

Berkley Insurance Company

Executive Liability Insurance Renewal Proposal Form

CLAIMS MADE WARNING FOR APPLICATION: This Proposal Form is for a Claims Made and Reported Policy, relating to claims made against the Insureds during the Policy Period or any Extended Reporting Period that may apply.

- Complete the sections of this Proposal Form for each Coverage Requested as indicated below.
- Provide details to all "Yes" answers, when applicable, by attachment whether or not prior coverage was in place.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the **Policy**. This Proposal Form is to be completed with respect to the entire Insured Entity. **Insured Entity** as used herein is defined to include the **Named Insured** and any **Subsidiaries**.

Name of **Named Insured** _____

Primary Location Street Address _____ Suite _____

City _____ County _____ State _____ Zip Code _____

Website Address (if applicable) _____ Federal Employer Identification Number (FEIN) _____

Name and title of officer designated as agent of all **Insureds** to receive any and all notices from the **Insurer**, including but not limited to complimentary Risk Management Services _____

E-mail Address _____ Telephone Number _____ Fax Number _____

The contact information provided will be used for internal purposes and will not be sold to any third party.

The mailing address is the same as the primary location. If not, provide mailing address:

Mailing Street Address _____ Suite _____

City _____ State _____ Zip Code _____

Coverage and Type of Limit Requested

Indicate Coverage and Limit Requested:

Directors, Officers and Corporate Liability Insurance Coverage:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limit Requested: \$ _____
Employment Practices Liability Insurance Coverage:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limit Requested: \$ _____
Fiduciary Liability Insurance Coverage:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limit Requested: \$ _____
Crime / Employee Dishonesty Coverage:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limit Requested: \$ _____
Kidnap / Ransom Coverage:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limit Requested: \$ _____
Employed Lawyers Professional Liability Insurance Coverage:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limit Requested: \$ _____

Indicate the Type of Limit Requested:

Policy Aggregate Limit of Liability for all **Coverage Sections**:

Separate Aggregate Limit of Liability for each **Coverage Section**:

Combination of Policy Aggregate and Separate Aggregate (provide details): _____

Current Insurance Information

1. Provide the following information regarding the **Insured Entity's** most recent insurance policies. If "None", so state.

Type of Coverage	Carrier	Expiration Date	Limit	Deductible	Premium
Directors and Officers Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Employment Practices Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Fiduciary Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Crime / Employee Dishonesty: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Kidnap / Ransom Coverage: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____
Employed Lawyers Liability: <input type="checkbox"/> None	_____	_____	\$ _____	\$ _____	\$ _____

2. Within the last 3 years, has any **Claim** been made or has notice been given under any of the above listed policies or similar insurance? Yes No

3. Within the last 3 years, has any of the above listed policies or similar insurance for the **Insured Entity** been cancelled or non-renewed? Yes No
(NOT APPLICABLE IN MISSOURI)

General Information

4. (a) Form of organization: Cooperative Corporation Joint Venture*
 Limited Liability Corporation Nonprofit Partnership*
 Sole Proprietorship / Individual Other: _____

*If a Joint Venture or Partnership, provide participation or ownership structure details by attachment.

- (b) Type of organization: Manufacturing / Production Public Administration Retail Trade
 Service Industry Web Based Wholesale Distributing

5. The **Named Insured** has been in continuous operation since: _____

6. (a) What is the **Insured Entity's** Primary Standard Industrial Classification ("SIC") Code? _____

(b) Describe the **Insured Entity's** nature of operations: _____

(c) Does the **Insured Entity** operate or participate in a Political Action Committee? Yes No

(d) Does the **Insured Entity** have a membership in any industry/trade association(s)? Yes No

If "Yes", provide the association name(s): _____

7. Is the **Named Insured** or any **Subsidiary** publicly held or a public reporting company under the Securities Exchange Act of 1934? Yes No

8. Provide the following financial information with respect to the **Insured Entity**:

Assets (000): \$ _____	Annual Revenues (000): \$ _____	Total Number of employees: _____
Equity (000): \$ _____	Net Income / Loss (000): \$ _____	Period Ending: / /

