Berkley Healthcare | a Berkley Company

QUARTO℠

FINANCIAL LINES INSURANCE

New Business Application

For Organizations with up to 250 Employees

NOTICE

NOTICE: THE LIABILITY COVERAGE SECTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMITS OF LIABILITY TO PAY INSURED LOSS SHALL BE REDUCED AND MAY BE EXHAUSTED BY PAYMENT OF DEFENSE COSTS AND DEFENSE COSTS SHALL BE APPLIED AGAINST ANY APPLICABLE RETENTION. IN NO EVENT SHALL THE INSURER BE LIABLE FOR DEFENSE COSTS OR INSURED LOSS IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

INSTRUCTIONS

WHENEVER USED IN THIS **APPLICATION**, THE TERM "**APPLICANT**" SHALL MEAN THE **NAMED INSURED** AND ITS SUBSIDIARIES. ALL OTHER BOLDFACE TERMS IN THIS **APPLICATION** ARE DEFINED IN THE **POLICY** AND HAVE THE SAME MEANING IN THIS **APPLICATION** AS IN THE **POLICY**. PLEASE ANSWER ALL QUESTIONS FULLY AND TYPE OR PRINT CLEARLY. IF YOU DO NOT HAVE A COPY OF THE **POLICY**, PLEASE REQUEST IT FROM YOUR AGENT OR BROKER.

NOTE: For any questions that require a "☐Yes" or "☐No" response followed by an asterisk (*), please provide or attach a full explanation.

I. General Information

1.	Legal Name of **Applicant**						
2.	Address	Street					
		City		State		Zip	
3.	**Applicant's** Website						
4.	State of Incorporation			Date of Incorporation			
5.	Individual authorized to receive notices and information regarding the proposed **Policy** and **Claims**						
	Name			Title			
	Address						
	Telephone			Email			
6.	Individual designated to receive risk management information						
	Name		Title		Email		

II. Insurance Information

	Coverage Requested	Limit Requested	Retention Requested	Shared Limit Requested	Current Limit	Current Retention	Current Premium	Current Carrier
☐	Directors & Officers Liability	$	$	☐	$	$	$	
☐	Employment Practices Liability	$	$	☐	$	$	$	
☐	Fiduciary Liability	$	$	☐	$	$	$	
☐	Crime	$	$		$	$	$	

MISSOURI APPLICANTS: DO NOT ANSWER QUESTIONS II(1) AND II(2):

1.	Has the **Applicant** been canceled or non-renewed for any of the insurance coverages listed above?	☐ Yes*	☐ No
2.	Has any insurer for any coverages listed above indicated an intent not to offer renewal terms to the **Applicant**?	☐ Yes*	☐ No

III. General Risk Information

1. NAICS Code that describes main operations (6 Digit) ____________

2. **Applicant's** business and operations include the following (check all that apply):

☐	Home Healthcare	☐	Hospital	☐	Long Term Care
☐	Managed Care	☐	Other Ambulatory Healthcare	☐	Physician Group or Clinic
☐	Social Services	☐	Surgery Center	☐	Other (describe below)

3. Provide description of the **Applicant's** business, including any explanation if "Other" was checked above: ____________________
____
____
____

4. List all states and countries in which the **Applicant** operates: ____________________
____

5. **Applicant** (as set forth in question I(1) is:

(a) Tax Status

☐	Not-For-Profit Tax Exempt 501(c)(3)	☐	For Profit - Private
☐	Not-For-Profit Taxable	☐	For Profit – Public

(b) Organizational Structure

☐	Not-For-Profit Corporation	☐	S-Corporation
☐	Professional Corporation (PC, PA)	☐	C-Corporation
☐	Partnership (GP, LLP)	☐	Joint Venture
☐	Limited Partnership (LP)	☐	Other (describe) ____________
☐	Limited Liability Corporation		____________

If the **Applicant** is a General Partnership, Limited Partnership, Limited Liability Partnership or joint venture, please provide a copy of the partnership or joint venture agreement.

