COPIC
Better Medicine • Better Lives

COPIC
A Risk Retention Group

FACILITY APPLICATION
CLAIMS-MADE POLICY

Please review your policy provisions carefully to understand all of your rights and duties.

GENERAL INFORMATION

1. Legal Name of Facility: _____

2. Primary Address: _____

   County _____ City _____ State _____ ZIP _____

   Website: _____

3. **Contacts**

   Chief Executive Officer: _____ Phone Number: _____ Email: _____

   Chief Financial Officer: _____ Phone Number: _____ Email: _____

   Primary Risk Manager: _____ Phone Number: _____

   Title: _____ Email: _____

   Primary Claims Contact: _____ Phone Number: _____

   Title: _____ Email: _____

   Secondary Risk Manager: _____ Phone Number: _____

   Title: _____ Email: _____

   Practice Administrator/Business Manager: _____ Phone Number: _____

   Title: _____ Email: _____

   Policy Billing Contact: _____ Phone Number: _____

   Title: _____ Email: _____

4. Choose all that are applicable:

Hospital

- ☐ Children's Hospital
- ☐ Critical Access
- ☐ Psychiatric Hospital
- ☐ Rehabilitation Hospital
- ☐ Teaching Hospital
- ☐ Woman's Hospital
- ☐ Other:

_____

Non-Acute Care

- ☐ Ambulatory Surgery Center
- ☐ Birthing Center
- ☐ Community Health Center
- ☐ Dialysis Center
- ☐ Endoscopy Center
- ☐ Imaging Center
- ☐ Health Department
- ☐ Urgent Care
- ☐ Other:

_____

5. Does the Applicant have any operations beyond your domicile state? ..... ☐ Yes ☐ No
   If "yes," please explain: _____

6. Does your facility conduct peer review activities? ..... ☐ Yes ☐ No
If "yes," are those activities conducted in compliance with the guidelines established by the appropriate statute or regulatory authority in your domicile state? ..... ☐ Yes ☐ No

7. Is your facility governmentally immune? ..... ☐ Yes ☐ No

SERVICES

8. Please indicate if the Applicant presently provides, plans to provide, or presently operates any of the following:

☐ Abortion Clinic	☐ Day Care	☐ Home Health Care	☐ Laboratory	☐ Off-Premises Clinics
☐ Ambulance Service	☐ Emergency Room	☐ Hospice	☐ Nursing Home	☐ Outpatient Surgical Centers
☐ Assisted Living	☐ Experimental Surgery	☐ Intensive Care Unit	☐ Nursery	☐ Off–Premises Pharmacy
☐ *Bariatric Surgery	☐ Fitness Center	☐ Independent Living	☐ Off-Premises Labs	☐ On-Premises Pharmacy

* Supplemental Application Required

☐ Other: _____

INSURANCE COVERAGE REQUEST

9. Requested Effective Date _____

10. Requested Limits
Professional Liability $ _____ / $ _____ Retroactive Date _____
Per Claim Aggregate
General Liability $ _____ / $ _____
Per Claim Aggregate

11. Deductible ❑ None
Professional Liability $ _____/ $ _____ General Liability $_____ / $ _____
Per Claim Aggregate Per Claim Aggregate
Deductible is to apply to: ❑ Indemnity Only ❑ Indemnity and Expense

12. Excess/Umbrella Liability desired? ❑ Yes ❑ No
Limit $_____ Retroactive Date _____

13. Umbrella schedule of underlying coverage:

Coverage	Carrier	Limits of Liability	Policy Number	Policy Period
Automobile Liability		☐ $1M CSL ☐ Other Please specify "Other": _____		
Employers Liability		☐ $500/$500/$500 ☐ Other Please specify "Other": _____		
Other Liability				
Other Liability				

14. Additional Coverage Options - Choose your desired limit for the coverage below

a. **Employee Benefits Administration Liability:**
☐ $250,000/$250,000 ☐ $500,000/$500,000* ☐ $1,000,000/$1,000,000* ☐ $1,000,000/$3,000,000*

b. **Limited Pollution and Contamination Liability:**
☐ $100,000/$100,000 ☐ $250,000/$250,000* ☐ $500,000/$500,000* ☐ $1,000,000/$1,000,000*

c. **Medical Expense:** ☐ $1.000 ☐ $5,000* ☐ $10,000*

d. **Products- Completed Operations:**
Do you desire this coverage? ☐ Yes ☐ No ☐ $1,000,000/$1,000,000* ☐ $1,000,000/$3,000,000*

*An additional premium will be charged if this limit is chosen.

