TRAVELERS

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Health Care Organization Directors, Officers and Trustees and Employment Practices Liability Coverage Application

Travelers Excess and Surplus Lines Company

NOTICE

ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED AND MAY BE EXHAUSTED BY THE AMOUNTS INCURRED AS DEFENSE EXPENSES, AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY–TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

GENERAL INFORMATION

1. Name of **Applicant**: _____
2. Street Address: _____

   City, State, ZIP Code: _____
3. Website Address: _____
4. Year **Applicant's** business was established: _____
5. Description of **Applicant's** operations: _____
6. **Applicant's** Standard Industrial Classification (SIC) code, if known (4-digit number): _____
7. Does the **Applicant** now have tax exempt status under the United States Internal Revenue Code? Yes ☐ No ☐
8. Is there now, or has there been within the last 12 months, any dispute as to the **Applicant's** Tax exempt status? Yes ☐ No ☐
   If yes, attach an explanation.
9. Does the **Applicant** currently file, or does it anticipate filing in the next 12 months, any documents with the Securities and Exchange Commission or similar foreign authority regarding any equity or debt securities? Yes ☐ No ☐
10. Provide a list of all subsidiaries and controlled organizations, percentage owned/controlled by the **Applicant**, nature of the business, tax status, entity type, and the date acquired or formed. *(Check here if not applicable* ☐*)*:

Name	% Owned	Year Started	Description of Operations	Tax Status*	Entity Type**
	%				
	%				
	%				

***Tax Status: FP = For Profit; NP = Non-Profit**
****Entity Type: for example 501(c)(3); S Corporation; GP = General Partnership; LP=Limited Partnership; LLC=Limited Liability Company; LLP = Limited Liability Partnership**

To enter more information, please attach a separate page or an organization chart with ownership detail. The listing of organizations does not mean coverage is automatically provided.

11. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:
    a. Any actual or proposed merger, acquisition, affiliation, or divestiture? Yes ☐ No ☐
    b. Any creation of a new business, subsidiary, or division? Yes ☐ No ☐
    c. Any registration for a public offering or a private placement of securities (stocks or bonds)? Yes ☐ No ☐
    d. Any debt issuance or tax exempt bond offerings? Yes ☐ No ☐
    e. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐
    f. Any branch, location, facility, office, or subsidiary closings, consolidations, downsizing or layoffs? Yes ☐ No ☐

    If any of the questions above were answered yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, whether outside legal counsel was consulted, impact on employee base, and the surrounding circumstances.

12. Complete the table by providing information for the **Applicant's** existing insurance programs:

Coverage	Date First Purchased	Current Insurer	Expiration Date	Expiring Limit	Expiring Retention	Expiring Premium
Directors, Officers & Trustees (D&O)				$	$	$
Employment Practices Liability				$	$	$
Cyber Coverage				$	$	$

13. Has any insurer declined, canceled, or refused to renew any of the coverages listed above? Yes ☐ No ☐
    If yes, attach full details. (not applicable in Missouri)
14. Does the **Applicant** currently purchase health care/medical professional liability coverage? Yes ☐ No ☐
15. Are any of the **Applicant's** health care/medical professional liability coverages self-insured or insured by means of a self-insured trust, captive, risk sharing arrangement or pool? Yes ☐ No ☐
    *If yes, regarding the **Applicant's** self-insurance program:*
    Does the program provide insurance to third parties? N/A ☐ Yes ☐ No ☐
    If yes, attach full details.
16. Does the **Applicant** have coverage for peer review and credentialing activities under any other insurance policy, self-insured trust, captive, risk sharing arrangement or pool? Yes ☐ No ☐

REQUESTED INSURANCE TERMS

The following coverage options are available under this policy. Please fill in the limit and retention for the coverages desired, complete the applicable section below, and sign and date the Application. Also provide the information required at the end of each Liability Coverage section.

