

OneBeacon Insurance Company
 (Stock company owned by the **OneBeacon Insurance Group**)
 One Beacon Lane
 Canton, MA 02021



MANAGED CARE ERRORS AND OMISSIONS LIABILITY APPLICATION

THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS AND CONDITIONS, ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. CLAIM EXPENSES ARE PART OF AND NOT IN ADDITION TO THE LIMIT OF LIABILITY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES WILL BE REDUCED AND MAY BE EXHAUSTED BY CLAIM EXPENSES, AND CLAIM EXPENSES WILL BE APPLIED AGAINST THE RETENTION. WE WILL HAVE NO OBLIGATION TO PAY JUDGMENTS, SETTLEMENTS OR CLAIM EXPENSES ONCE THE APPLICABLE LIMIT OF LIABILITY IS EXHAUSTED.

APPLICATION INSTRUCTIONS: Whenever used in this Application the term "you" means the entity or individual identified in response to Question 1 of PART I TELL US WHO YOU ARE ("Applicant") and all other entities and individuals proposed for this insurance.

PART I. TELL US WHO YOU ARE

1. Name of Applicant: _____

2. Address: _____

City: _____ State: _____ ZIP: _____

Website: _____ Telephone: _____

3. Risk Manager or Contact person and title: _____

Email address: _____ Telephone: _____

4. Your Corporate Structure: For-Profit Private Company Publicly Traded
 Not-for-Profit Taxable Corp. Not-for-Profit Tax-Exempt Corp.
 Partnership Limited Liability Company
 Joint Venture Other (describe): _____

5. Date you were incorporated: _____ Date you began operations: _____
 State(s) where you operate: _____

6. Within the past 36 months or within the next 12 months, have you or do you expect to:

a) Merge, acquire or consolidate with another entity? Yes No NA

b) Enter into any new business activities or services? Yes No NA

If "Yes" to either of the above, please explain and describe the essential terms of each such transaction. (If needed, use an attachment to this Application): _____

7. If you are seeking coverage for any other entities (e.g., subsidiaries, joint ventures, or partnerships), list each entity below and **include all exposure data**. If needed, list additional entities on a separate attachment. (Please note that coverage for these entities is not automatically included. The policy, if issued, will determine actual coverage.)

Name & Address	Relationship	Description of Operations	Tax Status	Percent Owned

8. You are:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> HMO (If so, please indicate: | <input type="checkbox"/> Staff Model | <input type="checkbox"/> Network/IPA Model | <input type="checkbox"/> Combined [both] |
| <input type="checkbox"/> PPO | <input type="checkbox"/> PHO | <input type="checkbox"/> IPA | <input type="checkbox"/> Peer Review |
| <input type="checkbox"/> Third Party Administrator | <input type="checkbox"/> Utilization Review Organization | | <input type="checkbox"/> MSO |
| <input type="checkbox"/> Medical Group or Clinic | <input type="checkbox"/> Accountable Care Organization | | <input type="checkbox"/> Medical Home |
| <input type="checkbox"/> Other (describe): _____ | | | |

PART II. GIVE US YOUR NUMBERS

A. ENROLLMENT:

Note: Wherever used, "enrollees" means covered lives, not just covered employees and not member months.

ENROLLMENT TYPE	ENROLLEES LAST 12 MONTHS As of / /	ENROLLEES ESTIMATE NEXT 12 MONTHS As of / /
HMO		
PPO		
Indemnity		
POS		
ASO		
IPA		
Medicaid		
Medicare		
Vision, Dental, PBM, STD, LTD or Other Carve-Out		
Other (please describe)		
Total Enrollment		

B. REVENUE:

	LAST 12 MONTHS As of / /	ESTIMATE NEXT 12 MONTHS As of / /
Total Revenue (all operations)		
PPO Revenue		
Utilization Review/ Case Management Revenue		
MSO Revenue		
PHO Revenue		
IPA Revenue		
Carve-Out Revenue		
TPA/ Claims Administration Revenue		

C. NUMBER OF HEALTH CARE PROVIDERS:

Provider type	LAST 12 MONTHS As of / /	ESTIMATE NEXT 12 MONTHS As of / /
Contracted Physicians		
Employed Physicians		

D. MANAGED CARE ACTIVITIES:

Please check the managed care activities or services which you perform or subcontract. If you plan on offering any of these services over the next 12 months, please include those as well. Please check all that apply. (Note: not all checked services may be covered):

