PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

1777 Sentry Parkway West, VEVA 14, Suite 300, Blue Bell, PA 19422
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com

APPLICATION FOR CORPORATION, PARTNERSHIP OR ASSOCIATION PROFESSIONAL LIABILITY INSURANCE
Limits of Liability: $500,000 Per Occurrence / $1,500,000 Per Annual Aggregate

POLICIES ARE ISSUED ON AN ANNUAL BASIS UNLESS OTHERWISE SPECIFIED AND APPROVED BY THE JUA
COVERAGE CANNOT BEGIN PRIOR TO APPLICATION AND PREMIUM RECEIPT BY THE JUA

Applicant's Name:

Legal Name of Corporation, Partnership or Association

Coverage Requested:	☐ **Occurrence** ☐ **Claims-Made**	**Requested Effective Date:**	
		Requested Retroactive Date:	

Coverage Period if less than 1 year (short-term policy): ***From:*** ***To:***

Reason for short-term policy:

PART I – GENERAL INFORMATION

Principal Office Address: _____

Number and Street City County State Zip

Business Phone: ( ) _____ **Mcare License Number:** _____

Business Fax: ( ) _____ **EIN:** _____

E-mail Address: _____ **Web Site:** _____

IS THE ABOVE ADDRESS THE ONLY LOCATION? ☐ **YES** ☐ **NO** **If no, attach a separate page listing all other locations including name, address, city, county, state and zip code for each location.**

PART II – BROKER INFORMATION (If this is being submitted by an insurance broker)

Broker: _____ **Contact Person:** _____

Phone: (**)** _____ **Fax No. (** **)** _____ **E-Mail Address:** _____

Address: _____

Number and Street City State Zip

If "new" to JUA:

EIN or SS No: _____

PART III – COVERAGE INFORMATION

List ALL Prior Insurers for the last 10 years (attach separate list if necessary):

Carrier or Self-Insurer	**Policy Number**	**Coverage Dates (Month, Day & Year) Eff. Exp.**	**Coverage Type (Occurrence or Claims-Made)**	**Retroactive Date (if Claims-Made)**	**Tail Coverage Purchased?**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**

If any of the above policies are still in force, explain why coverage is requested from the JUA:

_____

Explain any gaps in coverage in the past 8 years including any period directly preceding JUA coverage:

_____

Explain why tail coverage was not purchased for any claims-made policy listed above:

_____

Attach copies of your current Declarations, documents listed in Part IV of this application for your type of entity and Policy History / Claim History Reports from each of the above carriers or self-insurers plus Mcare.
You need to contact each of your current or prior carriers and request they send you these reports. They are required to provide these reports to you if you request them. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if you have had no claims.

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

Claims or Suits:
Have any claims been made or suits brought against the corporation, partnership or association during the past 10 years as a result of professional services rendered? (Regardless of whether the claim was dismissed or a judgment rendered)
☐ Yes ☐ No If yes, attach a description of all claims made or suits brought including the date and status.

Medical Incidents:
Are you aware of any medical incidents which occurred during one of the claims-made policies *for which a claim has not yet been made*? ☐ Yes ☐ No If yes, attach a complete description of the incidents including the date and status.

Never Events:
Have any claims been made or suits brought against the organization for an incident where the patient's medical insurance or Medicare refused to pay because it was on their preventable serious adverse event or "never event" list?
☐ Yes ☐ No If yes, attach a description of the incident including the date and status.

