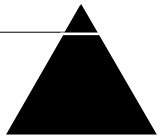
Executive Risk Specialty
Insurance Company

Home Office:
82 Hopmeadow Street
Simsbury, Connecticut 06070-7683



APPLICATION FOR MANAGED CARE ORGANIZATION ERRORS AND OMISSIONS LIABILITY POLICY

NOTICE: THE POLICY WHICH IS APPLIED FOR APPLIES, SUBJECT TO ITS TERMS, ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND ARE REPORTED TO THE UNDERWRITER IN WRITING DURING THE "POLICY PERIOD" OR WITHIN 60 DAYS AFTER THE EXPIRATION DATE OF THE POLICY OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES, SETTLEMENTS, OR JUDGMENTS SHALL BE REDUCED BY PAYMENT OF "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" ALSO SHALL BE APPLIED AGAINST THE RETENTION.

ALL APPLICANTS MUST COMPLETE PART I OF THIS APPLICATION.

PART I. GENERAL INFORMATION, OPERATIONS, AND STRUCTURE

1. a) Name of **Applicant**: _____
(Note: Wherever used, "**Applicant**" means this entity and any other entities listed in response to Question 3.)

   b) Address: _____
City: _____ State: _____ ZIP: _____

   c) Contact person and title: _____

   d) Name of risk manager (if different than contact person): _____

2. a) **Applicant** is:
☐ For-Profit Corp. ☐ Not-for-Profit Tax-Exempt Corp.
☐ Not-for-Profit Taxable Corp. ☐ Limited Liability Company
☐ Partnership ☐ Joint Venture
☐ Other (describe): _____

   b) Date of incorporation: _____ Date operations began: _____

   c) State(s) where **Applicant** operates: _____

3. If coverage is desired for any other entities (e.g., subsidiaries, joint ventures, or partnerships), please list each such entity below. If required, list additional entities on a separate attachment. (Attach additional information, if necessary.)

Name and Address	Relationship to Applicant	Description of Operations	Tax Status	Percent Owned

4. a) **Applicant** is:
☐ HMO (If so, please indicate: ☐ Staff Model ☐ Network or Panel Model ☐ Combined [both])
☐ PPO ☐ PHO ☐ IPA ☐ MSO ☐ Medical Group
☐ Third Party Administrator ☐ Utilization Review Organization ☐ Peer Review Organization
☐ Other (describe): _____

b) Does the **Applicant** have any exclusive agreements with providers? ☐ Yes ☐ No

5. a) Is the **Applicant** licensed by federal, state, or local government? ☐ Yes ☐ No
If "Yes," identify the licensing government: _____

b) Is the **Applicant** accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA) or any state or federal agency? ☐ Yes ☐ No
If "Yes," identify the accrediting or certifying organization(s): _____

c) Has the **Applicant's** license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? ☐ Yes ☐ No
If "Yes," please explain: _____

6. REVENUES:

	Last 12 Months	**Next 12 Months (est.)**
a) Total Gross Revenues:	_____	_____
b) Percent of Gross Revenues from "at risk" agreements: (Note: Wherever used, "at risk" means capitation, withhold or bonus.)	_____	_____

7. ENROLLMENT:

Total number of enrollees: (Note: Wherever used, "enrollees" means covered lives.)	_____	_____
a) Number of enrollees in managed care plan(s):	_____	_____
b) Number of enrollees in non-managed care plan(s):	_____	_____

8. HEALTH CARE PROVIDER:

a) Total number of physicians under contract:	_____	_____
(1) Number of employed physicians:	_____	_____
(2) Number of independent contractor physicians:	_____	_____
b) Total number of non-physician health care professionals under contract:	_____	_____
c) Total number of hospitals under contract:	_____	_____
d) Total number of other facilities under contract (e.g., clinics, nursing homes, laboratories, pharmacies):	_____	_____

e) Are all contracted health care providers (physicians, hospitals, and others) required to maintain medical malpractice insurance? ☐ Yes ☐ No
If "Yes," what minimum limits are required? _____

f) Provide details of the **Applicant's** compensation or participation arrangements with contracted health care providers or attach copies of sample contracts.
_____
_____

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

Type of Coverage	Insurance Carrier(s)	Limits	Deductible/ Retention	Premium	Policy Period	If Claims Made, Retroactive Date
Medical Malpractice						
D&O*						
Fiduciary*						
Stop Loss*						
Insolvency*						
Fidelity*						
General Liability						
Other						

