



www.aauins.com
800.866.3897

- FaithGuard Application Agent Number: _____
 General Application

HOME OFFICE USE ONLY	
Policy No. _____	Policy Type _____
Original Date _____	Premium Received \$ _____
Account No. _____	Denomination Code _____

DIRECTIONS TO THE AGENTS

REQUIRED: 2 pictures of each building (front and rear), a current copy of the three year loss run, a diagram showing distances between buildings, and a current copy of the cost guide estimate for each building.

1. Quote needed by _____

2. This coverage is bound (money and copy of binder must be attached)

3. Indicate additional policies requested and attach application(s): Business Auto Umbrella Workers' Compensation

COMMON POLICY INFORMATION

1. Issue effective _____ Expiration _____

2. Remittance with app \$ _____ Pay Mode: _____

*Complete the **Authorization for EFT Monthly Bill Payment Plan** and **EFT Financial Account Information** forms.

3. First Named Insured and other Named Insureds _____

4. Mailing Address: Street _____
City _____ State _____ Zip _____
Web site _____ E-mail _____
Phone Number _____

5. Insured FEIN _____

6. Insured is:

7. Insured has filed for bankruptcy.

8. Insured is a for-profit organization.

9. Average Weekly Attendance _____ Number of Employees _____

10. Specific Denomination _____

11. Operation (Check all that apply): Church Office Headquarters Day Care School Camp Other

12. **MISSOURI APPLICANTS – do not answer this question. Any application received for a Missouri applicant that has this question answered will have to be returned as it can no longer be accepted due to the state law.**

a. Has the insured had any coverage declined or non-renewed within the last 3 years? Yes No
If "yes," explain _____

b. Enter all claims from the past three years or attach loss runs from previous carrier

DATE OF LOSS	POLICY TYPE	DESCRIPTION OF LOSS	AMOUNT PAID

13. Prior Carrier Information

NAME OF CARRIER	RENEWAL DATE	NO. OF YEARS	POLICY TYPE	ANNUAL PREMIUM

INSTITUTIONAL PROPERTY SURVEY

BUILDING INFORMATION

	1. Premises No. Bldg. No.	2. Premises No. Bldg. No.	3. Premises No. Bldg. No.	4. Premises No. Bldg. No.
Area: Ground Floor/Total Bldg. Sq. Ft.	/	/	/	/
Basement Square Footage				
Number of Stories				
Type of Heating System				
Electrical System				
Date of last electrical system inspection by licensed electrician				
Type of Roof				
Date of last roof replacement				
Are there known structural concerns with the building? If "yes," explain in notes section below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Servicing of Extinguishers Annually	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sprinkler System				
Masonry Bell Tower If "yes," answer questions from the Bell Tower Questionnaire.	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Bell Tower Questionnaire</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Bell Tower Questionnaire</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Bell Tower Questionnaire</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Bell Tower Questionnaire</u>
Is your kitchen equipped with a deep fat fryer, wok, broiler, griddle, or flat top grills? If "yes," answer questions from the Commercial Cooking Survey.	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Commercial Cooking Survey</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Commercial Cooking Survey</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Commercial Cooking Survey</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>Commercial Cooking Survey</u>
Alarms: Smoke Detectors on each floor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pull Alarms				
Central Detectors				
Burglar Alarms				
Responding company	Name: _____ Phone: _____			
Building locked when not in use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Building is converted dwelling? If "yes," explain in notes section.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

GENERAL INFORMATION

Building on Historical Register	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------------	--	--	--	--

NOTES:

COMMERCIAL PROPERTY COVERAGE PART

Total Number of Mortgagees _____ If more than two, complete schedule.

Premises No. _____ Bldg. No. _____ Loan # _____

Name and Address: _____

Premises No. _____ Bldg. No. _____ Loan # _____

Name and Address: _____

Loss Payee (leased equipment/property):

Premises No. _____ Bldg. No. _____ Ref/Loan # _____

Name and Address: _____

Description of Leased Equipment/Property: _____

LIABILITY COVERAGE PART

1. Limits of Insurance (Occ./Agg.):
- Damage to Premises Rented To You Limit: Occurrence Limit is equal to General Liability occurrence limit
- Medical Expense Limit per accident:
- Lost Wages:

2. Schedule of Exposures

PREM	BLDG	CLASSIFICATION (DESCRIPTION)	CLASS CODE	EXPOSURE	PREMIUM BASIS

Additional Interest / Certificate Recipient

NAME	ADDRESS	INTEREST TO APPLICANT

Lessor's Risk – Space Rented To Others

NAME	ADDRESS	OCCUPANCY	SQUARE FEET LEASED OUT	NUMBER OF TIMES USED PER YEAR

Are Certificates of Insurance Required? Yes No

3. Swimming Pool Yes No If swimming pools are present, answer the following questions.

Quantity _____

Pool is fenced and locked when not in use Yes No Pool depth is marked Yes No

Diving boards present Yes No Swimming allowed without a lifeguard on duty Yes No

4. Does the applicant have any trampolines or rebounding equipment owned or used? Yes No

LIABILITY COVERAGE PART continued on next page

LIABILITY COVERAGE PART continued

5. Does the applicant use security personnel? Yes No

Employed by the insured? Yes No

Contracted security personnel? Yes No

If contracted security is used, are certificates required and kept on file? Yes No

Number of armed security _____ Frequency of armed security used _____

Total annual payroll of all armed guards _____

Number of unarmed security _____ Frequency of unarmed security _____

Special Operations or Events – Check ALL that apply:

<input type="checkbox"/> Animals: riding/owned	<input type="checkbox"/> Climbing Wall	<input type="checkbox"/> Martial Arts
<input type="checkbox"/> Auto Repair	<input type="checkbox"/> Counseling – Alcohol	<input type="checkbox"/> Skateboarding Ramp
<input type="checkbox"/> Bounce House	<input type="checkbox"/> Counseling – Drug	<input type="checkbox"/> Soup Kitchen, ongoing
<input type="checkbox"/> Broadcasting - Radio	<input type="checkbox"/> Fireworks	<input type="checkbox"/> Trampoline
<input type="checkbox"/> Broadcasting - TV	<input type="checkbox"/> Haunted House	<input type="checkbox"/> Other:
<input type="checkbox"/> Building(s) is/are under const.	<input type="checkbox"/> Homeless Shelter	

Please describe all indicated operations or activities:

Is Builder's Risk coverage desired? Yes No

If "yes," fill out the **Builder's Risk Supplemental Application**.

6. Do you own a cemetery/columbarium? Yes No

If "yes," is the cemetery/columbarium located adjacent to an owned location? Yes No

If the cemetery/columbarium is not adjacent to an owned location, please provide:

Cemetery/Columbarium Address: _____

Number of Acres: _____

7. OPTIONAL COVERAGES: Check the box if you desire this coverage.

Directors and Officers Liability Coverage.

Occurrence

NOTE: Limits match occ/agg general liability limits

Claims-made:

Asset Size: _____

Retro Date: _____ (mm/dd/yyyy) +++

NOTE: Claims-made coverage is non-binding subject to completion of the **D&O Liability Supplemental Application**.

Does the applicant currently carry Claims-made Directors and Officers Liability Coverage and is now requesting Occurrence? Yes No

If "yes," Retro Coverage will be added for the initial policy term.

LIABILITY COVERAGE PART continued on next page

LIABILITY COVERAGE PART continued

Employment Practices Liability (Occurrence/Aggregate)

Limits of Insurance:

Total number of employees: _____

NOTE: Coverage greater than \$500,000 or 25 employees is non-binding subject to approval of the **EPL Supplemental Application**.

Retention \$0 unless otherwise indicated:

Retro Date: _____ (mm/dd/yyyy) +++

Are there any interruptions of claims-made coverage from the proposed retroactive date? Yes No

If "yes," submit written details including the dates of such interruptions.

Employee Benefits Liability Coverage

Counselors Liability Coverage:

Total Number of Counselors: _____

Number of Non-Licensed Counselors: _____

Number of Licensed Counselors other than ministers: _____

Number of Fee Based Counselors: _____

- NOTES:**
- The **Counselors Liability Supplemental Application** must be submitted for quote or issue.
 - If a Counselor has both a license and charges a fee, please include total within the fee based counseling only.
 - Licensed Ministers do not need to be included if they do not charge a fee, unless coverage is written on General Form.

Hired and Non-Owned Automobile Liability



www.aauins.com
800.866.3897

AGENT INSTRUCTIONS	
Complete this box when using this page as a "supplemental" application.	
Policy No. _____	Effective Date _____
Name Insured _____	
Agent # _____	

SEXUAL MISCONDUCT LIABILITY

Limits of Insurance (Occ/Agg): Occurrence Claims-Made

*This coverage is non-binding.