Health Care Organization Directors, Officers and Trustees D&O Limit of Liability: $_____ Retention: $_____

Health Care Organization Employment Practices Liability Limit of Liability: $_____ Retention: $_____

1. What is the **Applicant's** preference for defense coverage? Duty to Defend ☐ Reimbursement ☐
2. What is the **Applicant's** preference for Liability Coverage limits: Individual Limits ☐ Shared Limits ☐

DIRECTORS AND OFFICERS LIABILITY – complete only if coverage is desired

1. Complete the table by providing information for the **Applicant**:

Total Shares	# Common	# Preferred	# Other
Authorized			
Outstanding			
Voting Shares Outstanding			
Voting Shares Owned by Directors and Officers (Direct and Beneficial)			
Number of Voting Shares			

If there are multiple classes of stock, attach full details, including the number of shareholders and shares held in each class.

2. Complete the table by providing information for all shareholders that own greater than 5% of any class of security:

Shareholder	Class of Security	% Owned	Director, Officer or Trustee?
		%	Yes ☐ No ☐
		%	Yes ☐ No ☐
		%	Yes ☐ No ☐

If there are additional shareholders attach full details.

3. Does the Charter or By-laws of the Organization provide indemnification to its Directors and Officers to the fullest extent permitted by law? Yes ☐ No ☐

4. Are any of the **Applicant's** securities convertible to voting stock? Yes ☐ No ☐
   If yes, attach an explanation.

5. Is any shareholder a trust that qualified as an Employee Stock Ownership Plan under ERISA or holds securities for the benefit of employees? Yes ☐ No ☐
   If yes, attach most recent stock valuation report.

6. Have there been any changes in the Board of Directors or Senior Management of the **Applicant** within the past 3 years for reasons other than death or retirement? Yes ☐ No ☐
   If yes, attach an explanation.

7. Is the **Applicant** presently JCAHO accredited? ☐ N/A Yes ☐ No ☐

8. During the last 3 years, has any regulatory or accrediting body denied, suspended, revoked or granted, or subjected to contingency or recommendation, any license, certification or accreditation of any operation, department or facility of the **Applicant**? ☐ N/A Yes ☐ No ☐
   If yes, attach full details.

9. Does the **Applicant** perform peer review or credentialing activities for its health care staff? Yes ☐ No ☐
   a. Does the **Applicant** have formal written policies and procedures in effect that address peer review, credentialing, re-credentialing and decisions that could adversely affect health care staff membership, privileges or licensing? Yes ☐ No ☐
   b. Is legal counsel consulted before any recommendation or decision is finalized that could adversely affect health care staff membership, privileges or licensing? Yes ☐ No ☐
   c. During the last five (5) years has any **Applicant** been subject to any legal recourse associated with restriction or suspension of the license or privileges of any member of the health care staff? Yes ☐ No ☐
      If yes, attach full details.

10. Does the **Applicant** render any standard setting, accrediting, peer review, credentialing, licensing or similar services to any third party? Yes ☐ No ☐
    If yes, attach full details.

11. Does the **Applicant** provide any non-clinical management or administrative services to any third party under any contract or agreement? Yes ☐ No ☐

    If yes, attach full details.

12. Is the **Applicant** managed or administered by any third party under contract or agreement? Yes ☐ No ☐

    If yes, attach full details.

13. Does the **Applicant**:

    a. contract with more than 25% of the providers in any specific field of practice within its geographic service area? Yes ☐ No ☐

    b. control more than 25% of the hospital beds or specialty services within its geographic service area? Yes ☐ No ☐

    c. have exclusive contracts with any providers or hospitals? Yes ☐ No ☐

    d. have provider agreements that contain "Most Favorable" pricing provisions? Yes ☐ No ☐

    e. have any provider agreements that contain non-compete provisions? Yes ☐ No ☐

    If yes, to any of 13a. – e. above, please attach full details.

    f. seek an opinion from antitrust legal counsel to confirm that any mergers, acquisitions and network development activities are not in violation of antitrust law? Yes ☐ No ☐

    g. seek an opinion from the Federal Trade Commission (FTC) to confirm that any mergers, acquisitions and network development activities are not in violation of antitrust law? Yes ☐ No ☐

    If no, to either f. or g. above, please attach full details.

