yes No
 - Are fire extinguishers installed in the kitchen? Yes No
 - When was the kitchen fire protection equipment last inspected? (Mo/Yr.) _____

- 8. Are "No Smoking" signs posted, and are smoking rules enforced? Yes No
- 9. Does facility meet state health, safety, and fire codes? Yes No
- 10. When was the last health, safety, and fire code inspection? (Mo./Yr.) _____
- 11. Are emergency evacuation procedures and floor plans posted? Yes No
- 12. Is the facility equipped with:
 - an automatic sprinkler system? Yes No
 - fire extinguishers? Yes No
- 13. Is the parking lot well lit? Yes No
- 14. Are the exterior walkways or parking lot in need of repair? Yes No
- 15. Is smoking prohibited inside the building? Yes No
- 16. How many exits are on the ground floor? _____
- 17. How many exits are on the second floor or higher? _____

IV. Insureds Members, Students or Clients/Clientele N/A

Age Group	Number of Members				% Developmentally Disabled				% Physically Disabled			
	Location				Location				Location			
0 to 3 years												
4 to 7 years												
8 to 12 years												
13 to 17 years												
18 and over												

- Indicate which of the following clients your nonprofit services (check all that apply):
- Developmentally disabled
 - Physically disabled
 - Clients requiring medical/psychiatric treatment by your agency
 - Clients requiring drug treatment by your agency
 - Youths with prior criminal convictions—indicate acceptable types of convictions or attach a copy of your agency's client acceptance policy: _____
 - Other, describe: _____

Student teacher ratio if applicable _____
 Does the insured provide accident insurance _____

V. Hiring Controls

- | | <i>Employees</i> | | <i>Volunteers</i> | |
|--|------------------------------|-----------------------------|------------------------------|-----------------------------|
| 1. Do employment applications require applicant's signature? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does your application ask about past convictions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Do you check prior employment and personal references? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you check qualifications and credentials? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does your employment application indicate that you will secure a criminal background check as part of the pre-employment screening process? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you conduct checks required by state, local or federal statute? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Do you work with a vendor who will conduct criminal background checks on your behalf? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ If yes provide name of vendor: _____ | | | | |
| 8. What type of criminal background check is obtained? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| County: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| State: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Federal: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. How often are background checks run on employees and volunteers? _____ | | | | |
| 10. What action does your non-profit take when the background report indicates that an employee or volunteer has been convicted of a sexually related offense? _____ | | | | |

Requested Coverage Form: Claims-made, Retroactive Date: _____ Occurrence
 Requested Limits of Liability (**Claims Made**/Aggregate per millions): _____

I. General Information

1. Do you use subcontractors or consultants who work with your clients? Yes No
 - If "Yes", do you require them to carry sexual abuse/molestation insurance? Yes No
 - Are certificates of sexual abuse/molestation liability insurance, that name your nonprofit Yes No
 2. Describe any sexual abuse/molestation incidents and/or insurance losses/claims: No Incidents
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II. Operational Activities

1. Location
 - Indicate where your operations with clients take place (check one or more):
 - Public Areas Private Offices Remote Locations School Facilities
 - Camping Private Homes Other, describe: _____
 - Do any of these areas allow for unsupervised one-to-one contact? Yes No
 - What controls are in place to prevent abuse in these situations?
 - None Office Window Open Door Cameras Other: _____
2. Supervision

Indicate the type of interaction your employees and volunteers have with your clients:

 - Single employee or volunteer may be alone with a client
 - Two or more employees or volunteers are required to be present with a client
3. Parental or Family Involvement

Indicate the amount of parental or family involvement in your activities:

 - Routine, ongoing involvement of parents or family members
 - Occasional parental or family involvement
 - No, or almost no, parental or family involvement
4. Interaction with Clients
 - How long is a client normally associated with your organization?
 - One-time visit Multiple opportunities for contact
 - Do your operations create opportunities for employee or volunteer contact with a client outside of your facilities? Yes No
 - If "Yes", indicate where: Private Homes Recreational Activities
 - Other, describe: _____
5. Physical Contact

Indicate the amount of physical contact between employees/volunteers and your clients:

 - None Occasional Daily
6. Personal Activities

Indicate the personal activities your employees or volunteers assist your clients with:

 - Bathing Toileting Putting clients to bed
 - Changing clothes Normally no assistance with personal activities

