



Managed Care Errors and Omissions Liability Plus+ Coverage Application

Travelers Casualty and Surety Company of America

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 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.

I. GENERAL INFORMATION

1. Applicant Information:

Name of Applicant:
Street Address:
City, State, ZIP Code:
Website Address:
Year Applicant's business was established:
Description of Applicant's operations:

2. Applicant is:

For Profit Corporation, Limited Liability Company, Partnership, Not for Profit Tax Exempt Corp., Not for Profit Taxable Corp., Joint Venture, Other (please describe):

3. Risk Manager or authorized representative(s) designated to receive any and all notices concerning this issue:

Name: Email:
Title: Phone:
Complete address if different than information provided under General Information:
Address: City, State, ZIP:

II. ORGANIZATION INFORMATION

1. Subsidiary and controlled partnership and non-profit organization information:

Table with 6 columns: Name, % Owned, Year Started, Description of Operations, Tax Status*, Entity Type**. Contains 3 rows for data entry.

*Tax Status: FP=For-Profit or NP=Non-Profit

**Entity Type: 501(c)(3); S Corporation, General Partnership (GP); Limited Partnership (LP); Limited Liability Partnership (LLP); Limited Liability Company (LLC)

To enter more information, please attach a separate page to the Application.

2. Provide the locations of each **Applicant's** organization and the total number of employees* for each category:

State or Foreign Country	Number of Locations	Full Time Employees		Part Time Employees	
		As of Date of Application	12 Months Ago	As of Date of Application	12 Months Ago

*Include leased, seasonal, temporary and volunteer employees

3. 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, or divestiture? Yes No
- b. Any creation of a new business, subsidiary, joint venture or division? Yes No
- c. Any issuance of debt, a tax exempt bond offering, a public offering or private placement of securities? Yes No
- d. Any reorganization or arrangement with creditors under federal or state law? Yes No
- e. Any branch location, facility, office, or subsidiary closings, consolidations, or layoffs? Yes No
- f. Any new government contracts (Medicare or Medicaid)? 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, and the surrounding circumstances.

4. Have any **Applicant's** had any changes in the Board of Directors, Board of Managers, Board of Trustees or executive officers within the past 3 years for reasons other than term completion or retirement? Yes No

If Yes, please attach full details.

5. Have there been any changes in the **Applicant's** CPA or outside legal counsel in the last 36 months? Yes No

If Yes, please explain: _____

6. Is the **Applicant** a subsidiary of a foreign parent? Yes No

7. Does the **Applicant** currently file, or does it anticipate filing in the next 6 months, any documents with the Securities and Exchange Commission or similar foreign authority regarding any equity or debt securities? Yes No

8. Nature of business (Check all that apply):

- HMO – Type: _____
- Combined Network & Staff Model
- Dental HMO or PPO
- Case Management
- Insurance Agency
- Staff Model HMO
- PHO
- TPA
- Disease Mgmt.
- Other – Describe: _____
- IPA Network
- IPA
- ASO
- Utilization Review Org.
- PPO
- Medical Group or Clinic
- MSO
- Peer Review Org.

9. Is any **Applicant** licensed by any federal, state, or local agency? Yes No

If Yes, identify the licensing agency: _____

10. Is any **Applicant** accredited or certified by any organization (such as the National Committee for Quality Assurance (NCQA) or URAC), state or federal agency? Yes No
If Yes, identify the accrediting agency, date and rating of the last certification below:

11. Has any **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 attach full details.

III. FINANCIAL AND AUDITOR INFORMATION

Please submit CPA audited financial statement as directed in the Required Attachments section. If Applicant does not have a CPA audited financial statement, please submit an internally prepared balance sheet and income statement for the most recent fiscal year end and most recent year to date.

1. Has any auditor issued a "going concern" opinion for the **Applicant's** financial statements during the past 3 years? N/A Yes No
If Yes, please attach an explanation.
2. Have the outside auditors stated there are material weaknesses in the **Applicant's** systems of internal controls? N/A Yes No
If Yes, please attach an explanation and provide the latest CPA letter to management and management's response.
3. Has the **Applicant** implemented all material recommendations of the auditor? N/A Yes No
If No, please attach an explanation.

