

### 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 may be reduced and may be exhausted by payment of defense costs and defense costs may be applied against any applicable retention. Please read the entire application carefully before signing.

### INSTRUCTIONS

Please answer all questions fully and print clearly.

If additional space is needed to fully answer a question please attach a separate document.

The application must be signed and dated by an authorized representative of the applicant. Authorized representative may include any executive officer, member of human resources, risk management or in-house general counsel.

For multi-location risks, please complete below at a corporate level and complete Berkley Healthcare Multi Location Supplemental for exposure information by location.

I. General Information													
1.	Legal Name of Applicant: _____												
2.	Address: Street _____ _____ City _____ State _____ Zip _____												
3.	Has there been any change in management companies in the last year? If yes, provide management company name: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>												
4.	<table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">Within the next 12 months does the Applicant plan to:</td> <td style="width: 40%; text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Obtain another operation or entity?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Divest any locations?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Expand the number of locations?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Begin operations in another state?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Expand or cease any services?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Within the next 12 months does the Applicant plan to:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obtain another operation or entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Divest any locations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expand the number of locations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Begin operations in another state?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expand or cease any services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the next 12 months does the Applicant plan to:	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Obtain another operation or entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Divest any locations?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Expand the number of locations?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Begin operations in another state?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Expand or cease any services?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
	If yes, please provide details: _____												

II. Applicant Credentials	
5.	When was the date of the Applicant's last state inspection or survey? <span style="float: right;">___ / ___ / ____</span>
6.	Was a Corrective Action Plan submitted to and accepted by the state? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>

7.	<p>If yes to any of below, please provide explanation on separate attachment.</p> <p>In the past 5 years:</p> <p>Has the Applicant's License been suspended, revoked or been placed on probation? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>Has the Applicant's Medicare or Medicaid Certification been revoked or suspended? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>Has the Applicant been fined by a state or federal agency? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>
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III. Risk Classification			
8.	<p><b>Description of Operations:</b> For more than 1 location, please document all locations in the multi-location Excel application.</p>		
	<b>Level of Care</b>	<b>Total # Licensed Beds/Units</b>	<b>Average # of Occupied Beds/Units</b>
	<b>Sub-Acute/High Acuity Care:</b> Dedicated beds for medically fragile residents requiring intensive care. This includes intravenous tube feeding, tracheotomy care, ventilator care, traumatic brain injury and complex wound care		
	<b>Skilled Nursing:</b> Dedicated beds for administration of medication, catheter care, physical and occupational therapy, routine changing of dressing, tube feeding and assistance for activities of daily living		
	<b>Memory Care/Alzheimer's Care:</b> Dedicated beds for residents with memory loss or impairment and/or Alzheimer's Care and Services		
	<b>Assisted Living:</b> Dedicated beds for residents that need assistance with medication, activities of daily living, meals, etc.		
	<b>Independent Living:</b> Dedicated units for individuals that are self-sufficient and occupy their own units. These residents do not receive health care services and administer their own medications without assistance.		
		<b>Total # Licensed Attendees</b>	<b>Average # of Daily Attendees</b>
	<b>Adult Day Care:</b> Social services provided for adults including but not limited to crafts, games, shopping, wellness programs. Services may include medication supervision, medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, physical therapy, occupational therapy and speech therapy.		
9.	<b>Additional Services</b>	<b>Total # of Visits</b>	<b>Total Revenue</b>
	<b>Home Health Care:</b> Services such as in-home hospice, rehabilitation therapy, respiratory services or skilled nursing care.		

10.	What is the percentage of residents based upon the below age ranges?					
	<18: _____	18-54: _____	55-64: _____	65-75: _____	76-94: _____	>94: _____
	If the facility has residents under 55, please provide details:					
<b>Questions 11-15: Complete below only if there have been any changes since prior renewal.</b>						
11.	Are there any swimming pools onsite?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is it open to the public?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is the pool locked when not in use?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If outdoors, is there a fence around the pool?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a lifeguard on duty full-time?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a telephone in the pool area?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Is there an exercise/weight room?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is it open to the public?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there an attendant on duty?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a required user orientation for demonstration and safety of equipment?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Is there a restaurant that is open to the public?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the facility have a liquor license?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes,				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is alcohol served?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a per drink charge?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Does the applicant have a day care center for children?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, please provide the following:					
	Total number of licensed centers:				# _____	
	Average occupancy:				# _____	
	Is facility open to public?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is it licensed?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Are pets allowed to live in the facility?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are vaccinations required and documentation maintained by the applicant?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