6. If the **Applicant** is a Not-For-Profit Tax Exempt Corporation, is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? ☐ Yes* ☐ No

7. If the **Applicant** is formed as a limited partnership, provide the name of all general partners and indicate the percentage ownership that each general partner has in the limited partnership.
____

8. Do any of the **Applicant's** subsidiaries act as a general partner for another organization? ☐ Yes ☐ No
*Please note that unless specifically endorsed onto the **Policy**, the term **Subsidiary** will not include partnerships.
If "Yes," describe the nature of the other organization's business, if different than the **Applicant**:
____

9. Does the **Applicant** have any subsidiaries, joint ventures or non-owned entities under management control? ☐ Yes ☐ No
If "Yes," please attach an organizational chart reflecting ownership, a description of operations, and the tax status of each such entity. Indicate whether coverage is requested for each such entity.

10. **Applicant's** Accreditation (check all that apply): ☐ JCAHO ☐ NCQA ☐ URAC ☐ Other: ________
(a) Has any **Applicant's** license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? ☐ Yes* ☐ No

11. Please provide the following financial information for the two most recent fiscal years (indicate month and year below):
(a) Financial Information

Category	**MM/YY: ___/___**	**MM/YY: ___/___**
Annual Revenue	$	$
Current Assets	$	$
Total Assets	$	$
Current Liabilities	$	$
Long Term Debt	$	$
Total Liabilities	$	$
Equity or Net Assets	$	$
Net Income (or Loss)	$	$
Cash Flow From Operations	$	$

(b) Please provide revenue breakdown (by percentage) for Medicare, Medicaid and Private Pay:

Medicare	_______%	Medicaid	_______%	Private Pay	_______%

	(c)	Does the **Applicant** have a defined benefit pension fund liability?	☐ Yes	☐ No
	(d)	Has the **Applicant** ever received a qualified opinion from its auditors?	☐ Yes*	☐ No
	Please attach a copy of the **Applicant's** financial statements for the last two (2) years (audited statements, if done).			

12.	Has the **Applicant** completed in the past eighteen (18) months, or proposed or contemplated in the next twelve (12) months, any of the following:				
	(a) Merger, acquisition or consolidation of any type?	☐ Past 18	☐ Next 12	☐ No	
	(b) Sale, Distribution or Divestiture of Assets or Stock?	☐ Past 18	☐ Next 12	☐ No	
	(c) A change in outside auditor?	☐ Past 18	☐ Next 12	☐ No	
	(d) Branch, location, facility, office, or subsidiary closings, layoffs or reductions in force?	☐ Past 18	☐ Next 12	☐ No	
	(e) Reorganization or arrangement with creditors under federal or state law?	☐ Past 18	☐ Next 12	☐ No	
	(f) Undertaking any new areas of business?	☐ Past 18	☐ Next 12	☐ No	
	(g) Entering into new governmental contracts?	☐ Past 18	☐ Next 12	☐ No	
	(h) Conversion from Not-For-Profit to For-Profit status?	☐ Past 18	☐ Next 12	☐ No	
	If the **Applicant** checked any of the "Past 18" or "Next 12" check boxes in response to question 12, please describe the material terms of each such transaction or event on a separate attachment.				
13.	Does the **Applicant** currently purchase medical professional liability coverage?	☐ Yes	☐ No*		
14.	Does the **Applicant** have coverage for peer review and credentialing activities under any insurance policy, self-insured trust, captive, risk sharing arrangement or pool?	☐ Yes	☐ No		

Submission Attachments

In addition to any attachments that are requested throughout this **Application**, please submit the following:

- Loss runs for the past five (5) years from any carrier for which coverage is requested and is a direct or indirect replacement; and
- Summary and status report of any litigation filed in the last five (5) years against any person or entity proposed for insurance including any litigation that is resolved, which is not included in the loss runs but may be covered under any of the coverage section(s) requested.