9. Is the **Insured Entity** currently in bankruptcy? Yes No

10. Within the next 12 months:
 (a) is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? Yes No

(b) does the **Insured Entity** anticipate raising funds by any venture capital, private placement or private offering of any equity or debt securities? Yes No

(c) does the **Insured Entity** anticipate any public sale of equity or debt securities and/or the filing of any registration statement or similar disclosure for an offering or sale of securities? Yes No

(d) does the **Insured Entity** anticipate any offering or sale of securities pursuant to Title III. Crowdfunding of the Jumpstart Our Business Startups Act of 2012? Yes No

(e) does the **Insured Entity** anticipate any plant, facility, branch or office closings, or layoffs? Yes No

(f) does the **Insured Entity** anticipate any consolidation, divestment, acquisition, tender offer or merger? Yes No

11. Within the last 18 months:
 (a) has there been any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer, Chief Financial Officer or Managing Partner (or equivalent position)? Yes No

(b) has the **Insured Entity** raised funds by any venture capital, private placement or private offering of any equity or debt securities? Yes No

(c) has the **Insured Entity** offered or sold to the public any equity or debt securities and/or filed any registration statement or similar disclosure for an offering or sale of securities? Yes No

(d) has the **Insured Entity** offered or sold securities pursuant to Title III. Crowdfunding of the Jumpstart Our Business Startups Act of 2012? Yes No

(e) has the **Insured Entity** conducted any plant, facility, branch or office closings, or layoffs? Yes No

(f) has the **Insured Entity** conducted any consolidation, divestment, acquisition, tender offer or merger? Yes No

IF "YES" TO ANY PART OF QUESTIONS 10. OR 11., PROVIDE DETAILS BY ATTACHMENT.

Subsidiary Information

12. Provide the following information on all **Subsidiaries** of the **Insured Entity**. If "None", so state. None

<u>Subsidiary Name</u>	<u>Nature of Business</u>	<u>Percent* Owned by Insured Entity</u>	<u>Date Created or Acquired</u>	<u>Domestic / Foreign</u>	<u>Nonprofit</u> <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

*If **Subsidiary** is less than 100 percent owned, provide details to all other owners, by attachment.

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED HERE OR BY ATTACHMENT.

Loss History Information

13. During the last 5 years, has any **Insured**, including any **Subsidiary**, received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative or arbitration, regulatory investigation or proceeding, including both domestic or foreign equivalents, involving:
- (a) any current or former employee or third party alleging discrimination, harassment, wrongful discharge and/or any wrongful employment act? Yes No
 - (b) the Equal Employment Opportunity Commission or any similar state or local agency? Yes No
 - (c) the U.S. Department of Labor or any similar state or local agency, alleging violations of any wage and hour law, including but not limited to, the Fair Labor Standards Act? Yes No
 - (d) any government agency such as the Labor Department or fair employment agency? Yes No
 - (e) the U.S. Immigration and Customs Enforcement Agency? Yes No
 - (f) the National Labor Relations Board? Yes No
 - (g) any investigation by the Internal Revenue Service, Department of Labor, Pension Benefit Guarantee Corporation, or any other local, state or federal agency? Yes No
 - (h) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? Yes No
 - (i) any Security Law or Regulation? Yes No
 - (j) any Anti-Trust or Fair Trade Law? Yes No
 - (k) the Foreign Corrupt Practices Act? Yes No
 - (l) the Office of Federal Contract Compliance Programs? Yes No
14. During the last 5 years, has any **Insured**, including any **Subsidiary**, been involved in any lawsuit not disclosed above? Yes No

IF "YES" TO ANY PART OF QUESTIONS 13. OR 14., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY PROVIDING THE FOLLOWING INFORMATION BY ATTACHMENT:

(a) Date Claim first made	(b) Claimant's Name	(c) Allegation	(d) Current Status
(e) Demand Amount	(f) Settlement (Indemnity) or Reserve Amount	(g) Attorney's fees	(h) Remedial Action Taken

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTIONS 13. OR 14.

Directors, Officers and Corporate Liability Section

➤ Complete the Directors, Officers and Corporate Liability section of the Proposal Form only if requesting this coverage.
 ➤ Provide a copy of the most recent interim and annual financial statements (audited, if available).