#### IV. Staffing and Hiring Information

16.	Has there been any change in facility Administrator? If so, please provide update below:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Name of Administrator:	State:	Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Years as Administrator:	Years at this facility:			
17.	Has there been any change in the Director of Nursing? If so, please provide update below:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Name of DON:	Professional Credentials:	<input type="checkbox"/> RN <input type="checkbox"/> LPN		
	Years as DON:	Years at this facility:			
18.	Has there been any change in the Medical Director? If so, please provide update below:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Name of Medical Director:	State:	# Hours Per Week:		
	Years as Director:	Years at this facility:			
19.	Is the Medical Director also acting as the attending physician to any residents?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, does the Medical Director carry their own coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
20.	Is a physician on site or on call on a 24-hour basis?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
21.	Have any leaderships' individual licenses been suspended or other disciplinary actions taken?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please provide details:				
22.	Please provide # of staff by shift and Turnover %:				
	Category	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Staff Turnover %
	RN				_____ %
	LPN/LVN				_____ %
	CNA/Personal Caregiver				_____ %
	Agency/Pool				_____ %
	What was the applicant's prior year's turnover rate?				_____ %
23.	Does the Applicant require employed nurses to carry malpractice coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, does the Applicant obtain and review the employed nurses' certificates of malpractice insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
24.	Are background checks performed on all staff for the following items?				
	Licensure type and status	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work History and Education	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	How frequently do you review?		How frequently do you review?		

	National Criminal Records <input type="checkbox"/> Yes <input type="checkbox"/> No How frequently do you review?	Driving records/MVRs <input type="checkbox"/> Yes <input type="checkbox"/> No How frequently do you review?
	State Criminal Records <input type="checkbox"/> Yes <input type="checkbox"/> No How frequently do you review?	Abuse Registry <input type="checkbox"/> Yes <input type="checkbox"/> No How frequently do you review?
25.	Is there a formal, documented assessment process to measure the competency skills of staff members? <input type="checkbox"/> Yes <input type="checkbox"/> No	
26.	Does the Applicant conduct regularly scheduled in-service education and training for all employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27.	How long are education records stored for employees?	

V. Resident Services						
28.	Does the Applicant provide the following services?					
	Service	Provided	# of Residents	Service	Provided	# of Residents
	Enteral Tube Feeding	<input type="checkbox"/> Yes <input type="checkbox"/> No		Developmentally Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Bariatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29.	Are certificates of insurance obtained for all outside clinical services and vendors?					<input type="checkbox"/> Yes <input type="checkbox"/> No
30.	Does the Applicant accept residents with a primary healthcare need related to mental health services? If yes, please provide on a separate document a summary of services, age distribution and types of diagnoses accepted at each location					<input type="checkbox"/> Yes <input type="checkbox"/> No

VI. Risk Management			
Procedures and Prevention			
31.	Are nursing assessment protocols in place and completed according to state and federal regulations to identify residents at risk for:		
	Elopement <input type="checkbox"/> Yes <input type="checkbox"/> No	Falls <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nutritional Deficiency <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Integrity <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Cognitive Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Harm Screening <input type="checkbox"/> Yes <input type="checkbox"/> No	
32.	Are risk assessments performed prior to admission of residents? <input type="checkbox"/> Yes <input type="checkbox"/> No		
33.	How often are residents monitored during the first 72 hours following admission? <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> As Needed		
34.	Are admission, discharge and transfer criteria established at time of admission? <input type="checkbox"/> Yes <input type="checkbox"/> No		
35.	Do facilities have policy/procedure in place for confidentiality of resident health information, including but not limited to, third party communications, access to resident information and records storage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
36.	Is there a risk management program implemented throughout all facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No		

