



Manchester Specialty

Phone: 1-855-972-9399

www.manchesterspecialty.com

Allied Health Care Providers Program – Home Health Care, Hospice and Medical Staffing Firms Professional Liability & General Liability Insurance Application

Instructions:

- Please answer all questions completely. If any questions do not apply, print “N/A” in the space. Check all Yes/No answers. This form must be completed, dated and signed by a Principal or Officer of the Applicant Firm.
- Submit with current insurance company loss reports for the past five (5) years. Specify date, description and amount outstanding/current reserve for each claim.

Applicant Information:

Applicant (Entity) Name:	(If more than one entity/subsidiary, please attach description and % owned for each)		
DBA (If Applicable):			
Date Business First Established:		Employer Federal Tax ID Number (Required):	
Mailing Address:	Street:	PO Box:	
	City:	State:	Zip Code:
Physical Address:	Street:		
	City:	State:	Zip Code:
	County:		
Phone Number:		Fax Number:	
Website:		Number of Years Under Current Ownership:	
Contact Name:			
Contact E-Mail Address:			

Description of Operations: (check all that apply)

<input type="checkbox"/> Home Health Care Firm	<input type="checkbox"/> Medical Equipment Supplier	<input type="checkbox"/> Nurse Registry
<input type="checkbox"/> Personal Care/Support Services	<input type="checkbox"/> Oxygen Equipment Provider	<input type="checkbox"/> Traveling Nurse Firm
<input type="checkbox"/> Companion Care Provider Visiting Nurse	<input type="checkbox"/> Infusion Therapy Firm	<input type="checkbox"/> Medical Staffing
<input type="checkbox"/> Visiting Nurse Association(VNA)	<input type="checkbox"/> Pharmacy (Closed Shop)	<input type="checkbox"/> Non-Medical Staffing
<input type="checkbox"/> Hospice	<input type="checkbox"/> Retail Pharmacy	<input type="checkbox"/> Other (describe):

Current Accreditation (check all that apply):

- Accreditation Commission for Health Care (ACHC)
- Commission on the Accreditation of Rehabilitation Facilities (CARF)
- Community Health Accreditation Program (CHAP)
- The Joint Commission (formerly JCAHO) Other: _____



Current Membership (check all that apply):

- Active Member – National Association for Home Care & Hospice (NAHC) *Exclusively Endorsed NAHC Affinity Partner*
- Active Member – State Home Care Association (name of assoc.): _____
- Active Member – Other (Association name): _____

Operations:

Total Number of Employees:	Total Annual Gross Receipts: \$
Permanent Employee Turnover Rate: _____ %	State(s) of Operation (list all):
Legal Entity - Choose One: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> Limited Liability Co.	Entity Type - Choose One: <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit <input type="checkbox"/> Government
Percentage of Receipts obtained for the following payor categories: (total must equal 100%) Medicare: _____ % Medicare Provider #: _____ Medicaid: _____ Private Pay: _____ Other: _____	

License/Certification Information:

1. Is the Applicant licensed in all states in which it is operating? If No, explain how non-licensed states are monitored:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Licensed Specialty:		
Licensing Agency:		
2. Has the Applicant’s License or Certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? Are any such charges pending against the Applicant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has any hospital or other healthcare entity ever denied, suspended, non-renewed, revoked, declined or in any way restricted the Applicant’s privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has a professional licensing board, certification board or professional ethics board ever taken disciplinary action against the Applicant? Are any disciplinary actions pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Has the Applicant ever been convicted of a misdemeanor or felony or is any such charge pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has the Applicant ever been investigated by a State Health Department, State Licensing Board or other Governmental Body (i.e. FBI, Dept. of Justice)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Location(s) Where Services are Provided: (total must equal 100%)