15. Is the **Insured Entity** engaged in any of the following activities? If "None", so state. None
- | | |
|---|---|
| <input type="checkbox"/> Activities that fall under The Investment Company Act of 1940
<input type="checkbox"/> Captive Insurance Company operations
<input type="checkbox"/> Franchising | <input type="checkbox"/> General Partnership operations
<input type="checkbox"/> Insurance Company operations
<input type="checkbox"/> Joint Venture(s) |
|---|---|
16. Total number of Shares of Stock or Membership Units outstanding:
 Common Stock / Membership Units: _____ Preferred Stock: _____
17. Provide the following information regarding the **Insured Entity's** outstanding ownership, including individual and corporate names:
- | <u>Names of Security Holders Owning More Than 10 Percent of Total Outstanding Common Stock, Membership Units or Preferred Stock</u> | <u>Percent Owned</u> | <u>Voting Rights</u> | <u>Representation on the Board of Directors?</u> |
|---|----------------------|--|--|
| _____ | % | <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 |
| _____ | % | <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 |

Employment Practices Liability Section

➤ Complete the Employment Practices Liability section of the Proposal Form only if requesting this coverage.

18. (a) Number of **Employees**: Do not include Leased Employees or Independent Contractors in numbers below.
- | | <u>Full Time</u> | <u>Part Time</u> | <u>Seasonal and/or Temporary</u> | <u>Volunteers and/or Interns</u> | <u>Annual Turnover Rate</u> |
|---------------|------------------|------------------|----------------------------------|----------------------------------|-----------------------------|
| Current Year: | | | | | |
| Last Year: | | | | | |
- (b) How many Leased Employees does the **Insured Entity** employ annually? _____
- (c) How many Independent Contractors does the **Insured Entity** utilize annually? _____
19. What percentage of the **Insured Entity's Employees** currently earn more than \$100,000? _____ %
20. Provide the following information on all plants, facilities, branches or offices of the **Insured Entity**. If "None", so state. None
- | <u>Location</u> | <u>Nature of Business</u> | <u>Number of Employees</u> | <u>Domestic / Foreign</u> |
|-----------------|---------------------------|----------------------------|---------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
21. Does the **Insured Entity** currently employ a full time Human Resources professional? Yes No
22. Indicate which formal written policies and procedures have been implemented. If "None", so state. None
- | | |
|--|---|
| <input type="checkbox"/> Employee Handbook / Manual
<input type="checkbox"/> Adherence to Employment "at-will" relationship with all Employees
<input type="checkbox"/> Anti-Discrimination Equal Employment Opportunity Policy
<input type="checkbox"/> Anti-Harassment Policy, including Sexual Harassment
<input type="checkbox"/> Social Media Policy | <input type="checkbox"/> I-9 Verification
<u>Employers with more than 50 Employees</u>
<input type="checkbox"/> Family Medical Leave Act
<u>California Employers Only</u>
<input type="checkbox"/> California Family Rights Act |
|--|---|
23. Does the **Insured Entity** (details to "Yes" or "No" answers are not required by attachment):
- | | |
|--|--|
| (a) utilize employment applications for all prospective Employees ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) require the Human Resource Department to review and approve each proposed Employee termination? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) have outside employment counsel review each proposed Employee termination? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) maintain a written policy prohibiting Sexual Harassment and distribute that policy to all Employees ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (e) conduct mandatory periodic Employee education regarding prohibited forms of harassment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- (f) periodically have its employment policies and procedures reviewed by outside employment counsel? Yes No
- (g) periodically have its employment policies and procedures distributed to all **Employees**? Yes No
- (h) have a written procedure for notification and handling of employment related grievances, disputes, notifications, or claims? Yes No

Fiduciary Liability Section

➤ Complete the Fiduciary Liability section of the Proposal Form only if requesting this coverage.
 ➤ Provide a copy of the most recent public accountant's audit report or IRS Form 5500 for each **Employee Benefit Plan**.

24. Provide the following information regarding each employee welfare benefit plan, employee pension benefit plan or pension plan, as defined by **ERISA**, (hereinafter referred to as **Employee Benefit Plans**) which the **Insured Entity** maintains or to which it contributes.