IV. Directors & Officers Liability Information

☐ If a quote for **Directors & Officers Liability** coverage is desired, tick the check box and answer the questions in Section A. If optional coverages are desired, complete the corresponding Sections B-E as instructed below.

A. Ownership & Control

1.	Do you have a board of directors or equivalent?	☐ Yes	☐ No*
2.	Please indicate the number of authorized _____ and currently filled _____ board seats (or equivalent).		
3.	Are these positions ☐ elected or ☐ appointed? If "appointed," please attach an explanation.		
4.	In the past twenty-four (24) months has the **Applicant** completed any change in directors other than due to term expiration or death?	☐ Yes*	☐ No
5.	Total number of outstanding shares or ownership instrument equivalents: _______________		

** Whenever used in the **Application**, the term shares or shareholders shall also include the equivalent ownership interest in organizations other than stock based corporations.*

6.	Does any shareholder of the **Applicant** own five percent (5%) or more of the voting shares directly or beneficially? If "Yes," please complete the table below. Attach additional pages if necessary.	☐ Yes	☐ No

Name of Shareholder	Ownership %	Director or Officer?	Family Relationship?
	%	☐ Yes ☐ No	☐
	%	☐ Yes ☐ No	☐
	%	☐ Yes ☐ No	☐
	%	☐ Yes ☐ No	☐

If any individual listed above is related by family to another shareholder, director or officer of the **Applicant**, please tick the corresponding check box.

7.	Has any shareholder changed their ownership percentage by more than five percent (5%) in the last year?	☐ Yes*	☐ No

8.	Recent, Pending or Potential Changes			
	(a)	Is the **Applicant** currently (or during the past twelve (12) months has the **Applicant** been) in breach or in violation of any debt covenant?	☐ Yes	☐ No
	(b)	In the past twenty-four (24) months has the **Applicant** had any change in executive officers?	☐ Yes	☐ No
	(c)	In the past twenty-four (24) months has the **Applicant** completed any:		
		(i) Public or private offering of securities?	☐ Yes	☐ No
		(ii) Issuance of debt?	☐ Yes	☐ No
	(d)	Is the **Applicant** currently anticipating any of the above?	☐ Yes	☐ No
	If "Yes" to any of the questions above, please attach a full explanation, including any private placement memoranda or any documents filed with the Securities and Exchange Commission and a description including the type and amount of the offering, the method of solicitation or advertising, and the verification method of investor qualification, if applicable.			
9.	Does the **Applicant** have a conflict of interest policy in place applicable to all directors, officers and trustees?		☐ Yes	☐ No
10.	Does the **Applicant** have a cybersecurity program in place that covers all aspects of cyber and data security, including Personal Health Information?		☐ Yes	☐ No*
11.	Does the **Applicant** currently purchase cyber/data security insurance?		☐ Yes	☐ No
	If "Yes," please attach a description of the insurance program (carriers, limits, etc.).			
B.	**Antitrust**			
☐	If a quote for **Antitrust Claim** coverage is desired, tick the check box and answer the questions in Section B.			
1.	Does the **Applicant** have any exclusive contracts with any providers?		☐ Yes*	☐ No
2.	With respect to the following markets, does the **Applicant** control more than twenty percent (20%) of the market in any given geographical area?			
	(a)	Providers in any one field of medical practice.	☐ Yes	☐ No
	(b)	Health care services.	☐ Yes	☐ No
	If "Yes" to question 2(a) or (b) above, please attach market share percentage(s).			
3.	Does the **Applicant** have any provider agreements that contain non-compete clauses?		☐ Yes*	☐ No
4.	Does the **Applicant** have any provider agreements that contain "Most Favored" pricing clauses?		☐ Yes*	☐ No
C.	**Provider Selection**			
☐	If a quote for **Provider Selection Claim** coverage is desired, tick the check box and answer the questions in Section C.			
1.	Does the **Applicant** perform Provider Selection (i.e. peer review and credentialing) for its health care staff, whether or not such staff is employed by the **Applicant**?		☐ Yes	☐ No
	(a)	Does the **Applicant** have formal written policies and procedures in effect that address peer review, credentialing, re-credentialing and decisions that could adversely affect health care staff membership, privileges or licensing?	☐ Yes	☐ No
	(b)	Does the Provider Selection process include querying the National Practitioner Data Bank?	☐ Yes	☐ No
	(c)	Is legal counsel consulted before any recommendation or decision is finalized that could adversely affect health care staff membership, privileges or licensing?	☐ Yes	☐ No
2.	(a)	Within the last two (2) years has the **Applicant** closed or restricted staff admissions of a provider to any patient service department for reasons other than professional competence, including but not limited to a conflict of interest? If "Yes," please attach details including the number of providers impacted.	☐ Yes	☐ No
	(b)	Are there any formal plans for future closings or restrictions, as described in C(2)(a) above?	☐ Yes	☐ No
	(c)	If the answer to any part of question C(2) is "Yes," has the **Applicant** consulted with legal counsel regarding proper procedures and safeguards prior to any such instance?	☐ Yes	☐ No
D.	**Healthcare Fraud & Abuse**			
☐	If a quote for **Healthcare Fraud & Abuse Claim** coverage is desired, tick the check box and answer the questions in Section D.			
1.	Is there a Compliance Program in effect? If "Yes,":		☐ Yes	☐ No
	(a)	Date Program implemented: __/__/__ (b) Most recently revised date: ___/___/___		
	(c)	How frequently does the Board receive reports about compliance issues? ______________________________________		
2.	Compliance Officer Information			
	(a)	Name and title of the individual responsible for Compliance: ____		
	(b)	Does the individual have direct access to the CEO?	☐ Yes	☐ No*
	(c)	Does this individual have direct access to the Board?	☐ Yes	☐ No*
3.	Does the **Applicant** provide compliance training and education to all employees, **Independent Contractors** and independently practicing medical providers?		☐ Yes	☐ No*