PART IV – BUSINESS ORGANIZATION

1. Type of Legal Entity: ☐ Professional Corporation ☐ Professional Association ☐ Partnership
   ☐ Professional Limited Liability Company
2. Description of operations/services provided (attach separate page if necessary): _____
   _____
3. a. Years legal entity has been in operation: _____ b. Years owned by current owners: _____
4. Does the entity utilize any fictitious or "dba" names? ☐ Yes ☐ No If yes, please list on the line below:
   _____
5. Are these fictitious or "dba" names registered with the Pennsylvania Department of State? ☐ Yes ☐ No
6. Does the entity maintain a website, blog or other internet, electronic or social media network presence?
   ☐ Yes ☐ No If yes, provide names of sites: _____

Please submit copies of the following documents appropriate for your type of legal entity. These are required to determine eligibility for coverage by the JUA:

Professional Corporation: Articles of Incorporation and any Articles of Amendment.

Professional Association: Articles of Association/Incorporation and any Articles of Amendment.

Partnership: Partnership Agreement and any Amendments.

Professional Limited Liability Company: Certificate of Organization, Operating Agreement and any amendments.

PART V - OFFICERS, MEMBERS, PRINCIPALS OR PARTNERS

1. List the names of all health care providers who are Officers, Members, Principals or Partners of the entity that is applying for JUA coverage. Attach a separate page if necessary.
   ***** A JUA Supplemental Application for Corporation, Partnership or Association must be completed for each Physician, Podiatrist or Certified Nurse Midwife <u>not</u> insured by the JUA.**

Name	License Number	Specialty	PA JUA Policy Number	Name of Company if **<u>NOT</u>** Insured by JUA ***

2. List any non-medical professionals who are Officers, Members, Principals or Partners of the entity applying for coverage:

Name	Position/Title	Occupation

3. Does any health care provider who is an Officer, Member, Principal or Partner of the entity practice in any state other than PA? ☐ Yes ☐ No If yes, complete a. through c. below for each. Attach a separate page if necessary.
   a. Name of Principal _____
   b. Name of Other State _____
   c. Percent of Patient Care in Pennsylvania _____%

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

PART VI – STAFFING – EMPLOYEES OR INDEPENDENT CONTRACTORS

1. List the names of all **Physicians, Podiatrists or Certified Nurse Midwives** that are employees or contractors of the entity that is applying for JUA coverage. Attach a separate list if necessary.
   ***** A JUA Supplemental Application for Corporation, Partnership or Association must be completed for each Physician, Podiatrist or Certified Nurse Midwife <u>not</u> insured by the JUA.**

Name	License Number	Specialty	Employee or Contractor	PA JUA Policy Number	Name of Company if **<u>NOT</u>** Insured by JUA ***

2. Check the box next to each of the types of Health Care Professionals listed below that are employees or contractors of the entity that is applying for JUA coverage. Provide numbers for each type. **If none indicate zero (0) for each type.** Please answer all. Attach a separate list if necessary.

   ☐ Aestheticians Number: _____
   ☐ Chiropractors Number: _____
   ☐ Laboratory Technicians Number: _____
   ☐ Medical Assistants Number: _____
   ☐ Nurse Anesthetists Number: _____
   ☐ Nurses (RN or LPN) Number: _____
   ☐ Nurse Practitioners Number: _____
   ☐ Occupational Therapists Number: _____
   ☐ Other (describe) _____ Number: _____
   ☐ Other (describe) _____ Number: _____
   ☐ Ophthalmology Technicians Number: _____
   ☐ Optometrists Number: _____
   ☐ Physician Assistants Number: _____
   ☐ Physical Therapists Number: _____
   ☐ Psychologists Number: _____
   ☐ Radiology Technicians Number: _____
   ☐ Social Workers Number: _____
   ☐ Surgical Assistants Number: _____

3. Does the entity obtain evidence of medical professional liability insurance in force for all physicians, podiatrists, certified nurse midwives and other health care professionals listed in 1. and 2. above? ☐ Yes ☐ No
   If no, explain: _____
4. How often is the evidence of insurance verified? ☐ Annually ☐ Other (describe) _____
5. Is there an employee orientation program? ☐ Yes ☐ No
6. Is in-service training conducted? ☐ Yes ☐ No If yes, what is the frequency? _____
7. Does the entity allow physicians, podiatrists, certified nurse midwives or other types of health care professionals who are **NOT** employees or contractors to use its facilities to provide health care professional services? ☐ Yes ☐ No
   If yes, provide a list by specialty, number and describe services provided. Attach a separate page if necessary.
   _____
   _____
   _____

I certify that I am authorized to act on behalf of the Insured.