INSURANCE HISTORY

Complete the following professional liability insurance history

15. **Current Carrier** _____
Policy Term: _____ Retroactive Date _____
Expiring Premium $ _____

16. **Limits**
Professional Liability $ _____ / $ _____ Retroactive Date _____
Per Claim Aggregate
General Liability $ _____ / $ _____ Retroactive Date _____
Per Claim Aggregate ❑ Occurrence Coverage

17. **Deductible** ❑ None
Professional Liability $ _____ / $ _____ General Liability $ _____ / $ _____
Per Claim Aggregate Per Claim Aggregate
Deductible applies to: ❑ Indemnity Only ❑ Indemnity and Expense

18. **Excess / Umbrella Liability**
Limit $ _____ Retroactive Date _____
Expiring Premium $ _____

19. Has any insurer ever canceled, declined to issue, refused to renew, or issued coverage to the Applicant with any restrictions or exclusions? ..... ☐Yes ☐ No

STAFFING

20. What is your total number of employees, contractors and volunteers? _____

21. Do you desire any of the following providers be covered under this facility policy? ..... ☐Yes ☐No

	Employed	Contracted
Physician/Surgeon		
Certified Registered Nurse Anesthetist		

If yes, please provide a roster of all providers.

ACUTE BEDS/VISITS/PROCEDURES SECTION

Complete this section only if the applicant is a hospital.

If you have more than one separately licensed facility, please photocopy this page and complete the section below for each additional separately licensed facility

22. Facility Name: _____

Hospital Inpatient	List the Number of Licensed Beds in Each Category	List your Projected Patient Days for the Next 12 Months in this Column
Acute Care Beds		
Cribs/Bassinets		
Sub-Acute/Transitional		
Skilled Nursing Beds		
Long Term Care Beds		
Psychiatric		
Physical Rehabilitation		
Chemical Dependency		
Hospice		
ICU/CCU Beds		
Other (please specify):		

Please list all of your projected patient visits for each category listed below. If there isn't a specific category that you need, list those patient visits under "Other" and please specify the type of visit.

Outpatient Visits	Outpatient Visits Projected for the Next Year
Outpatient and Clinic Visits (not listed below)	
Emergency Room Visits	
DME Revenue	
Urgent Care Visits	
Outpatient Surgery	
Chemical Dependency Visits	
Rehabilitation and Therapy	
Psychiatric Visits	
Home Health Care Visits	
Reference Lab Visits (non-patient/ third party)	
Retail Pharmacy Revenue (for non-patients)	
Retail Pharmacy Revenue (for patients)	
Inpatient Surgery	
Number of Births	
Other (please specify):	

For free-standing/retail pharmacies only:

Is the freestanding facility wholly owned by the hospital? ..... ☐ Yes ☐No

Does the Applicant compound in bulk, manufacture or wholesale drugs or products? ..... ☐ Yes ☐No
If Yes, please explain:

_____

NON-ACUTE VISITS/PROCEDURES SECTION

Complete this section only if the applicant is a facility OTHER than a hospital.

If you have more than one separately licensed facility, please photocopy this page and complete them for each additional separately licensed facility.

23. Do you maintain any beds for overnight recovery? ..... ☐ Yes ☐No
If "Yes," please explain.

_____

24. Facility Name: _____

Total Number of Licensed Beds: _____ Projected Patient days for the next 12 months: _____

Accreditations: ☐ AAAHC Accredited ☐ ASCA Accredited

Please list all of your projected patient visits/procedures for each bolded category listed below. If there isn't a specific category listed, use the "Notes" section to add this information.