CLAIMS-MADE COVERAGE

- Retroactive Date: _____ (mm/dd/yyyy) +++
- Are there any interruptions of claims-made coverage from the proposed retroactive date? Yes No
If "yes," submit written details including the dates of such interruptions.
- Are any claims pending of which you or any ++authorized person are aware? Yes No
If "yes," submit a detailed explanation.
- Are there any incidents or circumstances known to you or any ++authorized person, that have not yet been reported to the prior carrier, and for which there is a reason to believe that such incident or circumstance may give rise to a future claim under the proposed coverage?
 Yes No
If "yes," submit a detailed explanation.

+++ Retro dates on claims-made Sexual Misconduct coverage will match the policy effective date. Refer requests for a retro date prior to the policy effective date to the underwriter for review.

IF COVERAGE IS DESIRED, THE SUPPLEMENTAL SEXUAL MISCONDUCT QUESTIONNAIRE MUST BE COMPLETED AND SIGNED, OTHERWISE THE POLICY WILL BE ISSUED WITHOUT MISCONDUCT COVERAGE.

- Does your organization have a formal written policy that includes procedures designed to prevent acts of sexual misconduct?
 Yes No
 - If "yes," does your policy include a procedure in which you ask employees and volunteers if they have ever been accused of, participated in, or been convicted of sexual misconduct? Yes No
 - If "no," would you be willing to implement a policy that includes employee/volunteer screening, risk management and claims response programs if the materials for setting this up were provided to you? Yes No
- Are all employees, and those volunteers involved with any activity involving a minor (anyone under the age of 18), required to sign a release from which you keep on file that allows you to request a criminal background check? Yes No
- Do you conduct criminal background and reference checks on employees and volunteers? Yes No
 - If "yes," **check all that apply for employees and all that apply for volunteers.** For purposes of this question, a volunteer is anyone involved in a Day Care or School, or overnight activity involving minors, counseling of minors, or one-on-one mentoring of minors.

For employees we conduct:	For volunteers we conduct:
<input type="checkbox"/> Nationwide criminal background checks on ALL employees <input type="checkbox"/> Reference checks* on ALL employees <input type="checkbox"/> No criminal background checks on employees <input type="checkbox"/> No reference checks* on employees <input type="checkbox"/> Other:	<input type="checkbox"/> Nationwide criminal background checks <input type="checkbox"/> Statewide criminal or statewide sexual offender background checks <input type="checkbox"/> Reference checks* on volunteers <input type="checkbox"/> No criminal background checks on volunteers <input type="checkbox"/> No reference checks* on volunteers <input type="checkbox"/> Other:

* The reference check includes contacting, at a minimum, two organizations in which the applicant has worked with minors in the past e.g. other churches, scouts, etc.

SEXUAL MISCONDUCT LIABILITY continued on next page

SEXUAL MISCONDUCT LIABILITY continued

- 4. Do you require that all volunteer be involved with your organization for at least six months before they are allowed in any position involving contact with minors? Yes No
- 5. Do you require that no minor is ever alone with only one adult on church premises or in any church-sponsored activity unless in a counseling situation? Yes No
- 6. Do you have a written response program in the event that a sexual misconduct event occurs? Yes No
- 7. Have you or any of your representatives ever submitted a claim for sexual misconduct liability to any insurer? If "yes," submit a detailed written explanation of the event. Yes No
- 8. Have any of your past or present ministers, employees, or volunteers ever been accused, charged, convicted, had a claim for damages submitted against, or sued in civil court for any type of sexual misconduct? If "yes," identify the person and submit a detailed written account. Yes No
- 9. Have you or any of your representatives ever received a complaint alleging sexual misconduct against any of your ministers, employees, or volunteers, even if no claim were ever submitted. If "yes," submit a detailed written explanation. Yes No
- 10. Have you or any of your representatives ever received a report, or investigated any event of alleged sexual misconduct against any of your ministers, employees, or volunteers, even if no claim was ever submitted? If "yes," submit a detailed written account. Yes No
- 11. Do you or any of your representatives have any investigation or inquiry pending at the time of this application, or knowledge of any information which may lead to an investigation or inquiry, regarding an event or occurrence of sexual misconduct involving you, or your officers, directors, trustees, elders, ministers, employees, or volunteers? If "yes," submit a detailed written explanation. Yes No
- 12. Has your insurance agent explained the GuideOne requirements for carrying Sexual Misconduct coverage at these limits and, if you are not currently in compliance, will you be working on a written plan that will incorporate all of the requirements so that they can be implemented within the next 6 months? (GuideOne may require a copy of your written plan for their file. Failure to provide evidence of compliance will result in a reduction in Sexual Misconduct coverage.) Yes No

THE APPLICANT ACKNOWLEDGES THAT THE FOREGOING DISCLOSURES AND REPRESENTATIONS ARE DEEMED TO BE MATERIAL, AND THAT GUIDEONE INSURANCE IS RELYING UPON THE ACCURACY AND COMPLETENESS OF SAID DISCLOSURES AND REPRESENTATIONS IN REACHING A DECISION TO ISSUE SEXUAL MISCONDUCT LIABILITY COVERAGE TO THE APPLICANT. THIS SUPPLEMENTAL APPLICATION IMPOSES AN AFFIRMATIVE DUTY TO MAKE FULL AND FAIR DISCLOSURES UPON THE APPLICANT. THE INSURED IS OBLIGATED TO REPORT ANY CHANGES IN ANY OF THE FOREGOING RESPONSES TO THE COMPANY.