IV. ENROLLMENT INFORMATION

Note: Wherever used, "enrollees" means covered lives not just covered employees and not member months. If there are enrollees in more than one state, please provide a breakdown by state on a separate attachment.

1. Provide breakdown of enrollment by product line:

Product Line	Last 12 Months	Next 12 Months - Estimate
HMO		
PPO		
POS		
ASO/TPA		
Indemnity		
Other		
Total number of all Applicant's enrollees:		

If 'Other' is completed, please describe:

V. CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

1.

Coverage	Carrier	Limit	Retention	Premium	Policy Period
Directors and Officers Liability (D&O)		\$	\$	\$	
Employment Practices Liability (EPL)		\$	\$	\$	
Excess D&O and/or EPL		\$	\$	\$	
Healthcare/Medical Professional Liability		\$	\$	\$	
Fiduciary Liability		\$	\$	\$	
Crime		\$	\$	\$	

2. Requested Managed Care Errors and Omissions Liability Insurance:

Effective Date: _____ Limit: \$ _____ Retention: \$ _____

VI. HEALTH CARE PROVIDER INFORMATION

	<u>Last 12 Months</u>	<u>Estimate Next 12 Months</u>
1. Total number of physicians under contract with any Applicant :	_____	_____
a. Number of employed physicians:	_____	_____
b. Number of independent contractor physicians:	_____	_____
2. Total number of non-physician health care professionals under contract:	_____	_____
3. Total number of hospitals under contract:	_____	_____
4. Total number of other facilities under contract (e.g., clinics, nursing homes, laboratories, pharmacies):	_____	_____
5. Are all contracted health care professionals required to maintain medical malpractice insurance? <i>If Yes, what limits are required and how often are limits verified?</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>
<hr/>		
6. Does any Applicant have any provider agreements in effect whereby the Applicant assumes responsibility for overseeing the quality of the services provided by the health care providers?		Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Does the Applicant review, profile, tier quality or costs of, or provide quality assurance of any provider of medical services?		Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Does the Applicant have contracts with any employers or other member groups in which the Applicant assumes any of the employer's liability, fiduciary obligations or decision-making?		Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Does the Applicant employ any physicians, psychologists, dentists, or any other medical professionals in any medical capacity other than for peer or utilization review or administrative duties?		Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Provide details of the Applicant's compensation or participation agreements with contracted health care professionals, or attach copies of sample contracts:	_____	

VII. MARKET POSITION

1. Does any **Applicant** have exclusive service contracts with any physicians, hospitals or other providers? Yes No
2. Does any **Applicant** have any provider agreements that contain "Most Favored" pricing clauses? Yes No
3. Does any **Applicant** have any provider agreements that contain non-compete clauses? Yes No
4. Has the **Applicant** received an opinion from the Federal Trade Commission confirming that their activities (mergers, acquisitions and network development) will not violate antitrust laws? Yes No
5. Has the **Applicant** obtained advice from antitrust legal counsel related to mergers, acquisitions or network development? Yes No
If Yes, please specify firm name and advice sought:

6. Does the **Applicant** contract with more than 25% 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 attach full details.
7. Do the **Applicant's** members control more than 25% of the hospital beds or specialty services within its geographic service area? Yes No
If Yes, please attach full details.

VIII. RISK MANAGEMENT OPERATIONS

1. Does the **Applicant** have a formal Risk Management program? Yes No
2. Does the **Applicant** have a full time risk manager? Yes No
3. Does risk management coordinate with legal on claims and litigation claims management? Yes No

IX. MANAGED CARE ACTIVITIES AND SERVICES

1. Indicate those managed care activities or services the **Applicant** currently performs or subcontracts, or plans to begin performing or subcontracting within the next 12 months (Note: Not all checked services may be covered.):