14. What percentage of the **Applicant's** total revenue is generated from federal, state or local government sources? _____%

15. Does the **Applicant:**

    a. have formal written regulatory compliance policies and procedures *(for example, the federal False Claims Act and Health Insurance Portability and Accountability Act (HIPAA))* addressing the responsibilities of the **Applicant**, its business partners, vendors and employees? Yes ☐ No ☐

    If yes: Date Implemented:_____ Date Last Revised:_____

    b. implement regular compliance education and training? Yes ☐ No ☐

    c. utilize audits or other evaluation techniques to monitor compliance? Yes ☐ No ☐

    d. utilize outside counsel to provide an opinion as to whether there could be a violation of law? Yes ☐ No ☐

16. Has the **Applicant:**

    a. been subject to any regulatory investigation or indictment involving patient billing, business referral(s) or any anti-kick back law? Yes ☐ No ☐

    b. been subject to any type of federal or state mandate or regulatory compliance oversight *(for example, a corporate integrity agreement)*? Yes ☐ No ☐

    c. been subject to any type of regulatory monetary settlement, fine or penalty? Yes ☐ No ☐

    If yes to any of the above, please attach full details.

17. Does the **Applicant** have a formal charity care policy that meets or exceeds applicable minimum state and federal requirements? Yes ☐ No ☐

18. Has any person or entity proposed for this insurance been a party to any securities claims, criminal actions, administrative or regulatory proceedings, charges, hearings, demands, or lawsuits during the past 3 years, including but not limit to, security holder, creditor, antitrust, fair trade law, copyright or patent litigation, whether or not insured? Yes ☐ No ☐

    If yes, attach full details, including the date, nature of the claim, amount paid for defense and/or damages, whether it was covered by insurance, any corrective procedures implemented, and the current status.

19. If the requested D&O limit of liability exceeds the limit of liability in the expiring D&O coverage, answer the following question:

    Solely with respect to any higher limits requested or that may ultimately be issued for the proposed insurance, is the **Applicant**, any of its subsidiaries, or any person proposed for this insurance aware

of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the D&O coverage for which the **Applicant** is applying? Yes ☐ No ☐
If yes, attach full details.

20. If D&O coverage is not currently purchased, or has been in place for less than 3 years, answer the following question:

    As of the date the **Applicant** first purchased the D&O coverage, or, as of the date of this Application if D&O coverage is not currently purchased, is the **Applicant**, any of its subsidiaries, or any person proposed for this insurance aware of a fact, circumstance, situation, event, or act that reasonably could give rise to a claim being made against them under the D&O coverage for which the **Applicant** is applying? Yes ☐ No ☐

    If yes, attach full details.

    With respect to the information required to be disclosed in response to the questions above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the Applicant had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.

As part of this Application, please provide copies of the documents listed below for each **Applicant** requesting insurance*:

- Most recent CPA audited financial statement or if CPA audit is not performed or not currently completed provide the most current year-end (12 months) internal financial report.
- Interim financial statements if CPA audited financial or year-end internal statements are six months or older.
- List of Directors and Officers.

*the documents, as well as the representations and facts contained within such documents are made a part of this Application; the Insurer may elect to obtain requested information from public sources, including the Internet.

EMPLOYMENT PRACTICES LIABILITY – complete only if coverage is desired

1. Total number of employees:* _____
2. Total number of employees* outside the U.S.: _____
3. Total number of locations: _____
4. Complete the table providing the number of Full Time and Part Time Employees*, Volunteers and natural person Independent Contractors:

As of Date of Application		Previous 12 Months		As of Date of Application	
Full Time Employees	**Part Time Employees**	**Full Time Employees**	**Part Time Employees**	**Volunteers**	**Independent Contractors**

**Full and part time including leased, seasonal, and temporary employees*

5. Complete the table providing employee information for the ***5 states or foreign countries*** with the greatest number of **Applicant** employees:

State or Foreign Country	Number of Employees

6. Complete the table providing the *maximum* number of employees at any one point during the previous 12 months for the following classifications (regardless of whether they are full or part time):

Leased	Temporary	Employed Physicians	Union

7. Within the past 24 months has the **Applicant** or outside employment counsel completed an audit regarding the payment of wages, including equal pay and overtime pay? Yes ☐ No ☐

8. What percentage of the **Applicant's** employee base is: Exempt: _____% Nonexempt: _____%

9. Within the past 24 months has the **Applicant** or outside employment counsel completed an audit regarding the classification of individuals as exempt v. non-exempt employees or as independent contractors? Yes ☐ No ☐

10. Complete the table by providing employee turnover figures for each of the last 3 years:

Type of Turnover	Year - 20____	Year - 20____	Year - 20____
Voluntary	#	#	#
Involuntary (excluding layoffs/downsizing)	#	#	#
Layoffs/Downsizing	#	#	#

11. Within the past 24 months how many officers have been involuntarily terminated or laid off? _____

12. Prior to employee terminations does the **Applicant** consult with:
    a. Human Resources personnel? Yes ☐ No ☐
    b. An attorney with experience in employment law? Yes ☐ No ☐

13. Does the **Applicant** provide severance packages to terminated or laid off employees? Yes ☐ No ☐
    *If yes, does the severance agreement include a waiver or release of an employee's rights to bring claim against the **Applicant**?* Yes ☐ No ☐

14. Does the **Applicant** have a Human Resources department? Yes ☐ No ☐
    If yes, *Number of Human Resources employees*: _____

15. Are all prospective employees required to complete a uniform employment application prior to hire? Yes ☐ No ☐

16. Does the **Applicant** have an employee handbook that is distributed to all employees? Yes ☐ No ☐

17. Are employees required to acknowledge, by signature, receipt of such employee handbook? Yes ☐ No ☐

18. Does the employment application or employee handbook contain an "Employment at Will" statement? Yes ☐ No ☐

19. Complete the table for guidelines, policies and procedures related to the following:

Guidelines, Policies, Procedures	Formal Written Policy	Employees Sign and Acknowledge Receipt
Workplace Discrimination	Yes ☐ No ☐	Yes ☐ No ☐
Sexual and Other Workplace Harassment	Yes ☐ No ☐	Yes ☐ No ☐
Equal Employment Opportunity	Yes ☐ No ☐	Yes ☐ No ☐
FMLA	Yes ☐ No ☐	Yes ☐ No ☐
Disabled Employees and Accommodations	Yes ☐ No ☐	Yes ☐ No ☐
Retaliation	Yes ☐ No ☐	Yes ☐ No ☐
Reporting, Investigating and Resolving Employee Complaints	Yes ☐ No ☐	Yes ☐ No ☐
Written Performance Appraisals/Reviews	Yes ☐ No ☐	Yes ☐ No ☐
Hiring/Interviewing	Yes ☐ No ☐	
Discharge/Termination	Yes ☐ No ☐	

20. Are the **Applicant's** employment practices policies, procedures and employee handbook periodically reviewed by an attorney with experience in employment law? Yes ☐ No ☐

21. Does the **Applicant** have written policies or procedures outlining employee conduct when dealing with the general public, customers, clients, vendors, or other third parties? Yes ☐ No ☐

22. Does the **Applicant** have written policies or procedures for dealing with complaints from the general public, customers, clients, vendors, or other third parties for issues involving harassment or discrimination? Yes ☐ No ☐

23. Does the **Applicant** conduct human resources training on guidelines, policies and procedures for all individuals who handle human resources functions? Yes ☐ No ☐

24. Does the **Applicant** conduct training for employees on issues of discrimination and sexual and other workplace harassment? Yes ☐ No ☐

25. If the **Applicant** is a federal contractor subject to the OFCCP, has the **Applicant** been subject to a compliance evaluation or investigation in the last 3 years? N/A ☐ Yes ☐ No ☐

If yes, attach an explanation.