I certify that I will not accept insurance from the JUA if I am able to obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information which is calculated to influence the judgment of the JUA in considering this application.

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.

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

GENERAL INFORMATION

We write **only** *professional liability* coverage (*general liability* is *not covered*), nor do we write any excess coverage (coverage that is over the Mcare).

Coverage is provided only for liability incurred by the Insured corporation, partnership or association for patient injury arising out of the rendering of or failure to render professional health care services by a person for whose acts or omissions the Insured corporation, partnership or association is legally responsible, subject to the terms and conditions of the JUA policy.

We provide coverage only for the corporation, partnership or association (not any holding company or other parent company). No additional insureds will be added. The name of the Insured will be as shown on the Articles of Incorporation, Partnership Agreement, Articles of Association or Certificate of Organization.

It is critical that the type of claim be indicated on loss history reports (professional liability separated from general liability; corporation professional separated from individual health care provider professional).

We require a **separate application for each physician, podiatrist and certified nurse midwife to be covered.**

We require a separate application for each corporation, partnership or association.

ORDERING MCARE LOSS RUNS/CLAIM HISTORIES

For facilities requesting their own information, requests are to be on the facility's letterhead and include position title with signature of person submitting request. Include the claim history date range or "all history" for a full report. Also include the name, email and/or address where the claim history is to be sent.

For individual health care providers, the request must be signed by the individual and include the individual's name and PA license number. Indicate the claim history date range or "all history" for a full report. Indicate the name of the person or entity authorized to receive the claim history and the email and/or address where the claim history is to be sent.

Requests are to be sent to Mcare by U.S. Mail, fax or email:

Mailing Address (for USPS first class mail):
Mcare
Claims Administration Division
P.O. Box 12030
Harrisburg, PA 17108-2030

Fax: (717) 787-0651 Email: RA-IN-CLAIMCOVERAGEINFO@pa.gov

If you have any questions regarding Mcare loss runs/claim histories call Mcare at (717) 783-3770 or email RA-IN-CLAIMCOVERAGEINFO@pa.gov.

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Supplemental Claims Information Form

Complete one form for each claim. Make additional copies of this form as needed.

Entity Name: _____

License Number: _____

Claimant's Name: _____
(First) (Middle) (Last)

Incident Date: _____
(Month, Day and Year)

Date Reported: _____
(Month, Day and Year)

Location Where Incident or Alleged Injury Occurred: _____

Carrier Name: _____

Policy Number: _____ Effective Date: _____

Status (check all that apply):

☐ Open ☐ Closed Date Closed: _____

☐ Settlement ☐ Judgment ☐ Dismissed

Amount of Indemnity Payment (if any): $_____

Description of Claim:

_____

_____

_____

_____

_____

_____

_____

_____

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SUPPLEMENTAL APPLICATION FOR CORPORATION, PARTNERSHIP OR ASSOCIATION

(Use this application to supply information regarding a physician NOT to be insured by the JUA)

Supplement for:

Legal Name of Corporation, Partnership or Association

Physician's Name ☐ **M.D.** ☐ **D.O.**
(NOT to be insured by the JUA):

First Name Middle Name Last Name

PART I – GENERAL INFORMATION

Principal Business Address:

_____

Number and Street **City** **State** **County** **Zip**

PART II – LICENSE INFORMATION

PA Medical License No.: _____ Federal DEA No.: _____

PART III – COVERAGE INFORMATION

List all Insurers for the last 10 years – include all places of employment: (attach separate list if necessary)

Carrier or Self-Insurer	Policy Number	Coverage Dates Eff. Exp.	Coverage (Occurrence or Claims-Made)	Retroactive Date/ Comments
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	

Attach Policy History Reports, Claim History Reports or Loss Runs From Each of the Above Carriers or Self-Insurers plus Mcare.