Activity or Service	You Perform or Subcontract	You Perform for Others for a Fee
Credentialing or peer review of health care providers	<input type="checkbox"/>	<input type="checkbox"/>
Utilization review	<input type="checkbox"/>	<input type="checkbox"/>
Drafting practice guidelines/Critical Pathways	<input type="checkbox"/>	<input type="checkbox"/>
Case management	<input type="checkbox"/>	<input type="checkbox"/>
Disease management	<input type="checkbox"/>	<input type="checkbox"/>
Handling and adjusting of enrollees' health care benefit claims	<input type="checkbox"/>	<input type="checkbox"/>
Application or enrollment processing for enrollees of health care plans	<input type="checkbox"/>	<input type="checkbox"/>
Billing/other processing of enrollees' claims under health care plans	<input type="checkbox"/>	<input type="checkbox"/>
Advertising, marketing, or selling health care plans/products	<input type="checkbox"/>	<input type="checkbox"/>
Establishing health care provider networks to provide managed care	<input type="checkbox"/>	<input type="checkbox"/>
Actuarial services for health care plans	<input type="checkbox"/>	<input type="checkbox"/>
Assisting customers in securing reinsurance	<input type="checkbox"/>	<input type="checkbox"/>
Services for automobile liability or disability	<input type="checkbox"/>	<input type="checkbox"/>
Third party administration (TPA) services	<input type="checkbox"/>	<input type="checkbox"/>
Employee Assistance Program (EAP)	<input type="checkbox"/>	<input type="checkbox"/>
Nurse call line	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (DESCRIBE):	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ARE AN **IPA, PHO OR MEDICAL GROUP OR CLINIC** AND **DO NOT** HAVE CLAIM HANDLING OR UTILIZATION REVIEW RESPONSIBILITIES SKIP PART III D. E. & F.

PART III. TELL US HOW YOU DO IT

A. GENERAL OPERATIONS:

1. Are you licensed by federal, state, or local government? Yes No NA
If "Yes," identify the licensing government: _____
 2. Are you accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? Yes No NA
If "Yes," identify the accrediting/certifying organization: _____
 3. Has your license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? Yes No NA
If "Yes," please explain: _____
 4. Do you have a formal risk management program? Yes No NA
 5. Are any of your operations subcontracted? Yes No NA
- | | |
|--------------------|--|
| Credentialing | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Utilization Review | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Claim Handling | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| Other | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |

6. Are written contracts used for all subcontracted work? Yes No NA
 If "No," please explain: _____
7. Do you require all subcontractors to carry their own errors and omissions insurance? Yes No NA
 If "Yes," what are required minimum limits? _____
 If "No," please explain: _____
8. Do you indemnify the subcontractor? Yes No NA
9. Does the subcontractor indemnify you? Yes No NA
10. Are any of your operations subcontracted outside of the United States? Yes No NA
 If "Yes," please describe: _____

B. HEALTHCARE REFORM:

1. Have you ever provided customer rebates based on Medical Loss Ratio obligations? Yes No NA
 If "Yes," how often? _____

2. Do you have written policies and procedures surrounding the disbursement of Medical Loss Ratio rebates? Yes No NA
3. Do you publish your Medical Loss Ratio calculation process? Yes No NA
4. Have you ever been sanctioned, fined, investigated or sued for non-compliance related to your Medical Loss Ratio requirements? Yes No NA
5. Do you have an individual that is responsible for compliance with health care reform? Yes No NA
6. Have you ever been sanctioned, fined, investigated or sued for Medicare/Medicaid fraud? Yes No NA
 If "Yes," please explain: _____
7. Have you made changes to your policies and procedures to comply with all healthcare reform acts? Yes No NA
8. Do you offer quality incentives to providers? Yes No NA
9. Do you disclose and explain the provider incentives to members? Yes No NA
 If "Yes," please provide details re: how and where the information is disclosed: _____

10. Do you have or plan to form a Medical Home facility? Yes No NA
 If "Yes," please provide details: _____

C. CREDENTIALING:

1. Do your written credentialing procedures comply with JCAHO or NCQA standards and all applicable laws? Yes No NA
2. Does legal counsel review and make recommendations before any final decision which adversely affects a provider's privileges or credentials? Yes No NA
3. Are providers allowed a hearing or appeal prior to termination? Yes No NA
4. Do you clearly express grounds for termination of providers in your contracts? Yes No NA
5. Do you require and verify that all contracted health care providers maintain medical malpractice insurance with minimum limits of \$1,000,000/\$3,000,000? Yes No NA
 If "No," what minimum limits are required? _____
6. Do you perform on-site visits of contracted health care providers? Yes No NA
 If "Yes," how often? _____
7. Do you disclose your reimbursement policies for non-par providers on your website? Yes No NA
 If "No," please explain: _____
8. Do your subscribers have access to non-par provider rates? Yes No NA
 If "No," please explain: _____
9. Do you have a provider tiering program? Yes No NA
 If "Yes," please provide details on tiering criteria and appeal process: _____

D. UTILIZATION REVIEW:

SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.