III. Operational /Risk Management Techniques

1. Do you have written policies and procedures for the prevention of abuse? Yes No
2. Do your written policies and procedures prohibit clients from having sexual relations with each other? (Attach a copy of your procedures). Yes No
3. Will you help prosecute anyone suspected of abuse or molestation? Yes No

4. Do you follow local governmental requirements for reporting an incident? Yes No
5. Indicate your abuse or molestation prevention training:

	None	Orientation	Formal Training	Are records kept of this training?	
Employees:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Volunteers:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clients:				<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Does your facility have security patrols or cameras monitoring client areas? Yes No
- If "Yes", do any of these areas allow one-on-one contact with clients? Yes No

Social Services Professional Liability Application

N/A

Requested Limits of Liability (Occurrence Form – per Claim/Aggregate): _____

I. General Information

1. Current coverage: Claims Made, Retroactive Date: _____ Occurrence None
2. Describe any professional liability or malpractice insurance claims: No prior claims

II. Insureds Operations

1. Indicate whether or not your nonprofit provides each of the following services:
- Marriage and family counseling Yes No
 - General psychological counseling Yes No
 - Pastoral counseling Yes No
 - Substance abuse Yes No
 - Vocational rehabilitation Yes No
 - Education Yes No
- Other, describe: _____

III. Medical Providers

Psychiatrists, physicians, or other professionals providing medical services to your clients **must carry separate medical professional insurance coverage**. Please answer the following questions pertaining to these professionals:

1. Do medical professionals (employee, volunteer, or subcontractor) provide services for your nonprofit? Yes No
If "Yes", describe the medical services provided: _____
2. Do you require that medical professionals maintain medical professional liability insurance? Yes No
If "Yes", do you require them to provide you with certificates of medical professional liability insurance? Yes No
3. Does your agency provide any medical services? Yes No
If "Yes", describe the medical services provided: _____
4. Does your agency dispense prescription drugs? Yes No
5. Are medications kept in a locked area? Yes No
6. Does a qualified staff member administer the medications? Yes No
7. Is medication administered at a doctor's direction only? Yes No
8. Are records kept of medication administration? Yes No

IV. Number and Type of Workers

The premium for this coverage is determined by a number of factors. One important consideration is the number and type of workers affiliated with your organization.

- | | | |
|---|-------------------|--------------------|
| | Employees* | Volunteers* |
| 1. Provide the number of workers used by your organization: | _____ | _____ |
| ▪ Each Licensed* Psychologist, Psychiatrist or Clinical Social Worker | _____ | _____ |
| ▪ Each Licensed* Clinical Social Worker, Psychologist, or Psychiatrist who is acting in the capacity as an administrator, director or employee only. | _____ | _____ |
| ▪ Each Unlicensed Therapist, Counselor, Analyst, Psychotherapist, Psychoanalyst or similar position | _____ | _____ |
| ▪ Each individual teacher. | _____ | _____ |

*Do not include clerical office workers, drivers, maintenance employees, or any other individual not directly involved in the delivery of social services.

Volunteers will be counted as one full time employee unless you provide more detailed information outlining a different level of involvement with your organization: _____

Automobiles

N/A

I. Non-owned Auto Exposure

- Do employees and/or volunteers use their own vehicles on your behalf? Yes No
 - What is the primary purpose of their driving?

<input type="checkbox"/> Errands/shopping	<input type="checkbox"/> Attend meetings
<input type="checkbox"/> Transport clients	<input type="checkbox"/> Other, describe: _____
- What is the total number of drivers who monthly operate their own vehicles on your behalf?
 Employees _____ Volunteers _____
- Do you obtain proof of personal automobile insurance from employees and volunteers who use their own vehicles on your behalf? Yes No
 - How often is this information updated? _____
 - What Personal Automobile Liability Limit do you require of these drivers?
 \$ _____ /person \$ _____ /accident or \$ _____ CSL

II. Client Transportation

Complete the following questions if your non-profit offers transportation of clients

- Is transportation provided in:

<input type="checkbox"/> Your non-profit's own vehicles	<input type="checkbox"/> Employees'/volunteers' vehicles	<input type="checkbox"/> Charter service*
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 - *If a charter service is used, do you require the service to name your non-profit as an additional insured on its automobile liability insurance policy? Yes No
 - What Automobile Liability Limit do you require the charter service to carry? _____
- How often are vehicles used for client transportation? _____
- Describe the type of clients transported:

<input type="checkbox"/> Elderly	<input type="checkbox"/> Mentally Handicapped	<input type="checkbox"/> Non-ambulatory/Wheelchairs
<input type="checkbox"/> Children	<input type="checkbox"/> Physically Handicapped	<input type="checkbox"/> Other, describe: _____
- Describe the purpose of transportation:

<input type="checkbox"/> School Bus – to school or school outings	<input type="checkbox"/> Church Bus – to services or church activities
<input type="checkbox"/> Van Pool – to work	<input type="checkbox"/> Other, describe: _____
- Is seat belt use or child/infant car seat mandatory for driver and all passengers? Yes No
- If children are transported, is one adult other than the driver assigned to supervise them? Yes No
- Are vehicles properly equipped to handle wheelchairs? Yes No
- Are drivers trained to handle the type of client transported? Yes No
- How many trips in excess of 200 miles one way do you make annually? _____
- Do you have any 15 passenger vans? Yes No

III. Driver Selection

- Do you order Motor Vehicle Reports (MVRs) on all employees and volunteers before allowing them to drive on your behalf? Yes No
 - How often is this information updated? Annually Semi-Annually Never
 - What do you consider an acceptable MVR?
 No violations
 No more than 2 moving violations or at-fault accidents in the last 3 years
 Other, describe: _____
 - Do you enroll your drivers in the DMV Pull Program?** Yes No
- Do you have driver-hiring standards? **If yes, attach a copy** Yes No
 - Are there any drivers under age 21? Yes No
 - Are there any drivers over age 65? Yes No
 - Have any drivers been licensed less than 2 years? Yes No
 - Do any of the above drivers transport clients? Yes No
- How do you control the use of cellphones while driving? _____

IV. Automobile Safety & Maintenance Program

- Do you have a written fleet safety & maintenance program? **If yes, attach a copy of your program.** Yes No
 - Is a manager responsible for implementing and monitoring the program? Yes No
- Do you have a formal driver-training program? **If yes, attach a copy of your program** Yes No
- How often are vehicles checked for maintenance needs? _____
- Is a maintenance log kept for each vehicle? Yes No
- Are drivers required to report any vehicle deficiencies? Yes No
- Are any vehicles covered under another policy? Yes No
Explain: _____
- Are employees allowed to use company vehicles for personal use? Yes No
- Do you extend the same safety requirements that you have for your owned vehicles to non-owned vehicles used to transport your clients? Yes No
- Do the same training standards that you have for drivers of your owned vehicles apply to drivers of non-owned vehicles used to transport clients? Yes No

Camp

N/A

I. Facility

- Is the camp accredited by the American Camping Association (ACA)? Yes No
- How many days is the camp open each year? _____
- What is the average number of campers daily? _____
- Do any buildings have wood burning fireplaces or stoves? Yes No
- How is the cooking equipment protected (fire extinguishers, ANSUL system, and so on)? _____
When was this protective equipment last inspected? _____
- Is the camp leased, rented, or otherwise made available to others? Yes No
Are certificates of general liability insurance that name your nonprofit as additional Insured obtained from the user? Yes No

II. Staff

- What is the counselor to camper ratio? _____
- What is the minimum age of the counselors? _____
- Describe training provided for new counselors: _____
- Are counselors' job responsibilities in writing? Yes No
- Are nurses or physicians on staff? Yes No
 - Do they carry their own medical professional liability coverage, and name the camp as an additional insured on these policies? Yes No

III. Safety Policies

1. Is a medical history obtained for each camper? Yes No
2. Are emergency phone numbers for both parents/guardians and physicians maintained for each camper? Yes No
3. Are parents required to give signed permission for:
 - Authorized emergency medical transportation/treatment Yes No
 - Participation in sporting or athletic activities? Yes No
4. Does the camp obtain signed waivers from parents? Yes No
5. What are the procedures for handling medication, injury, and illness? _____
6. Is the staff certified in CPR and emergency first aid? Yes No
7. Is a first aid kit kept on premises? Yes No
8. What are the procedures for handling emergency medical evacuation? _____
9. What is the distance to the nearest hospital? _____
10. Are smoke detectors installed in all buildings used as sleeping quarters? Yes No
11. Are fire extinguishers kept in all buildings? Yes No
12. Is there a written fire evacuation plan including scheduled fire drills? Yes No
13. How is the camp secured for the off-season? _____
14. Is accident insurance carried on campers and counselors? Yes No