37.	Is there a formal safety program related to the following?			
	Life Safety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hazardous Materials	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Service Providers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Environment	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Emergency Evacuation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Public Health Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Food Handling and Safety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Resident Lift Safety	<input type="checkbox"/> Yes <input type="checkbox"/> No
38.	What security measures are used to control unauthorized entrance to and exit from the facility? Please provide details:			
39.	Number of Elopements in the past 3 years?			# _____
40.	Are Wander Guards or similar devices used as part of elopement prevention practices?			<input type="checkbox"/> Yes <input type="checkbox"/> No
41.	Is there an automatic medication dispensing system in place?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are overrides monitored and addressed?			<input type="checkbox"/> Yes <input type="checkbox"/> No
42.	Does the facility have a procedure for monitoring side effects after medication changes and adjustments?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If so, does the facility have a protocol for reporting to the residents' primary care physician?			<input type="checkbox"/> Yes <input type="checkbox"/> No
43.	Does the Applicant have a formal grievance procedure in place to address resident and/or family complaints?			<input type="checkbox"/> Yes <input type="checkbox"/> No
44.	Does the facility have an "incident reporting" policy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are all related incidents reviewed by DON and Administrator?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Infection Control</b>				
45.	Do all facilities follow CDC Recommendations for infection control?			<input type="checkbox"/> Yes <input type="checkbox"/> No
46.	Do all facilities have written infection control policy and procedures based on CDC Standards?			<input type="checkbox"/> Yes <input type="checkbox"/> No
47.	Do all facilities have adequate PPE supplies?			<input type="checkbox"/> Yes <input type="checkbox"/> No
48.	Is annual education provided on infection control based on previous year's issues and/or concerns?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sexual Abuse</b>				
49.	Do all facilities have a formal, documented Abuse Policy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, does it include the following:			
	Documented, annual training with staff/volunteers including how to identify symptoms or signs of abuse with a recommended course of action?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policy with restrictions on use of electronic devices and social media?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the organization express in writing that volunteers are prohibited from being alone with residents?			<input type="checkbox"/> Yes <input type="checkbox"/> No

	Protocols on reporting incidents and suspicious or inappropriate behavior?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Guidelines on what behaviors may be inappropriate (verbal comments, touching, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Written procedures for responding to and reviewing allegations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Written procedures for reporting allegations to authorities within regulated time frames?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Action Planning to prevent any future similar incidents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
50.	Are staff members required to complete annual abuse prevention training?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
51.	Are staff members required to review the written abuse policy annually and is completion documented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## VII. Claim History and Prior Known Incidents

52.	Has any claim, suit or regulatory proceeding been made against the Applicant, or any facility proposed for coverage at any time during the last 3 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
53.	Does the Applicant have any knowledge of any wrongful act, fact, circumstance, situation, transaction or event which could reasonably be expected to give rise to a future claim or loss? This includes but is not limited to: Death of resident or client other than natural causes Incident resulting in hospitalization or transfer of resident or client Injury to resident or client that required medical care Incident that generated a formal complaint or notice from any licensing agency Elopement of a resident or client Improper medication or improper dosage resulting in medical complications Request for medical records If yes, please provide full details on a separate attachment to this application.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
54.	Have you had any abuse incidents, claims or suits, or do you have any knowledge or information which might reasonably be expected to give rise to a claim of sexual abuse or molestation? If yes, please provide details on a separate document	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## VIII. Submission Attachments

1. Loss History – submit a currently valued loss run(s) from prior carriers for the past five years
2. Detailed narrative for any claim greater than \$250,000 and remedial actions taken as a result of the claim
3. Financials – submit a copy of the most recent audited financial statement
4. Resume for Administrator and Director of Nursing (if any changes since last renewal)
5. List of Named and Additional Insureds including Retroactive Dates (if any changes since last renewal)
6. Sample copy of admission risk assessment (if any changes since last renewal)
7. Details to “yes” responses as required in above questions

## Fraud Warnings

**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, 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.**

**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 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.

**Notice to Florida Applicants:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim 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 (in Alabama; additionally, restitution).

**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 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.

### SIGNATURE

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 this 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 and 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 an authorized representative of the applicant. Authorized representative may include any executive officer, member of human resources, risk management or in-house general counsel. 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 Authorized Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**UTAH APPLICANTS ONLY (NO SIGNATURE REQUIRED)**