Authorized Person ++

Print name and title or position e.g. Pastor or Board Member

Date

++ Authorized person means any employee that is elected, appointed or authorized to give or receive notice of a claim, offense, incident, or circumstance.

COMMERCIAL CRIME COVERAGE PART

Select either Church Theft **or** Crime Coverage

Church Theft – Deductible - \$500 unless indicated otherwise:

Money and Securities Only \$ _____ (Limit)

Blanket Excluding Money and Securities \$ _____ (Limit)

Blanket Including Money and Securities \$ _____ (Limit)

If \$25,000 or more is entered in any blank, fill out the Institutional Crime Survey below.

Name of Fourth Day _____

Crime Coverage – Theft, Disappearance, and Destruction (Form C)

Deductible - \$500 unless indicated otherwise:

Inside Limit \$ _____ Outside Limit \$ _____ Other Limit \$ _____

If \$25,000 or more is entered in any blank, fill out the Institutional Crime Survey below.

Select either Church Fidelity Bond Coverage **or** Bond Coverage

Church Fidelity Bond Coverage \$ _____ (Limit - \$10,000 maximum – no deductible)

Bond Coverage

Employee Dishonesty Blanket (Form A) \$ _____ (Limit) \$ _____ (Deductible)

Forgery and Alteration (Form B) \$ _____ (Limit) \$ _____ (Deductible)

INSTITUTIONAL CRIME SURVEY

Complete the Institutional Crime Survey for limits in excess of \$25,000

1. Is an audit performed? Yes No

If so, who performs the audit? CPA Public Accountant Staff Other _____

If so, how often is the audit performed? Annual Semi-Annual Quarterly Other _____

If so, does the audit include inventory? Yes No

If so, to whom is the audit report rendered? Owner Partner Board of Directors Other _____

2. Are bank accounts reconciled by someone not authorized to deposit or withdrawal? Yes No

3. Is countersignature of checks required? Yes No

If "yes," who (position) signs the checks? _____

4. Will securities be subject to joint control of two or more responsible employees? Yes No N/A

INLAND MARINE COVERAGE PART

Attach schedule for each coverage indicated. Show Location, Description (model #, etc.) and Value for each item.

Ded. \$500 unless indicated otherwise \$ _____ Maintenance Equipment Coverage \$ _____

Musical Instruments \$ _____ Ministers' Business Property Coverage \$ _____

Photographic Equipment \$ _____ Replacement Cost Actual Cash Value

Fine Arts \$ _____ Scheduled Property Endorsement \$ _____

Blanket Coverage for Fine Arts \$ _____ Other:

Breakage Coverage for Fine Arts \$ _____

Data Processing Equipment Coverage \$ _____

DAY CARE INFORMATION (INCLUDING PRESCHOOL)

A. GENERAL INFORMATION

YES NO

- 1. Is the Day Care run by the insured? If "no," please explain. _____
- 2. Square footage of the building area used: _____
- 3. Appropriate licensing requirements are met (e.g., state, county, city, etc.)
- 4. Day care is provided in a residence.
- 5. What are the days and hours of operation? _____
- 6.

AGE GROUP	ADULT/CHILD RATIO	AGE GROUP	ADULT/CHILD RATIO
Two weeks to 2 years	_____	5-10 years	_____
2 years	_____	10+ years	_____
3 years	_____	Adult Day Care	_____
4 years	_____		
- 7. Total number of children on premises at any given time: _____

B. SAFETY INFORMATION

YES NO

- 1. A written policy outlining the entity's fire protection program exists and routine fire drills are performed.
- 2. Emergency evacuation procedures are in effect (tornado, earthquake, etc.).
- 3. Strictly enforced guidelines are in effect for the authorized pick-up of children.
- 4. Electrical outlets have cover protectors.
- 5. Properly functioning UL-listed smoke detectors are installed in each room.
- 6. Properly functioning Carbon Monoxide (CO) detectors are installed.