Club

N/A

I. Facility

1. What hours is the club open?
2. Are the facilities leased, rented, or otherwise made available to others? (Y/N)
If "yes", do you require lessees to name your nonprofit as an additional insured on their general liability insurance policies? (Y/N)
3. Is liquor served? (Y/N)
If "yes", are all servers required to verify guests' ages, and is there a policy in place to prevent intoxication of the guests? (Y/N)

Location Number			
1	2	3	4

Yes No

II. Safety Policies

1. Are there posted, written rules, and an enforcement policy for the adequate supervision and safe use of all club facilities? (Y/N)
2. Do you carry an accident policy on your club members? (Y/N)
3. Is the staff trained in CPR and Red Cross certified in first aid? (Y/N)
4. Are parents required to give signed permission for their children's participation in athletic and sporting events? Are waivers obtained?
5. What is the policy regarding the supervision of minors? _____

Location Number			
1	2	3	4

Liquor Legal Liability Questionnaire

N/A

1. Are you in the business of manufacturing, selling or serving alcoholic beverages? Yes No
2. Are you required to obtain a temporary liquor license? Yes No
3. Have you ever had a liquor liability claim made against you or been cited for a Liquor Control Board violation? Yes No

If yes, explain: _____

4. If you hire a contractor to sell or serve alcohol at your function(s), do you request and retain a certificate of insurance showing that the contractor carries general liability and liquor liability limits of at least \$1M/\$2M and names you as an additional insured? Yes No
5. Do you require staff serving or selling alcohol, or those you hire to do so, to be trained in an alcohol beverage intervention program such as TIPS? Yes No
- **If yes**, specify the intervention program applied: _____
 - **If no**, please describe your policies on serving or selling alcoholic beverages to your customers or guests (checking IDs, handling those who appear to be intoxicated, arranging for rides, etc.): _____
6. When a customer or guest is refused alcohol, how is the incident documented? _____

School

N/A

I. Staff

1. What is the staff to student ratio? _____
2. Is corporal punishment an accepted discipline method? (Y/N) _____

Location Number			
1	2	3	4

II. Field Trips

1. Describe the number and types of field trips taken annually: _____
2. Are signed permission slips or waivers obtained from parents or guardians? Yes No
3. Describe your procedure for monitoring students during a field trip, or attach a copy of your procedure: _____
4. How are students transported? Charter Service Employees'/Volunteers' Vehicles Agency's Own Vehicles
 Other, describe: _____

III. Safety Policies

1. Do you carry an accident insurance policy on your students? Yes No
2. Describe your procedure for handling medication, injury, or illness; or attach a copy of your procedure: _____
Does the staff have training in CPR and emergency first aid? Yes No
Is a first aid kit kept on premises? Yes No
3. Describe the procedure for releasing children to others, or attach a copy of your procedure: _____
4. Are emergency phone numbers for both parents and physicians maintained and updated regularly for each student? Yes No
5. Describe your intruder prevention policy, or attach a copy of your policy: _____
6. Is your school equipped with metal detectors? Yes No
7. Does the school have zero tolerance policy towards students who violate school rules, especially those who engage in acts of violence? Yes No

IV. Playground

1. Do you have playground equipment? (If "Yes", complete the remaining questions.) Yes No
2. What playground equipment do you have, and when was it installed? _____
3. How tall is the tallest piece of playground equipment? _____
4. What type of protective surfacing material is used under and around the equipment? _____
How thick is this protective surfacing material? _____
How far out does the protective surfacing extend beyond the equipment? _____
5. Is access to the playground completely restricted by fences or gates? Yes No
6. Is supervision provided during play sessions? Yes No

Residential

(Group homes, Transitional Living, Ronald McDonald Houses, Retreat Centers and Homeless Shelters)

N/A

I. Facility

1. Are residents allowed to prepare their own meals? (Y/N)
2. Is there supervision over the residents' cooking activities? (Y/N)
3. Are bathrooms equipped with grab bars and nonslip surfaces? (Y/N)