4.		Does the **Applicant** provide annual training and education to employees, **Independent Contractors** and independently practicing medical providers who do billing and coding?	☐ Yes	☐ No*
5.		Does the **Applicant** conduct an annual, internal review of its billing and coding for compliance with applicable laws and regulations?	☐ Yes	☐ No*
6.		Does the **Applicant** have policies that address the protection of whistleblowers?	☐ Yes	☐ No*
7.		Does the **Applicant** utilize an external audit firm to monitor billing and coding compliance?	☐ Yes	☐ No*
8.		Does the **Applicant** utilize billing edit/checking software?	☐ Yes	☐ No*
9.		Does the **Applicant** centralize its billing and coding function?	☐ Yes	☐ No*
10.		Does the **Applicant** maintain a procedure, such as a hotline, to receive complaints and allegations of regulatory non-compliance or wrongdoing?	☐ Yes	☐ No*
	(a)	If "Yes," what is the average number of complaints or allegations per month? ____________________		
	(b)	Are all complaints recorded and investigated?	☐ Yes	☐ No*
11.		**Healthcare Fraud & Abuse Past Activities**		
		In the past five (5) years, has any **Applicant** proposed for this insurance:		
	(a)	Been subject to any regulatory inquiry, investigation, indictment or proceeding for any actual, alleged, or potential violations of the following, regardless of whether or not such inquiry was a result of voluntary self-disclosure:		
	i.	Federal False Claims Act of 1863, or any similar federal, state or local statutory or common law?	☐ Yes*	☐ No
	ii.	Ethics in Patient Referrals Act of 1986 (Stark Law) or any similar federal, state, or local statutory or common law?	☐ Yes*	☐ No
	iii.	Any other similar federal, state, or local statutory or common law, rules or regulation?	☐ Yes*	☐ No
	(b)	Violated any healthcare fraud and abuse law?	☐ Yes*	☐ No
	(c)	Entered into a criminal or civil settlement with the United States, a state, or any party acting on behalf of the United States or a state by which claims against such **Applicant** were resolved?	☐ Yes*	☐ No
E.		**Additional Directors & Officers Optional Coverages**		
☐		If a quote for **EMTALA Claim** coverage is desired, tick the check box and answer the question E(1).		
1.		Does the **Applicant** conduct annual training pursuant to a formal training plan with respect to EMTALA?	☐ Yes	☐ No*
☐		If a quote for **HIPAA Claim** coverage is desired, tick the check box and answer the question E(2).		
2.		Does the **Applicant** conduct annual training pursuant to a formal training plan with respect to HIPAA/HITECH and applicable state and federal privacy and data security laws?	☐ Yes	☐ No*
☐		If a quote for **IRC Claim** coverage is desired, tick the check box and answer the questions E(3-4).		
3.		Are all compensation arrangements and business transactions evaluated annually for compliance with Excess Benefits Transactions rules as defined in Section 4958 of the Internal Revenue Code of 1986, as amended?	☐ Yes	☐ No*
4.		Has the **Applicant** been subject to an investigation or paid a fine for an Excess Benefit Transaction violation?	☐ Yes*	☐ No
F.		**Directors & Officers Past Activities (other than Healthcare Fraud and Abuse Past Activities)**		
1.		Has the **Applicant** or any person proposed for coverage been the subject of, or been involved in, any of the following in the past five (5) years:		
	(a)	Anti-trust, copyright or patent litigation?	☐ Yes*	☐ No
	(b)	Deceptive or unfair trade practices or consumer fraud?	☐ Yes*	☐ No
	(c)	Civil, criminal or administrative proceeding alleging violation of any federal or state securities law?	☐ Yes*	☐ No
	(d)	Any other criminal action?	☐ Yes*	☐ No
2.		Other than those identified in your response to question F(1), has any **Claim** that might be covered by this **Policy** been brought at any time during the last five (5) years against, (i) any **Applicant** or (ii) any proposed **Insured Person** in his or her capacity as a director or officer of any entity?	☐ Yes*	☐ No