Activity/Service	For the Applicant	For Others for a Fee	Fee Revenue
Credentialing or peer review of health care providers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Utilization review	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Drafting practice guidelines/critical pathways	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Case management	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Disease management	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Handling and adjusting of enrollees' health care benefit claims	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Application or enrollment processing for enrollees of health care plans	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Billing/other processing of enrollees' claims under health care plans	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Advertising, marketing, or selling health care plans/products	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Establishing health care provider networks to provide managed care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Third Party Administrative Services for Healthcare plans	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Assisting Self-Insured Plans in purchasing reinsurance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$

Activity/Service	For the Applicant	For Others for a Fee	Fee Revenue
Actuarial services for health care plans	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Administering health savings accounts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Administering employee assistance programs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Wellness, health promotion activities or education services	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Administering nurse call line or other telephonic triage programs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$

2. Does the **Applicant** provide or render advice on, or comparisons of, eligibility requirements processes or procedures for enrollment or changes in participation status, or coverage features for customers? Yes No
 3. Does the **Applicant** design or implement benefit plans or financial incentive plans, including any Pay for performance programs that compensate providers of medical services? Yes No
 4. Does the **Applicant** subcontract for services including Utilization Review or the handling or processing of claims to any organization where the subcontracted services are performed outside of the United States? Yes No
 5. Does the **Applicant** have any programs that provide members with the option of having Medical Services performed outside of the United States? Yes No
 6. Has the **Applicant** ever had its Medicare or Medicaid participation status revoked or restricted? Yes No
- If Other services provided, please describe below:
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X. HIPAA AND COMPLIANCE PROGRAMS

1. Does the **Applicant** have a privacy officer? Yes No
2. Has the **Applicant** conducted a HIPAA risk analysis? Yes No
3. Does the **Applicant** have a program for on-going HIPAA privacy training?
If Yes, how often is the training performed? _____ Yes No
4. Has the **Applicant** modified its policies and procedures to comply with all changes and updates to HIPAA? Yes No
5. Does the **Applicant** have policies and procedures addressing the responsibilities of its "business partners" under HIPAA? Yes No
6. Does the **Applicant** have a written corporate compliance program? Yes No
7. Does the **Applicant** have an employee hotline as part of the compliance program?
If Yes, how many calls are made to the hotline per month? _____ Yes No
8. Is employee and vendor adherence to confidentiality/non-disclosure requirements audited? Yes No

XI. CREDENTIALING OF PROVIDERS

If the **Applicant** does not perform or sub-contract credentialing of contracted healthcare providers, check here and skip to the next section below. Otherwise, please answer the following questions.

1. a. Who performs the credentialing of contracted health care providers? **Applicant?** Yes No
Subcontractors? Yes No
- b. If credentialing is subcontracted:
 - (i) What percentage of credentialing is subcontracted? _____ %
 - (ii) Does **Applicant** review or audit the process? Yes No
 - (iii) Is the subcontractor required to maintain E&O insurance? N/A Yes No
If Yes, what limits are required? \$ _____

- (iv) Does the subcontractor indemnify the **Applicant**? N/A Yes No
- (v) Does the **Applicant** indemnify the subcontractor? N/A Yes No
2. Does the **Applicant** have written policies and procedures in place for the following:
- a. Peer review? Yes No
- b. Credentialing? Yes No
- c. Re-credentialing? Yes No
3. Do the **Applicant's** written credentialing procedures follow JCAHO or NCQA standards and comply with all applicable laws? Yes No
4. Are the **Applicant's** credentialing and peer review procedures given to the health care providers? Yes No
5. Is the **Applicant's** legal counsel consulted before any recommendation or decision is made which might adversely affect a provider's privileges or credentials? Yes No
6. What group has the final authority for credentialing or peer review decisions:
- a. Board of Directors? Yes No
- b. Other Board Committee(s)
If Yes, please specify: _____ Yes No
- c. Other? Yes No
If Yes, please describe: _____
7. Does the **Applicant** query the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank of the Federal or State Medical Boards as part of the credentialing process? Yes No
8. How often does the **Applicant** re-credential contracted health care providers? Yes No
9. Does the **Applicant** perform on-site visits of contracted health care providers?
If Yes, how often are the visits? _____ Yes No
10. 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?
If Yes, please attach full details. Yes No
11. Have any providers been removed or disqualified from the **Applicant's** network panel in the last 12 months? Yes No
- a. How many for credentialing or professional conduct reasons? _____
- b. How many for reasons other than professional competence? _____
- c. Is complete documentation maintained on all terminations? Yes No
12. Have any removed or disqualified providers been reinstated in the last 12 months? Yes No
13. Are the policies and procedures governing the reasons for termination of providers expressly enumerated by the **Applicant** in its contracts? Yes No
14. Has the **Applicant** established or implemented any pay for performance, tiered networks, or any other financial performance incentives for its providers? Yes No
- If yes, are the standards for these programs available to all providers? Yes No
- If yes, is there an appeals process available to all providers address disputes? Yes No