Location Number			
1	2	3	4

II. Residents

1. Indicate type of residents: (Not applicable to Ronald McDonald houses)
 - substance abusers (alcohol or drugs)
 - behavioral problems
 - severe mental illness (severe depression, paranoid, schizophrenic, etc.)
 - developmentally disabled
 - other, describe: _____
2. Is average length of stay less than 30 days? (Y/N)
3. Are residents' conditions maintained with medications? (Y/N)
4. Are all residents ambulatory? (Y/N)
5. Do you accept residents that are referred to you by the judicial system as an alternative to incarceration? (Y/N)
 - If "Yes", do you have any restrictions on accepting residents based on the types of offences they have committed? (Y/N)
 - List unacceptable offenses: _____
6. Do you accept residents that were previously involved in violent crimes, sex crimes, or arson? (Y/N)
7. Indicate the number of residents under 18:
8. Indicate the number of residents age 18 and over:
9. Indicate if residents are male (M), female (F), or coed (C):
10. If home is coed, how are male and female residents separated? _____
11. Do your written policies and procedures prohibit clients from having sexual relations with each other? (Y/N) Attach a copy of your procedures.

Location Number			
1	2	3	4

III. Supervision

1. Is there 24-hour awake supervision? (Y/N)
2. What is the minimum number of staff on duty at any one time?
3. Are medications kept in a locked area? (Y/N)
4. Does a staff member administer the medications? (Y/N)
5. Is medication administered at a doctor's direction only? (Y/N)
6. Are records kept of medication administration? (Y/N)
7. How does management control visitors to the premises? _____

Location Number			
1	2	3	4

Special Events

(Such as Fund Raisers, Trips, Parades, Exhibitions, Entertainment, and so on) Additional details may be required.

N/A

1. List all Special Fund Raising Events – Do not list regularly scheduled meetings whether on or off premises

Name of Event	Proposed Date of Event	Description of Event	Estimated Attendance	Estimated Income From This Event	Estimated Liquor Sales*	Has Insured ever had this event before?		
						No	Yes	# of Years Event Has Been Held
				\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
				\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
				\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
				\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
				\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	
				\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	

*If liquor liability coverage is desired, please indicate the limits on the ACORD general liability application, and show the estimated sales receipts above.

Enter all claims or occurrences that may give rise to claims for the prior 5 years: Check here if none

Date of Occurrence	Description of Occurrence or Claim	Date of Claim	Amount Paid	Amount Reserved	Claim Status	
					Open	Closed
			\$	\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	\$	<input type="checkbox"/>	<input type="checkbox"/>

Insured Signature

Date

FRAUD STATEMENT

Please read the statement applicable to your state and the final statement. Then sign, date and return with your application.

- CALIFORNIA:** In addition, any person who knowingly makes an application for motor vehicle insurance coverage containing any statement that the applicant resides or is domiciled in this state when, in fact, that applicant resides or is domiciled in a state other than this state, is subject to criminal and civil penalties.
- 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 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.
- 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 a denial of insurance benefits.
- MASSACHUSETTS: NOTICE:** If you or someone else on your behalf gives us false, deceptive, misleading or incomplete information in this application and if such false, deceptive, misleading or incomplete information increases our risk of loss, we may refuse to pay claims under any or all of the Optional Insurance Parts and we may cancel your policy. Such information includes the description and the place of garaging of the vehicle(s) to be insured, the names of operators required to be listed and the answers to questions in this application about all listed operators. Check to make certain that you have correctly listed all operators and the completeness of their previous driving records. The Merit Rating Board may verify the accuracy of the previous driving records of all listed operators, including that of the applicant for this insurance.
- MICHIGAN:** Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000.00.
- MINNESOTA:** A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- NEW YORK:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.
- OHIO:** ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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 and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state 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 the person to criminal and civil penalties.
- RHODE ISLAND:** *In Rhode Island this question must be answered by any applicant for property insurance. Failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one year of imprisonment.* DURING THE LAST TEN YEARS, HAS ANY APPLICANT BEEN CONVICTED OF ANY DEGREE OF THE CRIME OF ARSON? ___ YES ___ NO
- UTAH:** For your protection, Utah law requires the following to be included in this application: "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."
- 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.
- WISCONSIN:** 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.
- ALL OTHER STATES:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

12/03

Signature of Applicant

Date