<u>Name of Plan</u>	<u>Type of Plan*</u>	<u>Name of Plan Sponsor</u>	<u>Number of Plan Participants</u>	<u>Fair Market Value of Plan Assets (000's)</u>
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

*Type of Plan: (DB)=Defined Benefit; (DC)=Defined Contribution; (ESOP)=Employee Stock Ownership Plan; (WB)=Health & Welfare Benefit; (MEP)=Multi Employer Plan or Multiple Employer Plan; (O)=Other

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR EMPLOYEE BENEFIT PLANS UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED HERE OR BY ATTACHMENT.

- 25. Has any employee pension benefit plan or pension plan invested in securities of the **Insured Entity**? Yes No
If "Yes", provide the following details by attachment: number of shares; cost of shares to the plan; fair market value of shares.
- 26. Has any employee pension benefit plan or pension plan invested in more than 10 percent of any entity (other than the **Insured Entity** or a pooled investment vehicle such as a mutual fund)? Yes No
If "Yes", provide name of entity and amount of investment.
- 27. Has any **Employee Benefit Plan** loaned or pledged any **Employee Benefit Plan** assets to any party-in-interest (including the **Insured Entity**)? Yes No
- 28. Are any defined benefit plans under funded by more than 20 percent? Yes No
- 29. Are there any overdue employer contributions for any plan, or has any plan requested or contemplated filing a request for a waiver of contributions? Yes No
If "Yes", provide plan name and amount of overdue contributions by attachment.
- 30. Within the last 3 years, has there been, or is there currently under consideration, any restructuring, termination or other similar transaction of any **Employee Benefit Plan**? Yes No
If "Yes", provide details of the transaction by attachment.
- 31. If any of the following questions are answered "No", provide details by attachment.
 - (a) Are all **Employee Benefit Plans** compliant with the Health Insurance Portability and Accountability Act ("HIPAA")? Yes No
 - (b) Does the plan sponsor comply with the summary plan description requirements under **ERISA** for all **Employee Benefit Plans**? Yes No
 - (c) Do all employee pension benefit plans or pension plans have a written investment policy? Yes No
 - (d) Are all employee pension benefit plan or pension plan assets managed by a third party investment manager? Yes No
 - (e) Do the fiduciaries review the investment guidelines used by the investment managers at least annually? Yes No
 - (f) Is the "fair market value" of all employee pension benefit plan or pension plan assets calculated at least annually? Yes No

Producer Information

Submitted by (Agency Name)	Dated
Agent's Name (Individual's Name)	Agent's License Number

Please Read Carefully

The undersigned, acting on behalf of all proposed **Insureds**, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each **Insured** proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the **Policy**. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the **Policy** inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any **Policy**, if issued, will be in reliance upon the truth of such representations, provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Insured Person** shall be imputed to any other **Insured Person**. If any person or persons knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons. However, if the President, Chief Executive Officer, Chief Financial Officer or Managing Partner of the **Insured Entity** knew as of the **Policy** inception date that such declarations and statements contained in the Proposal Form(s) were untrue, inaccurate or incomplete, and such statements materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under this **Policy**, then this **Policy** shall not apply as to that person or persons and the **Insured Entity**;
- the information contained in this Proposal Form shall not be used by the **Insureds** as notice as provided for in section VII. of the Common Policy Terms and Conditions Section of this **Policy**;
- this Proposal Form has been completed as respects the entire **Insured Entity**;
- the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

Dated

President, Chief Executive Officer, Chief Financial Officer, or Managing Partner (Signature)

President, Chief Executive Officer, Chief Financial Officer, or Managing Partner (Print Name)

Title

Dated

Human Resources Manager, or equivalent position (Signature)

This Berkley Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.

Please submit this Proposal Form including appropriate documentation to:
Monitor Liability Managers, 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039

NOTICE TO COLORADO APPLICANTS: 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

NOTICE TO NEW MEXICO, PENNSYLVANIA APPLICANTS: 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.

NOTICE TO APPLICANTS OF KENTUCKY: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO APPLICANTS OF NEW JERSEY AND OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE, MASSACHUSETTS, TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO APPLICANTS OF 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.

NOTICE TO ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, AND RHODE ISLAND APPLICANTS: 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.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.