You need to contact each of your current or prior carriers and request they send you these reports. They are required to provide these reports to you if you request them. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if you have had no claims.

Claims or Suits:

Have any claims been made or suits brought against you during the past 10 years as a result of professional services rendered? (Regardless of whether the claim was dismissed or a judgment rendered) ☐ Yes ☐ No If yes, attach a description of all claims made or suits brought including the date and status.

Medical Incidents:

Are you aware of any medical incidents which occurred during one of the claims-made policies *for which a claim has not yet been made*? ☐ Yes ☐ No If yes, attach a complete description of the incidents including the date and status.

Never Events:

Have any claims been made or suits brought against you for an incident where the patient's medical insurance or Medicare refused to pay because it was on their preventable serious adverse event or "never event" list? ☐ Yes ☐ No If yes, attach a description of the incident including the date and status.

PART IV – LOCATIONS (AT LEAST ONE LOCATION MUST BE LISTED – all locations must total 100%)

A. List ALL locations and Hospitals at which you will practice during the policy period (even if outside Pennsylvania). Base percentage of practice on the number of patients. Attach a separate page if necessary.

Practice Locations:

1. _____ _____ _____
Suite Number & Street City State Zip County % of Practice

2. _____ _____ _____
Suite Number & Street City State Zip County % of Practice

3. _____ _____ _____
Suite Number & Street City State Zip County % of Practice

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

Hospital Locations:

1. _____ _____ _____ _____
Name of Hospital | City | State | Type of Privileges | County | % of Practice

2. _____ _____ _____ _____
Name of Hospital | City | State | Type of Privileges | County | % of Practice

3. _____ _____ _____ _____
Name of Hospital | City | State | Type of Privileges | County | % of Practice

B. If practice at any location listed in A. above is not work for the entity for which coverage is to be provided, please indicate below. Attach a separate page if necessary.

_____

_____

C. History:

List other locations and hospitals at which you have practiced in the past 10 years:

1. _____ _____
Address or Name of Hospital | City | State | County | Dates of practice

2. _____ _____
Address or Name of Hospital | City | State | County | Dates of practice

3. _____ _____
Address or Name of Hospital | City | State | County | Dates of practice

PART V – EDUCATIONAL BACKGROUND (attach separate sheet if needed to fully describe)

Medical School: _____ **Year Graduated:** _____

Location of School: _____ **Degree:** _____
City State Country

If this is a foreign medical school, are you certified by the Educational Council for Medical School Graduates? ☐ Yes ☐ No

Internship: _____
Name of Hospital City State
From _____ to _____ Type of Internship: _____
Month/Year Month/Year

Residency: _____
Name of Hospital City State
From _____ to _____ Type of Residency Completed: _____
Month/Year Month/Year

Residency: _____
Name of Hospital City State
From _____ to _____ Type of Residency Completed: _____
Month/Year Month/Year

Additional Training/Fellowship: _____
Name of Hospital City State
From _____ to _____ Type of Training Completed: _____
Month/Year Month/Year

Board Certification: **Are You Board Certified?** ☐ **Yes** ☐ **No**

If Yes, list Board Certificates and date certified:

_____

PART VI – LICENSES

Have you ever been licensed in a state other than Pennsylvania? ☐ Yes ☐ No If Yes please complete:

State	License Number	Date Received	Currently Active?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

PART VII – RATING INFORMATION

1. What is your current Medical Specialty? _____

Other Specialty? _____ Sub-Specialty? _____

2. General Description of practice: _____

3. Procedures and Practices

In **Column A** check the box for all of those items applicable to your practice **Now** and **During the Coverage Period**.
In **Column B** check the box for all of those items that were applicable to your practice at any time **During the Last 10 Years**.
If neither Column A or B apply, check the box in the column labeled **No** (at least one column must be checked for each)