Visits/ Procedures	**Visits/Procedures projected for next 12 months**	**Notes**
Urgent Care Visits		
Rehabilitation and Therapy		
Chronic Pain Visits/ Procedures		
Cosmetic – facial		
Outpatient and Clinic Visits		
Dermatology - Procedures		
Pain Management Procedures		
Orthopedic - Procedures		
General Surgery - Procedures		
Radiology Vascular Interventional Procedures -		
Radiology – All Other		
GI - Procedures		
Gynecology - Procedures		
Ophthalmology – Procedures		
ENT – Procedures		
Urology – Procedures		
Podiatry - Procedures		
Other Procedures		

OBSTETRICAL SECTION

25. Do you offer obstetrical services? ..... ☐ Yes ☐No

If "no," please skip to the next section.

26. Is the Applicant a regional referral center for newborns requiring intensive care or for high-risk pregnancies? ..... ☐ Yes ☐No
If "no," does a written procedure exist for transferring all high-risk mothers or babies which the hospital is not qualified to treat? ..... ☐ Yes ☐No

27. How many vaginal births after C-section (VBACs) were performed in the past 12 months? _____

28. Can C-sections be performed at all times within 30 minutes from "decision to incision"? ..... ☐ Yes ☐No
If "no," please explain.

_____

29. Is an obstetrician available in-house 24 hours per day for the obstetrical suite? ..... ☐ Yes ☐No

If "no," what is the maximum time for arrival at the hospital? _____

30. Is continuous electronic fetal monitoring performed on all patients in active labor? ..... ☐ Yes ☐No

31. Is an anesthesiologist or CRNA available in-house 24 hours per day for the obstetrical suite? ..... ☐ Yes ☐No
If "no," what is the maximum time for arrival at the hospital? _____

32. Are all of your Family Practice Physicians who deliver babies ALSO certified? ..... ☐ Yes ☐No

EMERGENCY ROOM SECTION

33. Do you provide emergency room (ER) services? ..... ☐ Yes ☐No
If "yes," what is your trauma level? _____

DAY CARE SECTION

34. Does the Applicant own or have a day care facility? ..... ☐ Yes ☐No
If "yes"; ☐ Adult or ☐ Child

If "no," please skip to the next section.

a) Does the Applicant check references or conduct background checks on the day care staff? ..... ☐ Yes ☐No
b) Is the day care facility on the hospital premises? ..... ☐ Yes ☐No
If "no," what is the address of the day care facility?
_____
c) Is the day care facility open to the public? ..... ☐ Yes ☐No
If "yes," who runs the day care facility? _____
d) If it's an independent operator/contractor, do they carry general liability coverage? ..... ☐ Yes ☐No
e) Does the day care comply with the state-required staffing ratios? ..... ☐ Yes ☐No

STAFF PRIVILEGES SECTION

35. Are credentials of all providers checked and approved prior to the granting of privileges? ..... ☐ Yes ☐No

36. Are providers' privileges and overall performances evaluated periodically? ..... ☐ Yes ☐No
How often? _____

37. Has the license or privileges of any provider ever been restricted or suspended, or has the facility had to notify the National Practitioners Data Bank of a suspension, peer review action, or liability payment of any provider? ..... ☐ Yes ☐No
If "yes," please provide details on a separate sheet of paper.

38. Are criminal background checks, including sexual offenses, performed on all employees, volunteers and contractors? ❑ Yes ❑ No
If "no," please explain:_____

39. Which of the following abuse prevention methods are used?
a) Written sexual abuse and molestation prevention policy that is read and signed off by staff annually; ..... ☐ Yes ☐No
b) Training on sexual abuse and molestation prevention provided to staff annually; ..... ☐ Yes ☐No
c) Zero tolerance policy regarding abuse; ..... ☐ Yes ☐No
d) Written policy addressing abuse prevention. ..... ☐ Yes ☐No

39. Do you have a formal process for documenting and investigating reports of suspicious or inappropriate behaviors including allegations of abuse? ..... ☐ Yes ☐No
If "no," please explain. _____

40. Have there been any physical abuse, sexual abuse or molestation judgments, settlements, payments, claims, suits or demands made against any person or entity proposed for this insurance? ..... ☐ Yes ☐No