* Would the **Applicant** be interested in proposals for these coverages? ☐ Yes ☐ No

10. a) Does the **Applicant** contract with more than 20% of the physicians in any given field of practice (including without limitation primary care, family practice, or any specialty) within its geographical service area? ☐ Yes ☐ No
If "Yes," please explain: _____

b) Do the **Applicant's** members control more than 20% of the hospital beds or specialty services within its geographic service area? ☐ Yes ☐ No
If "Yes," please explain: _____

c) 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 the **Applicant's** directors and officers: _____

d) 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 the **Applicant's** outstanding stock.

e) Have there been any changes in the **Applicant's** board of directors or senior management within the past 3 years for reasons other than death or retirement? ☐ Yes ☐ No
If "Yes," please explain: _____
_____

f) Number of **Applicant's**: Full-time employees: _____
Part-time employees: _____

g) Has the **Applicant** been involved in within the past 36 months, or does the **Applicant** contemplate being involved in within the next 12 months, any of the following, whether or not such transactions were or will be completed? If "Yes," please describe the essential terms of each such transaction as an attachment to this Application.

1) Merger, acquisition, or consolidation with another entity? ☐ Yes ☐ No
2) Sale, distribution, or divestiture of any assets or stock, other than in the ordinary course of business? ☐ Yes ☐ No
3) Any registration for a public offering or private placement of securities? ☐ Yes ☐ No
4) Any joint ventures? ☐ Yes ☐ No
5) Any new business activities or services? ☐ Yes ☐ No
6) Any new Medicare or Medicaid contracts? ☐ Yes ☐ No

11. List the primary professional groups or associations to which the **Applicant** belongs:

_____

_____

12. ACTIVITIES OR SERVICES:
Please indicate those Managed Care Organization Business Activities or Services which the **Applicant** performs now or intends to begin performing within the next 12 months:

Activity or Service	**Yes**	**No**	**Yes, For Others For Fee**
a) Credentialing or peer review of health care providers	☐ (Complete Part II)	☐	☐ (Complete Part II)
b) Utilization review	☐ (Complete Part III)	☐	☐ (Complete Part III)
c) Drafting practice guidelines/ critical pathways	☐	☐	☐
d) Case management	☐	☐	☐
e) Disease management	☐	☐	☐
f) Handling and adjusting of enrollees' health care benefit claims	☐ (Complete Part IV)	☐	☐ (Complete Part IV)
g) Application or enrollment processing for enrollees of health care plans	☐	☐	☐
h) Billing/other processing of enrollees' claims under health care plans	☐	☐	☐
i) Advertising, marketing, or selling health care plans/products	☐ (Complete Part V)	☐	☐ (Complete Part V)
j) Establishing health care provider networks to provide managed care	☐	☐	☐
k) Actuarial services for health care plans	☐	☐	☐
l) Other third party administrator services for health care plans (please describe): _____			

_____

_____

m) Any other services (please describe): _____

_____

_____

APPLICANT: PLEASE COMPLETE THE FOLLOWING SECTIONS WHICH CORRESPOND TO "YES" ANSWERS IN QUESTION 12 ABOVE. IF NO CORRESPONDING SECTIONS ARE INDICATED, PLEASE PROCEED TO PART VI.

PART II. CREDENTIALING OR PROVIDER SELECTION OF HEALTH CARE PROVIDERS

13. Total revenue for credentialing/peer review services performed for others for a fee: **Last 12 months** $ _____ **Next 12 months** $ _____

14. a) Who does the credentialing of contracted health care providers? **Applicant:** ☐ Yes ☐ No
Subcontractor: ☐ Yes ☐ No
Other: _____ ☐ Yes ☐ No

b) If credentialing is subcontracted:
(1) Does the **Applicant** review or audit the process? ☐ Yes ☐ No
(2) Is subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No
(3) What minimum limits are required? _____

15. Does the **Applicant** have written policies and procedures in place for provider selection, credentialing, re-credentialing, and making decisions which adversely affect a provider's credentials? ☐ Yes ☐ No
a) Do the written credentialing procedures follow JCAHO or NCQA standards and comply with any applicable law? ☐ Yes ☐ No
b) Are the procedures given to health care providers? ☐ Yes ☐ No
c) Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials becomes final? ☐ Yes ☐ No
d) What group has the final authority for credentialing or provider selection?
Board of Directors or Trustees: ☐ Yes ☐ No
Committee: ☐ Yes ☐ No
Other: _____ ☐ Yes ☐ No