V. Employment Practices Liability Information

☐ If a quote for **Employment Practices Liability** coverage is desired, tick the check box and answer the questions in Sections A, B, D & E. If optional **Third Party Liability** coverage is desired, complete Section C as instructed below.

A. Employee Information

1. Total current worldwide employees		Number of in-house counsel	

2. Number of employees by category:

Category	Current Year (as of MM/YYYY) Total	California	Foreign	Prior Year (as of MM/YYYY) Total	California	Foreign
Full-time (not including employed physicians)						
Part-time (not including employed physicians)						
Independent Contractors (other than **Independent Medical Providers**)						
Volunteers						
Employed Physicians						
Independent Medical Providers						

3. Terminations & Layoffs:

	Total	California	Foreign	Total	California	Foreign
Voluntary Terminations						
Involuntary Terminations						
Layoffs (5% or more of workforce or more than 50 employees)						

4. For the past three (3) years, list the annual percentage turnover rate of employees at all locations:

Current Year	_____%	Prior Year	_____%	Two Years Ago	____%

5. Salary Ranges (provide percentage of employees who fall into the following salary ranges; should total 100%):

Salary Range	Current Year %	Prior Year %
Up to $50,000		
$50,000 -$150,000		
$150,000 - $250,000		
$250,000 - $500,000		
Over $500,000		

Adjust part time salaries to full time equivalent.