41. Is any person or entity proposed for this insurance aware of any facts, circumstances, or situations which might afford grounds for any physical abuse, sexual abuse or molestation claim(s)? ..... ☐ Yes ☐No

42. Has the Applicant or any other associated entity ever lost a license, been denied a license or been disciplined (probations, sanctions, fines, etc.) by any governmental licensing agency, by any accrediting review body, or by any state or federal agency? ❑ Yes ❑ No
If "yes," please explain: _____

RISK MANAGEMENT SECTION

43. Is there a written risk management program that has been approved by the governing body? ..... ☐ Yes ☐No

44. Does the governing body review the effectiveness of the program and approve necessary changes? ..... ☐ Yes ☐No

45. Does the risk management program include the following?

Occurrence reporting?	☐ Yes ☐No	Contract review and evaluation?	☐ Yes ☐No
Formal link to quality management?	☐ Yes ☐No	Review and participation in medical staff committees?	☐ Yes ☐No
Safety program and safety committee?	☐ Yes ☐No	Claim management?	☐ Yes ☐No

PHYSICAL PREMISES SECTION

46. Does the Applicant plan any new construction for the coming year? ..... ☐ Yes ☐No
If "yes", please explain.

_____

_____

47. Are there any additions or deletions to your schedule of locations? ..... ☐ Yes ☐No
If "yes," please explain using a separate sheet.

YOUR POLICY CANNOT BE PROCESSED WITHOUT THE FOLLOWING ATTACHMENTS:

☐ A copy of the most recent Joint Commission report and your response(s) to any contingencies and/or a copy of your most recent Department of Public Health and Environment Survey - Statement of Deficiencies and Plan of Correction and/or Critical Access survey results (if applicable).

☐ A copy of your state license.

☐ Loss history is required from your prior carriers for the last ten (10) years. Please call your prior carriers and request a currently valued loss run. A total of 10 years prior history is required.

☐ A copy of your current policy including all endorsements.

☐ A copy of the FTCA deeming letter (if applicable).

☐ Roster of Providers that are to be covered under the facility policy.

STATE FUND APPLICANTS ONLY:

PARTICIPATION UNDER FACILITY MEDICAL LIABILITY LAWS IN YOUR DOMICILE STATE

48. If approved for COPIC coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under facility medical liability laws in your domicile state? ..... ☐Yes ☐No

49. Have you at all times subsequent to the retroactive date indicated on the insurance declarations page(s) been a qualified health care provider under facility medical liability laws in your domicile state? ..... ☐Yes ☐No
If "no," please explain.

_____

_____

Note: *For purposes of this question "qualified health care provider" means that you have filed proof of financial responsibility with the Department of Insurance in your domicile state.*

The Applicant represents that the application statements and facts are true and that no material facts have been suppressed or misstated. Completion of this form does not bind coverage. Applicant's acceptance of Company's proposal is required before Applicant may be bound and a policy issued.

The facility agrees to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the facility undertakes in managing its medical professional exposures.

Application must be signed by an officer of the company

Applicant Signature: _____ *Date:* _____

Applicant Name: _____ *Title:* _____

*Agent (if any):*_____

Telephone Number: _____*E-mail Address:* _____

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A Risk Retention Group

The Applicant understands and agrees that all information contained in the application(s) and supplemental information submitted to COPIC[1] in connection with the insurance being applied for will be relied upon by COPIC underwriters in issuing the policy and are the basis for the proposed insurance. Such application(s) and information submitted to COPIC shall be deemed attached to, and made a part of, this Warranty Statement.

The Applicant also understands and agrees that the policy, for which this Warranty and application are made subject to its terms and conditions, does not apply to claims or potential claims the Applicant is aware of, or should be aware of after reasonable inquiry, prior to the effective date of coverage. All claims or potential claims should be reported to the Applicant's carrier prior to the effective date of the new policy.

The Applicant warrants, after reasonable inquiry, that it is not aware of any dispute, error, omission, act or circumstance that is, or could reasonably be expected to become, a claim under the policy of which the application(s) and supplemental information are submitted to COPIC, including, but not limited to, an attorney's request for records, patient/family dissatisfaction, or unanticipated death/paralysis/disability.