C. MEDICAL PRACTICES

YES NO

- 1. Medicines are kept in appropriately locked cabinets; procedures for their distribution are in place.
- 2. Record of injuries and action taken exists.
- 3. Parents sign permission slips authorizing emergency medical transportation or treatment.
- 4. Two on-duty staff members are certified in CPR and First Aid.

D. PERSONNEL INFORMATION

YES NO

- 1. Written employment practices exist.
- 2. Corporal punishment is administered.

E. OPTIONAL COVERAGE

YES NO

- 1. Day Care Medical
- 2. Directors and Officers Including Educators Legal Liability. Retro Date: _____ (mm/dd/yyyy) +++

NOTE: Coverage is claims-made and non-binding subject to completion of the **D&O/ELL Supplemental Application**.

+++ Retro dates on claims-made coverage options will match the policy effective date unless a retro date is listed on the application. Retro dates over three years old should be referred to the underwriter for approval.

SCHOOL INFORMATION

A. GENERAL INFORMATION

1. Number of Students (K-8) _____ (9-12) _____
Number of Teachers (K-8) _____ (9-12) _____

Check all that apply:

2. School is accredited (list accrediting organization: _____)
3. Teachers have four year teaching degrees
4. Teachers have four year degrees and are state certified
5. The school has been in operation for a minimum of 10 years.
6. Maximum student to teacher ratio is 25 to 1.
7. Appropriate Fire Marshall Inspection Report and evidence of any required remediation are on file.
8. Exposure is:
9. Additional School Care:
- Before and/or After School Care (total number of children): _____
- Summer Day Camp Programs (total number of children): _____
10. Are there dormitories or residence halls? Yes No
11. Are there outdoor bleachers or grandstands? Yes No
Number: _____ Capacity of each: _____

B. COURSE AND ACTIVITIES INFORMATION (CHECK ALL THAT APPLY)

1. Activities or classes conducted or sponsored by school (Check all that apply):
- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Archery | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Riflery | <input type="checkbox"/> Snow Skiing |
| <input type="checkbox"/> Auto Repair | <input type="checkbox"/> Horseback Riding | <input type="checkbox"/> Scuba Diving | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Driver's Training | <input type="checkbox"/> Mountain Climbing/Rappelling | | <input type="checkbox"/> Shop Class with Power Tools |
| <input type="checkbox"/> Other: _____ | | | |
2. Sports offerings – Interscholastic/Intramural (Check all that apply):
Indicate Number of Students Participating beside each selected checkbox
- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Field or Ice Hockey | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Track/Cross Country |
| <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Football | <input type="checkbox"/> Soccer | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Diving | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Swimming | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Other: _____ | | | |

C. SAFETY INFORMATION

1. A written policy outlining the entity's fire protection program exists and routine fire drills are performed.
2. Emergency evacuation procedures are in effect (tornado, earthquake, etc.)

D. MEDICAL PRACTICES

1. Medicines are kept in appropriately locked cabinets, procedures for their distribution are in place
2. Record of injuries and action taken exists
3. Parents sign permission slips authorizing emergency medical transportation or treatment

SCHOOL INFORMATION continued on next page

SCHOOL INFORMATION continued

E. OPTIONAL COVERAGE

Directors and Officers Including Educators Legal Liability. Retro Date: _____ (mm/dd/yyyy) +++

NOTE: Coverage is claims-made and non-binding subject to completion of the D&O/ELL Supplemental Application.

Student Medical (Excess Coverage)

Interscholastic Athletics Medical Coverage (Excess Coverage)

Number of Athletes _____

Corporal punishment* is administered in grades K-12 only under approved guidelines that are outlined in the Student Handbook. (Send Corporal Punishment Guidelines.)

Number of Teachers _____ Number of administrators _____

* Not available for Day Care

+++ Retro dates on claims-made coverage options will match the policy effective date unless a retro date is listed on the application. Retro dates over three years old should be referred to the underwriter for approval.

COMMENTS/SCHEDULES

Name of Applicant			
Policy No./Quote No.	City	State	ZIP

INSURANCE FRAUD WARNING:

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.

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: 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 restitution, fines, or confinement in prison, or any combination thereof. *Applies in MD only.

Applicable in CO: 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: 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).* *Applies in FL only.

Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 material 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ACKNOWLEDGEMENT AND SIGNATURES:

The undersigned is an authorized representative of the applicant and represents that reasonable enquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/her knowledge.

INSURED MUST SIGN THIS APPLICATION IN ORDER FOR IT TO BE VALID

Authorized Insured Representative		Date	
Print Name		Title or Position	
Agent No	Agency	Producer's Signature	License No