6.	Are any providers required to maintain credentials at any other institution as a contingency of their employment with the **Applicant**?	☐ Yes	☐ No

B. Policies and Procedures

1.	Does the **Applicant** have an employee handbook?	☐ Yes	☐ No*
	If "Yes," is the employee required to sign and acknowledge receipt of the handbook?	☐ Yes	☐ No
2.	Is there a written process, policy or procedure for:	**Yes**	**No**
	Equal Employment Opportunity	☐	☐
	Anti-Discrimination	☐	☐
	Anti-Harassment (including sexual harassment)	☐	☐
3.	Does the **Applicant** conduct anti-discrimination and anti-harassment (including sexual harassment) training for all individuals for whom it is seeking coverage including **Independent Contractors** or **Independent Medical Providers**?	☐ Yes	☐ No
4.	Does the **Applicant** restrict employee access to employees' personal information such as social security numbers, account information and health care information?	☐ Yes	☐ No

C. Third Party Liability

☐ If a quote for **Third Party Claim** coverage is desired, tick the check box and answer the questions in Section C.

1.	Does the **Applicant** have established policies and procedures outlining employee conduct when dealing with customers, vendors, service providers, business invitees or other third parties?	☐ Yes	☐ No
2.	Does the **Applicant** conduct training for all individuals for whom it is seeking coverage regarding anti-discrimination and anti-harassment (including sexual harassment) policies and procedures with respect to third parties?	☐ Yes	☐ No

D.	Employment Practices Past Activities			
1.	During the past three (3) years has any **Applicant**, in any capacity, been involved in any of the following matters:			
	(a)	EEOC or any similar administrative proceeding?	☐ Yes*	☐ No
	(b)	Employment or labor-related litigation or disputes resulting in payment (including defense costs) greater than $10,000 during the last five (5) years?	☐ Yes*	☐ No
	(c)	Any action or civil suit brought against them by any customers, vendors, service providers, business invitees or other third parties alleging harassment, discrimination, or civil rights violations?	☐ Yes*	☐ No
	(d)	Any violation of, or payment of any **Claims** related to, any law governing wage, hour or payroll policies and practices?	☐ Yes*	☐ No

VI. Fiduciary Liability Information

☐	If a quote for **Fiduciary Liability** coverage is desired, tick the check box and answer the questions in Sections A & C. For **Applicants** with Defined Benefit Plans, also complete Section B.		
For each **Fiduciary Optional Coverage** quote desired, tick the corresponding check box below.			
☐	**Voluntary Compliance Notice**	☐	**IRC 4975 Claim**
☐	**HIPAA Claim**	☐	**ERISA 502(c) Claim**
☐	**PPACA Claim**	☐	**PPA Claim**

A.	Plan Information
1.	Provide the following information for each **Plan** to be covered:

Plan Names	Plan Assets (current year)	Type of Plan*	Number of Participants	Plan Status**	Funded Status (if DB Plan)

*Defined Benefit (DB), Defined Contribution (DC), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP), Church Plan (CP), Other (O) – Attach Explanation | ** Active (A), Merged (M), Sold (S), Terminated (T), Frozen (F)

2.	Does the **Applicant** handle any investment decisions in-house?	☐ Yes*	☐ No
3.	Are any **Plans** currently not in compliance with **Plan** agreements or ERISA?	☐ Yes*	☐ No
4.	In the past three (3) years, has the **Applicant** merged, terminated or frozen any **Plan**?	☐ Yes	☐ No
	If "Yes," please attach details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance.		
5.	Are all **Plans** compliant with the Health Insurance Portability and Accountability Act (HIPAA)?	☐ Yes	☐ No*
B.	**Defined Benefit Plans**		
	Applicants with Defined Benefit Plans please complete this Section.		
1.	Has an actuary certified that all Defined Benefit Plans are adequately funded in accordance with ERISA or any applicable similar law of the United States, or any state or other jurisdiction anywhere in the world?	☐ Yes	☐ No*
2.	Is there ERISA fidelity bond coverage currently in place with respect to any **Plan**?	☐ Yes	☐ No
3.	Please attach audited pension financial statements for each Defined Benefit Plan.		
C.	**Fiduciary Past Activities**		
1.	Has the **Applicant** or any **Plan** experienced an event reportable to the PBGC or been the subject of an investigation by the DOL, the IRS or any similar foreign agency in the last three (3) years?	☐ Yes*	☐ No
2.	Has any fiduciary been accused, found guilty or held liable for a breach of trust?	☐ Yes*	☐ No
3.	Has any fiduciary been convicted of criminal conduct?	☐ Yes*	☐ No
4.	Have any **Claims** (other than for benefits) been made during the past three (3) years against any benefit program or any current or past fiduciaries?	☐ Yes*	☐ No
5.	Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any **Plan**?	☐ Yes*	☐ No