☐ Check this box if the Applicant warrants that the above statements are true.

I. By signing below, the Applicant warrants that the foregoing is true and complete and acknowledges that the insurer is relying on the accuracy of this statement in acceptance of the risk. This does not bind the company to offer insurance.

II. The Applicant acknowledges and agrees that this warranty statement shall be the basis of the proposed insurance and shall be considered incorporated into and constituting part of the proposed insurance.

III. The Applicant agrees that if the information supplied on this warranty statement changes between the date of the warranty statement and the inception date of the insurance, the Applicant will immediately notify the insurer of such a change, and the insurer may modify or deny coverage.

Print Name: _____ **Title**: _____

Signed: _____ **Date**: _____

Authorized signature of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

[1] The reference to COPIC may be to either COPIC Insurance Company or COPIC, A Risk Retention Group. Each of those companies are members of the COPIC family of companies. The specific COPIC company to which this Warranty applies is the company from which you are seeking coverages.

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

The applicant understand that this is an application for insurance and not an insurance binder.

The applicant hereby declares and warrants that all answers and statements herein given are true and complete to the best of their knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. The applicant understands that these answers and statements are material and as such will be relied upon in the determination by the company to grant liability insurance as requested. If there is a misstatement or failure to disclose any pertinent information, the application for coverage may be declined. If the application is approved and it includes any misstatement or failure to disclose pertinent information, COPIC/COPIC RRG has the right to cancel the insurance. COPIC/COPIC RRG also has the right to decline coverage for a specific claim if COPIC/COPIC RRG would have declined to issue insurance or limited coverage if the misstatement or omission did not occur.

Further, as a prerequisite to acceptance of this application and consideration for granting of liability insurance, COPIC/COPIC RRG and/or its assigns may conduct a peer review investigation of the practice or individuals insured. As part of such peer review investigation, consent is provided to the release of any prior Practice Assessments and to periodic chart and medical record reviews conducted as COPIC/COPIC RRG may request or direct. We agree to abide by any recommendations arising from that review.

By submitting this application, authorization is given to any state board of medical examiners or licensure, hospital board or committee, hospital records department, insurance company, professional society, past or present, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC/COPIC RRG or its assigns. The applicant approves the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC/COPIC RRG policy, consent is provided to COPIC/COPIC RRG to release of the following information about insureds under this policy, which may change from time to time, to credentials verification organizations, health plans, hospitals, health care organizations, professional liability insurance carriers, and state and federal regulatory entities, including but not limited to boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank and to the fullest extent permitted by law, hereby release all providers of such information, including COPIC/COPIC RRG, its employees and agents, from any and all liability therefore. This release applies to the following information: insured(s) name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank.

Signature of Authorized Representative: _____ Date _____

Name (Printed): _____

WE SUGGEST YOU RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

INSURANCE FRAUD WARNINGS

ALABAMA

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 restitution fines or confinement in prison, or any combination thereof. Ala. Code 1975 § 27-12A-20

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for 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. A.C.A. § 23-66-503

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include Imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or in formation 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. C.R.S. § 10-1-128 (6)(a)

DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any 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. DC ST § 22-3225.09

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. West's F.S.A. § 817.234

KENTUCKY

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. KRS § 304.47-030

LOUISIANA

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. LSA-R.S. 40:1424

MAINE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. 24-A M.R.S.A. § 2186(3)

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. MD INSURANCE § 27-805(b)(1)

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. NJ ST 17:33A-6(c)

NEW MEXICO

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 subject to civil fines and criminal penalties. NM ST § 59A-16C-8

NEW YORK

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. N.Y. Ins. Law § 403

OHIO

Any person who, with intent to defraud or knowing that he 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. OH ST § 3999.21

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. OK ST T. 36 § 3613.1

RHODE ISLAND

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. Gen Laws 1956, § 27-54.1-3

TENNESSEE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. T. C. A. § 56-53-111(b)(1)(A)

VIRGINIA

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. VA Code Ann. § 52-40. B

WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. RCWA 48.135.080

WEST VIRGINIA

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. W. Va. Code, § 33-41-3(a)

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.