XII. UTILIZATION REVIEW

If the **Applicant** does not perform or sub-contract utilization review, check here and skip to the next section below. Otherwise, please answer the following questions.

1. a. Who performs utilization review? **Applicant?** Yes No
- Subcontractors? Yes No

- b. If utilization review is subcontracted:
- (i) What percentage of utilization review is subcontracted? _____ %
 - (ii) Does **Applicant** review or audit the process? Yes No
 - (iii) Is the subcontractor required to maintain E&O insurance? N/A Yes No
If Yes, what limits are required? \$ _____
 - (iv) Does the subcontractor indemnify the **Applicant**? N/A Yes No
 - (v) Does the **Applicant** indemnify the subcontractor? N/A Yes No
2. What is the **Applicant's** utilization review denial rate for the last 12 months? _____ %
3. How many of the **Applicant's** denials were appealed in the last 12 months? _____
4. How many of the appeals in the last 12 months were reversed? _____
5. Does the **Applicant** have written policies and procedures in place for utilization review? Yes No
If Yes, does the **Applicant** follow NCQA or URAC standards and comply with all applicable laws? Yes No
6. Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the individual who makes decisions regarding appeals? Yes No
7. Does a physician review all proposed denials of benefits prior to issuance of the denial? Yes No
8. Are external reviewers involved in the final level of review before appeal? Yes No
9. Does the **Applicant** have an external review process in those states where external review is not mandated by law? Yes No
If Yes, does the Applicant abide by the external review decisions in every case? Yes No
If No, please explain: _____

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10. Does the **Applicant** have a "fast track" appeal system regarding denial of benefits or postponement of benefit procedures for organ transplant or any other procedure which may severely impair the quality of life for an enrollee if not performed? Yes No
11. Does the **Applicant** use practice guidelines as part of its utilization review process? Yes No
If Yes, do guidelines state in writing that a physician's judgment may override a guideline? Yes No
12. Does the **Applicant** utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with utilization reviewers? Yes No

XIII. CLAIM HANDLING OF ENROLLEES' HEALTH CARE BENEFITS

If the **Applicant** does not perform or sub-contract claim handling for health care benefits, check here and skip to the next section below. Otherwise, please answer the following questions.

1. a. Who performs the claim handling for health care benefits? **Applicant?** Yes No
Subcontractors? Yes No
- b. If claim handling is subcontracted:
- (i) What percentage of claim handling is subcontracted? _____ %
 - (ii) Does **Applicant** review or audit the process? Yes No
 - (iii) Is the subcontractor required to maintain E&O insurance? N/A Yes No
If Yes, what limits are required? \$ _____
 - (iv) Does the subcontractor indemnify the **Applicant**? N/A Yes No
 - (v) Does the **Applicant** indemnify the subcontractor? N/A Yes No
2. Does the **Applicant** utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with claim handlers or adjusters? Yes No
3. How many claims did the **Applicant** process in the last 12 months? _____

4. What was the percentage of the claims denied in the last 12 months? _____ %

XIV. ADVERTISING/MARKETING/SALES

If the **Applicant** does not have contracts, sales literature or brochures, check here and skip to the next section below. Otherwise, please answer the following questions.