VII. Crime Non-Liability Information

☐	If a quote for any **Crime Non-Liability** coverage is desired, tick the check box and answer the questions in Section A below. *Complete the "Social Engineering Fraud Supplemental Application" if a quote for **Social Engineering Fraud** is desired.

For each **Crime Optional Coverage** quote desired, tick the corresponding check box below.

☐	**Employee Theft**	☐	**Funds Transfer Fraud**
☐	**Premises**	☐	**Money Orders & Counterfeit Currency Fraud**
☐	**In Transit**	☐	**Credit Card Fraud**
☐	**Forgery**	☐	**Client**
☐	**Computer Fraud**	☐	**Social Engineering Fraud***
☐	**Expense**		

A.		**Crime Information**		
1.		Does someone other than the person responsible for reconciling bank accounts make deposits, withdrawals or sign checks?	☐ Yes	☐ No*
2.		What is the limit above which the **Applicant** requires countersignature for their checks?	$______________	
3.		Do employees have access to resident's bank accounts?	☐ Yes*	☐ No
4.		Does the **Applicant** conduct background screening (including criminal, credit and prior employment checks) on all prospective employees?	☐ Yes	☐ No*
5.		Does the **Applicant** use a Positive Pay System?	☐ Yes	☐ No*
6.		Does the **Applicant** have inventory? If "Yes," please answer the following:	☐ Yes	☐ No
	(a)	Does the **Applicant** have physical safeguards such as surveillance, security and lockup procedures?	☐ Yes	☐ No*
	(b)	How often, and by whom, are inventory (including but not limited to pharmaceuticals and other controlled substances) counts conducted? ______________________________		
	(c)	Is inventory audited and counted by someone other than the person in charge of the daily management of the inventory?	☐ Yes	☐ No*
	(d)	Are pharmaceuticals and other controlled substances stored in locked spaces?	☐ Yes	☐ No*
7.		If applying for **Client** Coverage, please answer the following:		
	(a)	Describe the services the **Applicant** provides for **Clients:**______________________________		
	(b)	Does the **Applicant** have custody or control over any funds, accounts, or materials of any of its **Clients**? If "Yes," please attach a description.	☐ Yes	☐ No
B.		**Crime Past Activities**		
		Has the **Applicant** or any proposed **Insured** sustained any crime-related losses in the past three (3) years? If "Yes," please provide a full explanation in a separate attachment.	☐ Yes	☐ No

VIII. Warranty Statement

No **Insured** proposed for coverage has knowledge of any **Wrongful Act,** fact, circumstance, situation, transaction or event which could reasonably be expected to give rise to any future **Claim** or loss except as follows:

☐ None, or ☐ Yes, (If "Yes," provide full details on a separate sheet.)

Without prejudice to any other rights and remedies of the **Insurer**, it is agreed by all concerned that if any such **Wrongful Act**, fact, circumstance, situation, transaction or event exists, whether or not disclosed above, any **Claim** or loss arising from such **Wrongful Act**, fact, circumstance, situation, transaction or event shall be excluded from coverage under the proposed **Policy**.