Col. A	Col. B	No		Col A	Col. B	No	
☐	☐	☐	Minor Surgery (see last page for definitions)	☐	☐	☐	Lithotripsy
☐	☐	☐	Major Surgery (see last page for definitions)	☐	☐	☐	Interventional Radiology
☐	☐	☐	Assistance in Major Surgery on own patients only	☐	☐	☐	Deep Radiation / X-ray Therapy – (Over 120 K.V.)
☐	☐	☐	Assistance in Major Surgery on other than own patients	☐	☐	☐	Contrast Material: Injection, supervision of others who inject, reading images
☐	☐	☐	Colon-Rectal Surgery: _____ % of surgical practice	☐	☐	☐	Swan Ganz Catheterization only
☐	☐	☐	Bariatric / Intestinal Surgery for Obesity	☐	☐	☐	Left or Right Heart Catheterization
☐	☐	☐	Laser Surgery (describe)				
☐	☐	☐	Biopsy (List types)	☐	☐	☐	Plastic Surgery
☐	☐	☐	Fracture Reduction – Open	☐	☐	☐	BoTox Injections (describe purpose)
☐	☐	☐	Fracture Reduction – Closed	☐	☐	☐	Dermal Fillers (List types)
				☐	☐	☐	Light Chemical Peels (List types)
☐	☐	☐	Prenatal care through 1st trimester	☐	☐	☐	Medium Chemical Peels (List types)
☐	☐	☐	Prenatal care through 2nd trimester	☐	☐	☐	Deep Chemical Peels (List types)
☐	☐	☐	Prenatal care through 3rd trimester	☐	☐	☐	Dermabrasion
☐	☐	☐	Caesarian Sections	☐	☐	☐	Sclerotherapy
☐	☐	☐	Normal Obstetrical Deliveries	☐	☐	☐	Mesotherapy
☐	☐	☐	Abortions	☐	☐	☐	Laser Therapy (List types)
				☐	☐	☐	Liposuction (List types)
☐	☐	☐	Administration of general, spinal or caudal anesthesia	☐	☐	☐	Blepharoplasty (indicate cosmetic or functional)
☐	☐	☐	Epidurals	☐	☐	☐	Hair removal (List types)
☐	☐	☐	Facet Injections	☐	☐	☐	Hair Transplant (List types)
☐	☐	☐	Trigger Point Injections	☐	☐	☐	Other Aesthetic/Cosmetic Procedures (provide list)
☐	☐	☐	Other Nerve Blocks (List types)				
☐	☐	☐	Spinal Cord Stimulation	☐	☐	☐	Complementary and Alternative Medicine Procedures (provide list)
☐	☐	☐	Endoscopic Procedures (List types)	☐	☐	☐	Chelation Therapy (provide details)
☐	☐	☐	Sigmoidoscopy greater than 60 cm				
☐	☐	☐	Polypectomy	☐	☐	☐	Addiction Medicine
				☐	☐	☐	Medical Marijuana Program

Details/descriptions/lists/types for above:

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

4. How many hours per week are generally spent in the practice of your medical profession? _____

5. If only a portion of your practice is associated with the entity applying for coverage, how many hours per week are generally spent in the portion of your practice associated with this entity? _____

6. Do you serve in a hospital emergency room? ☐ Yes ☐ No If yes, how many hours per week? _____

7. Do you serve in a prison environment? ☐ Yes ☐ No If yes, how many hours per week? _____

8. Do you practice at a wound care clinic or center? ☐ Yes ☐ No If yes, how many hours per week? _____
Clinic/Center name and address: _____