- 1. Do you have written policies and procedures for utilization review, including for denials and appeals? Yes No NA
- 2. Do your written Utilization Review Procedures:
 - a) Follow NCQA or URAC standards and comply with all applicable laws? Yes No NA
 - b) Require physician review of all proposed denials? Yes No NA
 - c) State that enrollees must be notified of all denials and appeals in writing including the identity of the person who makes decisions regarding appeals? Yes No NA
 - d) Require consultation with legal counsel when considering appeals? Yes No NA
 - e) Allow for a physician to override a practice guideline? Yes No NA
 - f) Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers? Yes No NA
 - g) Utilize same specialty reviewers for benefit/coverage denials? Yes No NA
 - h) Adhere to government mandated external review requirements in the states where you operate? Yes No NA
 - i) Utilize the external review process in states where it is not mandated? Yes No NA

E. CLAIM HANDLING:

SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.

- 1. Do you utilize profit sharing, risk sharing, or other financial incentives in compensation arrangements with claim handlers or adjusters? Yes No NA

F. ADVERTISING/MARKETING/SALES:

SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.

- 1. Do all contracts, sales literature, brochures and marketing materials:
 - a) Expressly identify covered and non-covered procedures? Yes No NA
 - b) Expressly refer to all contracted providers as independent contractors? Yes No NA
 - c) Make statements or warranties as to the quality of health care, breadth of plan? Yes No NA
 - d) Go through legal counsel review and approval prior to their use? Yes No NA

PART IV. TELL US WHAT YOU HAVE

Limits of Liability desired: \$1,000,000/\$1,000,000 \$1,000,000/\$3,000,000 \$2,000,000/\$2,000,000
 (Each Claim/ Aggregate) \$3,000,000/\$3,000,000 \$5,000,000/\$5,000,000 \$10,000,000/\$10,000,000
 \$15,000,000/\$15,000,000 \$20,000,000/\$20,000,000 Other: \$ _____

Retention Desired: \$7,500 \$10,000 \$15,000 \$25,000 \$50,000
 \$100,000 \$150,000 \$200,000 \$250,000 \$500,000
 \$1,000,000 \$2,500,000 Other: \$ _____

Please provide details of insurance/self-insurance/reinsurance currently in force (if none, please state):

Type of Coverage	Insurance Carrier(s)	Limits	Deductible/ Retention	Premium	Policy Period	If Claims Made, Retroactive Date
Managed Care Errors & Omissions						
Medical Malpractice*						
D&O*						
EPL*						
Fiduciary*						
Stop Loss*						
Insolvency*						
Crime*						
Network Security & Privacy *						
Other						

*Would you be interested in proposals for these coverages? If yes, please complete the appropriate section below:

OPTIONAL COVERAGES

For an option containing D&O and/or EPL, please fill out the following:

1. a. Stock ownership of the Applicant:
 Total number of authorized common shares: _____
 Total number of outstanding common shares: _____
 Total number of common shareholders: _____
 Total number of common shares owned by Applicant’s directors and officers: _____
- b. As an attachment to this Application, please provide the names and number of shares for all persons or entities that presently own or control, or have stated the intention to acquire, of record or beneficially, more than 5% of Applicant’s outstanding stock.
- c. Have there been any changes in Applicant’s board of directors or senior management within the past 3 years for reasons other than death or retirement? Yes No NA
 If “Yes,” please explain: _____
- d. Number of your: Full-time employees: _____
 Part-time employees: _____
- e. Within the past 36 months, have you or do you expect to:

(1) Merge, acquire, or consolidate with another entity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
(2) Sell, distribute, or divest of any assets or stock?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
(3) Register for a public offering or private placement of securities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
(4) Form any joint venture?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
(5) Enter into any new business activities or services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

 If “Yes” to any of the above, please explain and describe the essential terms of each such transaction. (If needed, use an attachment to this Application): _____

For an option containing Network Security and Privacy please fill out the following:

1. Do you employ a Chief Information/Security Officer? Yes No NA
2. Do you have a corporate-wide privacy policy? Yes No NA
3. Have your privacy policies been reviewed and approved by an attorney? Yes No NA
4. How often are your policies reviewed and updated? _____
5. Do you have restricted employee access to private information? Yes No NA
6. Do you have internal training for employees concerning the handling of data security and private, personal and sensitive information? Yes No NA
7. In the past twenty-four (24) months, have you undergone an internal or external privacy audit?
If "Yes", have all recommendations been implemented? Yes No NA
If "No", please explain: _____
8. Do you collect, receive, process, transmit, or maintain private, sensitive, or personal information as part of your business activities? Yes No NA
 - a. Is any of this information regulated by HIPAA, GLB, the Data Protection Act or any other law or regulation protecting private, sensitive, or personal information? Yes No NA
 - b. Do you have written procedures in place to comply with laws governing the handling or disclosure of such information, including any Red Flag Rules? Yes No NA
 - c. Do you share private, sensitive, or personal information gathered from customers with third parties? Yes No NA
9. Do you have a vendor approval process? Yes No NA
10. Do you require that contracts with outside companies and vendors require they defend and indemnify you in the event there is any loss arising out of the release or disclosure of private, sensitive, or personal information due to the outside company's or vendor's negligence? Yes No NA
11. Do you have a written and tested:
 - a. Disaster recovery plan? Yes No NA
 - b. Business continuity plan? Yes No NA
 - c. Computer security policy? Yes No NA
 - d. Procedure to change default credentials? Yes No NA
12. Do you store sensitive data on laptops or web servers?
 - a. If "Yes", is all data that is both "at-rest" and "in-transit" encrypted? Yes No NA
 - b. If "No", please describe any offsetting measures: _____
13. Do you use security and firewall technology? Yes No NA
14. Is it your policy to up-grade all security software as new releases/improvements become available? Yes No NA
15. Do you use anti-virus software?
 - a. Is anti-virus software installed on all of your computer systems, including laptops, personal computers, and networks? Yes No NA
16. Do you use intrusion detection software to detect unauthorized access to internal networks and computer systems? Yes No NA
17. Do you have a formal documented user and password procedure in place? Yes No NA
18. Do you limit access to network servers and hardware? Yes No NA
19. Do you provide remote access to your network?
 - a. Is remote access restricted to Virtual Private Networks (VPNs)? Yes No NA
20. How often is private/personal/sensitive/valuable information archived? _____
 - a. How long is the information stored? _____
 - b. Is the information stored in an off-premises secondary site? Yes No NA
21. Do you terminate all associated computer access and user accounts when an employee leaves the company? Yes No NA
22. Are your internal networks and computer systems subject to third party audit and monitoring?
 - a. If "Yes", when was the last audit? _____
 - b. Have all improvements and recommendations been implemented? Yes No NA
 - c. If "No", please explain: _____

PART V. TELL US ABOUT YOUR CLAIM HISTORY

1. During the past five (5) years, has any claim that would fall within the scope of the proposed insurance been made against you or against any entity or individual proposed for coverage? Yes No
If yes, please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed): _____

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. During the past five (5) years, have you or any entity or individual proposed for coverage, submitted any claims or given notice of any act, error or omission, or course of conduct which you had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement? Yes No
If yes, please provide details: _____

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 AND ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

3. Are you or any entity or individual proposed for coverage, aware of any act, error or omission, or course of conduct which you have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance? Yes No
If yes, please provide details: _____

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION, OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 3 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VI. WHAT ELSE WE NEED

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application:

1. Currently valued loss runs (if you are currently insured elsewhere) including losses you may be handling within a self insured retention;
2. Your most current audited or accountant-prepared financial statements with notes;
3. If you are newly formed, Pro Forma financial statements;
4. Copies of all promotional or marketing materials that are not readily available on your website;
5. If operation is a start-up, business plans and resumes (including professional qualifications/designations) of all partners, principals and key employees.

If you want a D&O/EPL quote in addition to the above, please include these:

1. The names, occupations, and business affiliations of all your directors and officers.

PART VII. FRAUD WARNINGS

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, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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 ARKANSAS, MINNESOTA, 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 or deceptive statement is guilty of insurance fraud, which is a crime.

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 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, NEW MEXICO 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 civil fines and criminal penalties.

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 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: 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 PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

PART VIII. DECLARATIONS AND SIGNATURES

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or

information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

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.

APPLICANT		
BY <i>(CEO, CFO or President)</i>	TITLE	DATE

NOTE: This Application must be signed by the CEO, CFO and/or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

PRODUCED BY <i>(Insurance Agent)</i>	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS <i>(No., Street, City, State, and ZIP Code)</i>	
EMAIL ADDRESS	

SUBMITTED BY <i>(Insurance Agency)</i>	INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS <i>(No., Street, City, State, and ZIP Code)</i>		

NOTE: For New Hampshire Applicants, producer's name and signature are required.