IX. Applicant Representations, Fraud Warnings and Signatures

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE INSURER TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE INSURER SHALL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT ACKNOWLEDGES THAT ITS BROKER/PRODUCER IS NOT APPOINTED BY THE INSURER AND IS ACTING AS THE APPLICANT'S REPRESENTATIVE, AUTHORIZED TO PRESENT THIS APPLICATION ON THE APPLICANT'S BEHALF TO THE INSURER. IN THIS CAPACITY THE BROKER/PRODUCER HAS NO UNDERWRITING OR BINDING AUTHORITY WITH THE INSURER AND CANNOT BIND COVERAGE OR MODIFY THIS

APPLICATION OR ANY INSURANCE POLICY. ANY BINDER OR POLICY MODIFICATION SHALL BE VALID ONLY IF ISSUED BY THE INSURER. APPLICANT FURTHER ACKNOWLEDGES THAT ANY FEES THAT IT PAYS TO THE BROKER/PRODUCER FOR THIS SERVICE IS AGREED TO IN WRITING BETWEEN APPLICANT AND THE BROKER/PRODUCER.

FRAUD WARNINGS

Notice to Arkansas, Minnesota, New Mexico and Ohio Applicants: Any person who, with 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

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 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.

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.

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 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 and 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.

Notice to Maine, 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 may include imprisonment, fines or a denial of insurance benefits.

Notice to Alabama and 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 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 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.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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 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.

SIGNATURES
THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED APPLICATION FOR INSURANCE AND IN ANY MATERIALS SUBMITTED WITH THIS APPLICATION ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY THE INSURER. IF THE INFORMATION IN THE APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT SHALL NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE INSURER IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.
THE INFORMATION REQUESTED IN THIS APPLICATION IS FOR UNDERWRITING PURPOSES ONLY AND DOES NOT CONSTITUTE NOTICE TO THE INSURER UNDER ANY POLICY OF ANY ACTUAL OR POTENTIAL CLAIM OR LOSS.
THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER (OR THE FUNCTIONAL EQUIVALENT) OF THE APPLICANT. BY SIGNING THIS APPLICATION, THE UNDERSIGNED AUTHORIZED REPRESENTATIVE AGREES TO CONDUCT ELECTRONIC COMMERCE AND TO ACCEPT AN ELECTRONIC INSURANCE POLICY AND OTHER DOCUMENTS ISSUED BY THE INSURER. THE UNDERSIGNED AUTHORIZED REPRESENTATIVE ACKNOWLEDGES THAT HE OR SHE MAY REQUEST A WRITTEN (PAPER) POLICY.

SIGNATURE OF INSURED AUTHORIZED REPRESENTATIVE	
SIGNATURE	
PRINTED NAME	
DATE	
TITLE	
INSURED'S AUTHORIZED REPRESENTATIVE (AGENT/BROKER)	
SIGNATURE	
STATE PRODUCER LICENSE NUMBER	
PRINTED NAME	
AGENCY NAME AND PHONE NUMBER	
DATE	

UTAH APPLCANTS ONLY (NO SIGNATURE REQUIRED)
ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE INSURER. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES IF ALLOWED BY STATE LAW AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

ARKANSAS, MISSOURI, NEW MEXICO, NORTH DAKOTA AND WYOMING APPLICANTS ONLY
THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT HEREBY ACKNOWLEDGES THAT HE/SHE IS AWARE THAT THE LIMIT OF LIABILITY CONTAINED IN THIS POLICY SHALL BE REDUCED, AND MAY BE COMPLETELY EXHAUSTED, BY THE COSTS OF LEGAL DEFENSE AND, IN SUCH EVENT, THE INSURER SHALL NOT BE LIABLE FOR THE COSTS OF LEGAL DEFENSE OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT TO THE EXTENT THAT SUCH EXCEEDS THE LIMIT OF LIABILITY OF THIS POLICY.
THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT HEREBY FURTHER ACKNOWLEDGES THAT HE/SHE IS AWARE THAT LEGAL DEFENSE COSTS THAT ARE INCURRED SHALL BE APPLIED AGAINST THE RETENTION AMOUNT.

SIGNATURE OF INSURED AUTHORIZED REPRESENTATIVE	
SIGNATURE	
PRINTED NAME	
DATE	
TITLE	