9. Do you provide follow-up care for patients who have had health care services performed outside Pennsylvania?
☐ Yes ☐ No If yes, provide: a description of the services performed outside Pennsylvania; the locations where the services were performed; and description of the follow-up care that you provide in Pennsylvania. Attach a separate page if necessary: _____

_____

_____

10. Do you participate as a member of any medical peer review or accreditation board or group? ☐ Yes ☐ No
If yes, give details: _____

11. Are you a Medical Director or Department Head of a hospital, nursing home, clinic, commercial enterprise or any other organization? ☐ Yes ☐ No If yes, provide position/title, organization name and location:

_____

12. Do you obtain a signed Informed Consent form from each patient prior to providing services? ☐ Yes ☐ No
If no, please explain: _____
If yes, please answer **all** of the following questions:
Is the consent form procedure specific? ☐ Yes ☐ No Is it witnessed? ☐ Yes ☐ No
Is the consent form reviewed orally with the patient? ☐ Yes ☐ No Is the patient provided a copy? ☐ Yes ☐ No
How do you handle language problems? _____

13. **Telemedicine.** Do you provide any telemedicine/telehealth/remote services for the entity applying for JUA coverage?
☐ Yes ☐ No
If **Yes**, please answer **all** of the following questions **a.** through **e.** If **No**, skip to Question 14.

a. What types of telemedicine/telehealth/remote services do you provide? Check all that apply.
☐ Telephone consultation ☐ Video Consultation ☐ Email Consultation
☐ Mobile Phones or Wireless Devices ☐ Reading Radiologic Images (X-ray, CT scan, MRI, etc.)
☐ Reading Pathology Images ☐ Reading Dermatology Images ☐ Robotic Telemedicine
☐ Electronic Health Monitoring Device (describe): _____
☐ Other (describe): _____

b. What percentage of your practice is devoted to telemedicine/telehealth/remote services? _____%

c. The patients for whom you provide telemedicine services are located at (check all that apply):
☐ Home ☐ Medical facilities

d. List all the cities and counties in Pennsylvania where the telemedicine patients are located:
_____

_____

e. Are any of the telemedicine patients located outside Pennsylvania? ☐ Yes ☐ No If **yes** list all the cities and states where the patients are located and the percentage of telemedicine practice for each:
_____

_____

14. Do you maintain or are you a member of any website, blog or other internet, electronic or social media network that is related to the practice which is applying for JUA coverage? ☐ Yes ☐ No
If yes, provide names of sites:

_____

15. Have any aspects of your practice changed in the past **5 years**? ☐ Yes ☐ No
If yes, give details including dates of change: _____

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

PART VIII – PRACTICE ORGANIZATION

Please check the box that describes your practice:

- ☐ Sole Corporation
- ☐ Partner or partnership
- ☐ Officer, Member or Principal
- ☐ Other (describe): _____
- ☐ Employee of individual/Group (not a shareholder)
- ☐ Corporate shareholder
- ☐ Independent contractor

PART IX – ADDITIONAL PROFESSIONAL INFORMATION

1. Have your staff privileges, license to practice, participation in any Medicaid or Medicare program, or ability to prescribe drugs ever been revoked, suspended, placed on probation, voluntarily surrendered or subject to reprimand or fine? ☐ Yes ☐ No
If yes, give details: _____
_____

2. Have you ever been charged or convicted of any crime, or are you currently under investigation for a criminal act, other than minor traffic violations? ☐ Yes ☐ No
If yes, give details: _____
_____

3. Has a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by any regulatory agency? ☐ Yes ☐ No
If yes, give details: _____
_____

DEFINITIONS

* Major Surgery:
Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis: any other operation which, because of the condition of the patient, or the length or circumstances of the operation, presents a distinct hazard to life. It also includes but is not limited to: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation performed under general anesthesia.

* Minor Surgery:
Any operation not defined as Major surgery.

* No Surgery
The term "no surgery" applies to general practitioners and specialist who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information which is calculated to influence the judgment of the JUA in considering this application.

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.

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)