16. Does the **Applicant** query the National Practitioner Data Bank or the Federation of State Medical Boards as part of the credentialing process? ☐ Yes ☐ No

17. How often does the **Applicant** re-credential contracted health care providers?
_____

18. Does the **Applicant** perform on-site visits of contracted health care providers? ☐ Yes ☐ No
If "Yes," how often? _____

19. Does the **Applicant** restrict the practice of any health care provider who has a mental or physical disorder which may impair his/her ability to practice? ☐ Yes ☐ No
If "Yes," please explain: _____

20. Have any providers been removed or disqualified from the **Applicant's** panel in the last 12 months? ☐ Yes ☐ No
If "Yes," a) How many for credentialing or professional conduct reasons? _____
b) How many for reasons other than professional competence? _____

PART III. UTILIZATION REVIEW

21. a) Please specify number or percentage (%) of enrollees by type of payor. If utilization review services are performed for others for a fee, indicate amount or percentage (%) of revenue generated by type of payor.

Type of Payor	No. /% Enrollees Last 12 Months	No./% Enrollees Next 12 Months	Amt./% Revenue Last 12 Months	Amt./% Revenue Next 12 Months
Private (non-government) employer plans or trusts				
Government employer plans				
Union plans				
Medicare or Medicaid plans				
Other				

b) Total revenue for utilization review services performed for others for a fee:
(1) Last 12 months: _____ (2) Next 12 months: _____

22. a) Who does utilization review? **Applicant:** ☐ Yes ☐ No
Subcontractor: ☐ Yes ☐ No
Other: ☐ Yes ☐ No

b) Number of benefits denied/avoided (e.g. denial rate): _____

c) Number of full-time equivalent (FTE) reviewers: _____
Number of part-time equivalent (PTE) reviewers: _____

d) If utilization review is subcontracted:
(1) Does the **Applicant** review or audit the process? ☐ Yes ☐ No
(2) Is the subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No
(3) What minimum limits are required? _____

e) Does the **Applicant** have written policies and procedures for utilization review, including for denials and appeals? ☐ Yes ☐ No
If "Yes," do such policies and procedures follow NCQA or URAC standards and comply with any applicable law? ☐ Yes ☐ No

f) Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals? ☐ Yes ☐ No

g) Does a physician review all proposed denials of benefits prior to issuance of the denial? ☐ Yes ☐ No

h) Does the **Applicant** have a "fast track" appeal system regarding denial of benefits or postponement of benefit procedures for organ transplants or any other procedure which may severely impair the quality of life for an enrollee if not performed? ☐ Yes ☐ No

i) Does the **Applicant** use practice guidelines as part of its utilization review procedures? ☐ Yes ☐ No
If "Yes," do guidelines state in writing that physician's judgment may override a guideline? ☐ Yes ☐ No

j) Does the **Applicant** utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers? ☐ Yes ☐ No

k) Does the **Applicant** utilize same specialty reviews for benefit/coverage denials? ☐ Yes ☐ No

23. Attach a sample copy of a utilization review denial letter (with the identity of the enrollee removed).

PART IV. HANDLING AND ADJUSTING OF ENROLLEES' HEALTH CARE BENEFIT CLAIMS

		Last 12 months	Next 12 months
24.	Total revenue for claims handling and adjusting services performed for others for a fee:	_____	_____
25. a)	Number of claims processed:	_____	_____
b)	Number of FTE claim adjusters:	_____	_____
c)	Number or percentage of PTE claim adjusters:	_____	_____
d)	Number or percentage of claims denied:	_____	_____

e) Who does the handling and adjusting of claims for health care benefits?

Applicant:	☐ Yes	☐ No
Subcontractor:	☐ Yes	☐ No
Other:	☐ Yes	☐ No

f) If claim handling and adjusting is subcontracted:

(1) Does the **Applicant** review or audit the process? ☐ Yes ☐ No

(2) Is the subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No

(3) What minimum limits are required? _____

g) Does the **Applicant** utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with claim handlers or adjusters? ☐ Yes ☐ No

PART V. ADVERTISING/MARKETING/SALES

26. a) Do all contracts, sales literature, and brochures expressly identify covered and non-covered procedures? ☐ Yes ☐ No

b) Do any contracts, sales literature, or brochures use the term(s) "investigative" or "experimental" procedures? ☐ Yes ☐ No