1. Do all contracts, sales literature and brochures expressly identify covered and non-covered procedures? Yes No
2. Do any contracts, sales literature, or brochures use the term(s) "investigative" or "experimental" procedures? Yes No
If Yes, are those terms defined in the **Applicant's** marketing material? Yes No
If Yes, does the **Applicant's** marketing material clearly state that the **Applicant** has discretionary authority in the interpretation and administration of the plan's provisions? Yes No
3. Do contracts, sales literature or brochures expressly refer to all contracted health care providers as independent contractors? Yes No
4. 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
5. Does the **Applicant's** legal counsel review and approve all contracts, sales literature, brochures, advertisements and other marketing material prior to their use? Yes No
If No, please attach full details.
6. Does the **Applicant** conduct enrollee satisfaction surveys? Yes No
If Yes, how often are the surveys conducted? _____
If Yes, how large is the survey sample size? _____

XV. LOSS INFORMATION

1. Has there been during the past 5 years, or are there now pending, any managed care errors and omissions claims, administrative proceedings, charges, hearings, demands or lawsuits against any **Applicant** or any entity or person proposed for this insurance, including claims involving independent contractors or full time, temporary, or leased employees, whether or not such claim or action would be covered under any managed care errors and omissions liability insurance? Yes No
If Yes, please attach full details of each, including the type of complaint, loss payments, defense costs, how resolved, whether any insurance responded to any aspect of the claim, and any corrective procedures implemented.
2. If managed care errors and omissions liability is currently purchased, please answer the following question:

As of the date the **Applicant** first purchased managed care errors and omissions liability insurance, did the **Applicant** or any person proposed for insurance have any knowledge of any fact, circumstance, or situation related to the managed care errors and omissions liability insurance that could have reasonably given rise to a claim against them? Yes No
If Yes, please attach full details.
3. If managed care errors and omissions liability insurance is not currently purchased, please answer the following question:

Does the **Applicant** of any person proposed for this insurance have any knowledge of any fact, circumstance, or situation related to the managed care errors and omissions liability insurance that could reasonably give rise to a claim against them? Yes No
If Yes, please attach full details.
4. If the requested limit of liability for which application is being made exceeds the expiring limit of liability, please answer the following questions:

With respect to the increased portion of the limit of liability requested, does the **Applicant** or any person proposed for this insurance have any knowledge of any fact, circumstance, or situation

related to the managed care errors and omissions liability insurance that could reasonable give rise to a claim against them?

Yes No

If Yes, please attach full details.

Without prejudice to any other rights and remedies of the Company, any claim arising from any facts circumstances required to be disclosed in Question 2, 3, or 4 above is excluded from the proposed insurance.

XVI. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents and indicate below which are included in conjunction with this Application (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the **Applicant** or are obtained by the Company from any public source, including the Internet*):

- Most recent consolidated CPA audited financial statements including notes and schedules
- Most recent CPA audited financial statements including notes and schedules for each unconsolidated subsidiary
- Interim financial statements, if audited financial statements are 6 months or older
- If newly formed organization, most recent business plan to include pro-forma balance sheet and income statement projections.
- Current organizational chart of the first named insured organization, listing each subsidiary, controlled non-profit organization and joint venture, including the ownership percentage and tax status of each
- A description of operations for each subsidiary
- A listing of the Board of Directors, Board of Managers or the Board of Trustees, as applicable, with employers and occupations of each, as well as other boards on which such directors, managers or trustees serve
- Copy of the **Applicant's** bylaws
- Copy of the **Applicant's** code of conduct policy
- Copy of the written credentialing and peer review procedures
- Copy of the written utilization review procedures, including the procedures for denial of benefits and the appeal process
- Copy of the member ship handbook or samples of contracts with enrollees
- Samples of sales literature, brochures advertisements and other marketing materials
- A copy of the results of the most recent enrollee satisfaction survey

XVII. 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.

XVIII. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Louisiana, 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.

XIX. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (CHAIRMAN, PRESIDENT, CEO, ADMINISTRATOR OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

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

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.**

- ELECTRONIC SIGNATURE AND ACCEPTANCE – AUTHORIZED REPRESENTATIVE**
- ELECTRONIC SIGNATURE AND ACCEPTANCE – PRODUCER**

XX. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number