26. If the requested limit of liability for EPL exceeds the limit of liability on the expiring EPL coverage, answer the following question:

Solely with respect to any higher limits requested or that may ultimately be issued for the proposed insurance, is the **Applicant**, any of its subsidiaries, or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the EPL coverage for which the **Applicant** is applying? Yes ☐ No ☐

If yes, attach full details.

27. If EPL coverage is not currently purchased, or has been in place for less than 3 years, answer the following question:

As of the date the **Applicant** first purchased the EPL coverage, or, as of the date of this Application if EPL coverage is not currently purchased, is the **Applicant**, any of its subsidiaries, or any person proposed for this insurance aware of a fact, circumstance, situation, event, or act that reasonably could give rise to a claim being made against them under the EPL coverage for which the **Applicant** is applying? Yes ☐ No ☐

If yes, attach full details.

28. Have any employment-related claims or administrative, criminal, or regulatory proceedings, charges, hearings, demands, or lawsuits been made against the **Applicant**, any of its subsidiaries, or any person proposed for this insurance during the past 3 years, whether or not insured, including claims involving employees or independent contractors? Yes ☐ No ☐

If yes, complete the table below.

29. Has any claim, demand, or lawsuit been made against the **Applicant**, any of its subsidiaries, or any person proposed for this insurance involving sexual harassment or discrimination brought by the general public, customers, clients, vendors or other third party? Yes ☐ No ☐

If yes, complete the table below.

Date of Such Claim	Nature of Claim	Amount Paid for Defense	Amount Sought or Paid for Damages	Covered by Insurance?	Corrective Procedures Implemented	Current Status
		$	$	Yes ☐ No ☐		
		$	$	Yes ☐ No ☐		

For additional claims, attach full details.

With respect to the information required to be disclosed in response to the questions above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the Applicant had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.

As part of this Application, please provide copies of the documents listed below for each **Applicant** requesting insurance*:

- If **Applicant** has 250 or more employees, attach employee handbook
- If **Applicant** has 1,000 or more employees, most recent EEO-1 report and complete the Wage and Hour Supplemental Application
- If limit requested is $2,000,000 or greater, most recent annual financial statement
- If **Applicant** layoffs are either 10% of the workforce or more than 100 employees, complete the Downsizing Supplemental Application

*the documents, as well as the representations and facts contained within such documents are made a part of this Application; the Insurer may elect to obtain requested information from public sources, including the Internet.

COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in 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 information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Attention: Insureds in 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.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania
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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and 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.

Attention: Insureds in Oregon
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should

aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (CHAIRMAN, PRESIDENT, OR CEO) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THIS APPLICATION FOR INSURANCE, INCLUDING ANY SUPPLEMENTS OR MATERIALS MADE PART OF THIS APPLICATION, ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF ANY INFORMATION IN THIS APPLICATION, OR ANY SUPPLEMENTS OR MATERIALS SUBMITTED THEREWITH, CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY THAT TRAVELERS MAY ISSUE TO THE APPLICANT, THE APPLICANT WILL NOTIFY TRAVELERS OF SUCH CHANGES AND TRAVELERS MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. TRAVELERS IS AUTHORIZED TO MAKE ANY INVESTIGATION OR INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND TRAVELERS TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IF THE POLICY IS ISSUED, IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY SUPPLEMENTS OR MATERIALS MADE PART OF THIS APPLICATION, WILL HAVE BEEN RELIED UPON BY TRAVELERS IN ISSUING THE POLICY, WILL BE THE BASIS OF THE INSURANCE, AND WILL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO, AND PART OF, THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature* of **Applicant's** Authorized Representative (Chairman, President, or CEO)

Name (Printed)

Title

Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND AGREE THAT YOUR USE OF A KEY PAD, MOUSE, OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES YOUR SIGNATURE, ACCEPTANCE, AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.**

AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, AND IOWA):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number