If "Yes":

(1) Do all such materials define what is considered "investigative" or "experimental"? ☐ Yes ☐ No

(2) Do all such materials clearly state that the **Applicant** has discretionary authority in the interpretation and administration of the plan's provisions? ☐ Yes ☐ No

c) Do contracts, sales literature, and brochures expressly refer to all contracted health care providers as independent contractors? ☐ Yes ☐ No

d) Do any contracts, sales literature, or brochures make statements or warranties as to the quality of health care, breadth of plan, providing all the needed care or being the "best" plan, etc.? ☐ Yes ☐ No

e) Does the **Applicant's** legal counsel review and approve all contracts, sales literature, brochures, advertisements, and other marketing materials prior to their use? ☐ Yes ☐ No

f) Are enrollee satisfaction surveys conducted? ☐ Yes ☐ No

If "Yes," how often? _____

g) Please attach or describe the results from the most recent enrollee survey: _____

_____

PART VI. CLAIMS INFORMATION

27. During the past 5 years, no claims such as would fall within the scope of the proposed insurance have been made against the **Applicant** or any individual or entity proposed for coverage, except as follows (include loss payments and defense costs). If answer is none, so state: _____

_____

_____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 27 IS EXCLUDED FROM THE PROPOSED INSURANCE.

28. During the past 5 years, neither the **Applicant** nor any individual or entity proposed for coverage, has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission to any insurer providing errors & omissions or directors & officers coverage, except as follows. If answer is none, so state: _____

_____

_____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 28 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 28 IS EXCLUDED FROM THE PROPOSED INSURANCE.

29. Neither the **Applicant** nor any individual or entity proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is none, so state:

_____

_____

_____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 29 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VII. ATTACHMENTS

30. Please attach copies of the following documents to this Application. These documents shall be a part of this Application:
    a) **Applicant's** last 2 audited or accountant-prepared financial statements with notes.
    b) Most recent actuarial report, if applicable.
    c) If the **Applicant** is newly formed, Pro Forma financial statements.
    d) If the **Applicant** is newly formed, Business Plan.
    e) **Applicant's** by-laws.
    f) The names, occupations, and business affiliations of all of the **Applicant's** directors and officers.
    g) **Applicant's** organization chart.
    h) Written utilization review procedures, including procedures for denials of benefits and appeals.
    i) Written credentialing and peer review procedures.
    j) Sample contract(s) with health care providers (physicians, hospitals, and others).
    k) Sample contract(s) with enrollee(s).
    l) Sample sales literature, brochures, advertisements, and other marketing materials (including enrollee packet).

PART VIII. 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 ARE TRUE AND COMPLETE.

THE INFORMATION IN THIS APPLICATION IS MATERIAL TO THE RISK ACCEPTED BY THE UNDERWRITER. IF A POLICY IS ISSUED IT WILL BE IN RELIANCE BY THE UNDERWRITER UPON THE APPLICATION, AND THE APPLICATION WILL BE THE BASIS OF THE CONTRACT.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER, AND ALONG WITH THE APPLICATION WILL BE CONSIDERED PHYSICALLY ATTACHED TO, PART OF, AND INCORPORATED INTO THE POLICY, IF ISSUED.

THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER'S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE OR ISSUE A POLICY.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

THE UNDERSIGNED DECLARES THAT ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE UNDERSTAND:

A. THE POLICY, IF ISSUED, SHALL APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND ARE REPORTED TO THE UNDERWRITER IN WRITING DURING THE "POLICY PERIOD" OR WITHIN 60 DAYS AFTER THE EXPIRATION OF THE POLICY; AND

B. THE LIMIT OF LIABILITY AVAILABLE UNDER THE POLICY, IF ISSUED, TO PAY DAMAGES, SETTLEMENTS, OR JUDGMENTS SHALL BE REDUCED BY PAYMENT OF "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" ALSO SHALL BE APPLIED AGAINST THE RETENTION.

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.

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 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 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 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 FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

<u>NOTICE TO NEW JERSEY APPLICANTS</u>: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

<u>NOTICE TO COLORADO APPLICANTS</u>: 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.

APPLICANT		
BY *(Chairman and/or President)*	TITLE	DATE

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

PRODUCED BY *(Insurance Agent)*	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*	
EMAIL ADDRESS	

SUBMITTED BY *(Insurance Agency)*	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*		