Location	Percentage of total revenue	Location	Percentage of total revenue
<input type="checkbox"/> Private Homes	%	<input type="checkbox"/> Doctors’ Offices	%
<input type="checkbox"/> Nursing Homes/ Assisted or Independent Living Facilities		<input type="checkbox"/> Adult Day Care Facilities/Centers	
<input type="checkbox"/> Hospitals		<input type="checkbox"/> Prison Facilities	
<input type="checkbox"/> Clinics		<input type="checkbox"/> Schools	
<input type="checkbox"/> Laboratories		<input type="checkbox"/> Other Locations (describe):	
<input type="checkbox"/> Hospices			

Types of Services Provided: (total must equal 100%)

Service	Percentage of total revenue	Service	Percentage of total revenue
<input type="checkbox"/> Home Health Nursing	%	<input type="checkbox"/> Medical Supplemental Staffing	%
<input type="checkbox"/> Personal Care/Companion/Sitter		<input type="checkbox"/> Non-Medical Supplemental Staffing	
<input type="checkbox"/> Infant Care/Pediatric Care		<input type="checkbox"/> Rehabilitation	
<input type="checkbox"/> Surg. Nursing/Operating Techs		<input type="checkbox"/> Medical Equipment Supplier	
<input type="checkbox"/> Obstetrical Services		<input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Post Partum Caregivers		<input type="checkbox"/> Closed Shop Pharmacy	
<input type="checkbox"/> Hospice		<input type="checkbox"/> Mail Order Pharmacy	
<input type="checkbox"/> Respite Care		<input type="checkbox"/> Mental Health/Counseling	
<input type="checkbox"/> Meals on Wheels		<input type="checkbox"/> Psychiatric Care	
<input type="checkbox"/> Respiratory Care		<input type="checkbox"/> Adult Day Care	
<input type="checkbox"/> Trach/Ventilator Care		<input type="checkbox"/> Child Day Care	
<input type="checkbox"/> Infusion Therapy		<input type="checkbox"/> Laboratory Services	
<input type="checkbox"/> Palliative Care/Pain Mgmt.		<input type="checkbox"/> Clinics Owned/Operated	
<input type="checkbox"/> Blood Transfusion		<input type="checkbox"/> Dialysis	
<input type="checkbox"/> Chemo Therapy		<input type="checkbox"/> Bereavement Camps	
<input type="checkbox"/> Radiation Therapy		<input type="checkbox"/> Other (describe):	

Risk Management:

1. Does the Applicant utilize a formal written Quality Improvement and Risk Management Program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the overall responsibility for risk management assigned to one individual in your firm? If Yes, Name/Title: _____ If No, please describe how risk management is monitored: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does the Applicant have an informed consent process in place?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Does the Applicant have a formal incident reporting procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Does the Applicant have a formalized training and education program with staff attendance required at mandatory in servicing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Are complete records kept on all patients? If so, are they stored in locked cabinets or password protected if electronic records? Are patient records protected in compliance and accordance with HIPAA? Does the Applicant require signed release forms for the release of records? Does the Applicant conduct semi-annual audits of all required paperwork?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

Hiring/Screening and Credentialing Procedures:

1. Does the Applicant perform criminal background checks on prospective employees, independent contractors and volunteers? If Yes, at what level is the criminal searched conducted? (check all those applicable) <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Convictions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the Applicant verify employment related references prior to an employee or independent contractor being hired/placed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does the Applicant verify certification and/or professional licensure status of all employees and independent contractors at hire date and on an ongoing basis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Hiring/Screening and Credentialing Procedures (continued):		
4. Does the Applicant confirm in writing any of the following relative to prospective employees: - Whether their medical professional liability insurance has ever been denied or canceled? - Whether they have ever been involved in any professional liability claims or litigation? - Whether any action has ever been taken on their clinical privileges? - Whether the individual has ever been convicted of any crime, including sexual abuse or molestation and/or assault & battery?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
5. Does the Applicant conduct a personal interview for each prospective employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has the Applicant formalized a drug and alcohol screening program requiring all employees and independent contractors to satisfy drug and alcohol testing prior to hire/placement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Is there a procedure for screening suspect employees/independent contractors when drug or alcohol abuse is alleged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Are all employees/independent contractors required to sign a formal confidentiality statement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Are written job descriptions provided to all employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Does your organization require that all contracted professionals (including physicians and physicians' assistants) maintain primary professional liability insurance? If so, please specify limits of liability required: _____ Are certificates of insurance obtained on an annual basis?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
11. Is there a formalized professional staff credentialing process in place, including verification of license, certification, education and training?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Professional Staff – License and Insurance Coverage Information:

Please provide the following information for each Physician, Physician Assistant and/or Nurse Practitioner:

Full Name of Professional	State of Licensure	Employee, Volunteer or Independent Contractor?	Average Hours per Month	Primary Insurance Coverage? (Yes/No)	Name of Primary Insurance Carrier

Services Provided – Additional Details:

1. Does the Applicant provide Pediatric Care ? If Yes, describe types of pediatric services:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you take on tracheotomy/ventilator dependent patients? If Yes, what is the percentage of total patients? _____ %	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are Apnea Monitors used in the delivery of care? If Yes, does the Applicant rent this equipment to others? If Yes, number of Monitors owned by Applicant:	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
4. Does the Applicant provide Psychiatric Care or Mental Health Services ? If Yes, please describe services:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Services Provided – Additional Details (continued):		
5. Does the Applicant provide any “live-in” home health care services ? If Yes, please provide the percentage of patients that use this service: _____ %	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the Applicant provide any services to Alzheimer’s, quadriplegic, or mentally incapacitated patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the Applicant own or operate any bed/board facilities (i.e. hospice, skilled nursing, etc.)? If yes, number of beds: _____ If yes, are all medications stored in a locked cabinet?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
8. Home Health Care – total number of patients treated in their homes (annually): _____ Percentage under 18 years of age: _____% Percentage Adult (19-65): _____% Percentage Senior (over 65): _____%		
9. Does the Applicant perform home-site surveys prior to the commencement of care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Are employees required to complete daily work reports ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Do all patients receiving any level of skilled care have a current and regularly updated physician treatment plan on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Is the Applicant a Durable Medical Equipment Supplier* (sales, lease and/or rental)? <i>*If Yes, please complete DME supplemental application.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Does the Applicant provide any Supplemental Staffing services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Total Revenue derived from Supplemental Staffing services: \$ _____ Percentage of total revenues by location of staffing services (total must equal 100%): <input type="checkbox"/> Nursing Homes/Assisted or Independent Living Facilities: _____% <input type="checkbox"/> Hospitals (see Q15.) _____ <input type="checkbox"/> Clinics/Laboratories: _____ <input type="checkbox"/> Hospices: _____ <input type="checkbox"/> Doctor’s Offices: _____ <input type="checkbox"/> Schools: Adult Day Care _____ <input type="checkbox"/> Facilities: _____ <input type="checkbox"/> Prison Facilities: _____ <input type="checkbox"/> Other (please specify): _____		
15. If Supplemental Staffing is provided to Hospitals , please specify percentage of total revenues by specialized service (total must equal 100%): <input type="checkbox"/> Obstetrical: _____% <input type="checkbox"/> Psychiatric: _____ <input type="checkbox"/> Intensive Care Unit: _____ <input type="checkbox"/> Neonatal: _____ <input type="checkbox"/> Emergency Department: _____ <input type="checkbox"/> Medical/Surgical Unit: _____ <input type="checkbox"/> Pediatric: _____ <input type="checkbox"/> Coronary Care Unit: _____ <input type="checkbox"/> All other units: _____		
16. Do you require that Contractual Agreements you enter into to provide temporary or supplemental staffing to client facilities include the following provisions: Mutual indemnification and hold harmless agreement? Require third parties to carry liability insurance with limits of at least \$1M/\$3M? Require the third party to provide the Applicant with a certificate of insurance? <i>Please provide a copy of your standard contract.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

EMPLOYEES/STAFF GRID:

Does Applicant provide services in more than one state? Yes** No STATE: _____

****If Yes, please make a copy of this page and complete this employees/staff grid for each state.**

Professional Classification	Total Number of Annual Hours Worked	Number of Employees		Number of Indep Contractors		Annual Payroll (or 1099 amount)
		FULL	PART	FULL	PART	
Administrative/Clerical						\$
Audiologist						
Cardiology Technician						
Companion/Sitter						
Clergy						
Dental Hygienist/Dental Assistant						
Dialysis Technician						
Dietician/Nutritionist						
EKG/EEG Technician						
Enterostomal Therapist						
Home Health Aide/CNA						
Homemaker						
Lab Technician						
LPN/LVN						
Medical Director						
Medical Technologist						
Mental Health Counselor						
MRI Technician						
Nuclear Medicine Technician						
Nurse Aide						
Nurse Practitioner						
Nurse/RN						
Occupational Therapist						
Pharmacist						
Pharmacy Assistant/Tech						
Phlebotomist						
Physical Therapist						
Physician						
Physicians' Assistant						
Psychologist						
Radiological Technologist						
Rehabilitation Counselor/Therapist						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Ultrasound Technician						
Volunteer						
Wellness Counselor						
X-Ray Technician						
Other:						

Operations/Exposure Information:

1. Will any new services be provided in the next 12 months? If yes, please describe:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Will any services be discontinued in the next 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have any services been discontinued in the last 24 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Within the next 12 month period, does the Applicant plan to: Obtain another operation or entity? If yes, please describe: _____ Add to the number of employees? Expand the number of locations?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
5. Are any residential facilities owned or operated by the Applicant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the Applicant's staff prescribe medication(s) to patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the Applicant utilize recreational activities in the treatment of patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the Applicant handle all billings in-house?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Does the Applicant have a compliance program in place for both HIPAA and billing errors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Is there a Medical Billings Compliance Officer on staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Are there any fundraising events planned for the upcoming year? If yes, please describe:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Abuse & Molestation Coverage Section: (if not requesting this coverage, please cross through this section)

1. Does the Applicant have written procedures that monitor the staff in day to day relationships with clients, both on (if applicable) and off the premises?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the Applicant have formal staff training on sexual abuse and molestation, including how to recognize the signs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does the Applicant have more than one person responsible for the welfare of any single patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Does the Applicant have a formal complaint reporting and documentation procedure for clients and employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities and the media if there is an incident of abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the Applicant's employment application include questions (if permissible) about whether the individual has ever been accused or convicted of any crime, including any sexual or molestation related offense?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has the Applicant ever had an incident that resulted in an allegation of sexual abuse or molestation? If Yes, please describe: _____ Was the case settled? Was the case taken to trial?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
8. Has the Applicant (or their insurance carrier) ever paid any damages as a result of an allegation of sexual abuse or molestation? If Yes, amount paid?: \$	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Is the Applicant aware of any fact, circumstance or situation which may lead to any future sexual abuse or molestation claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Non-Owned & Hired Auto Coverage Section: (If not requesting this coverage, please cross through this section)

1. Does the Applicant own any vehicles use for business purposes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the Applicant purchase a business owned auto liability insurance policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. How many employees, independent contractors (ICs) or volunteers use their own vehicle for company business? Employees _____ ICs _____ Volunteers _____	Yes	No
4. Does the Applicant obtain a copy of driver's licenses for all employees, ICs and volunteers and confirm they are valid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Does Applicant require each employee, IC and volunteer to provide evidence of Insurance with personal auto limits of at least the state required minimum?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the Applicant make a visual check of all employee, IC and volunteer personal vehicles to be sure the unit is safe and operational?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does Applicant check the Motor Vehicle Reports/MVRs on an annual basis of all employees/ICs/volunteers under age 25 & for all those that transport patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do any of the Applicant's employees, ICs or volunteers drive patient/client owned vehicles during the course of your business?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Is the Applicant aware of any auto accident or loss which may result in a claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PROFESSIONAL LIABILITY Insurance Coverage Information (past three years):

Policy Period	Carrier	Limits	Deductible	Premium	CM/Occurrence	
Current:					<input type="checkbox"/> Claims Made (CM) Retro date: _____ <input type="checkbox"/> Occurrence	
					<input type="checkbox"/> Claims Made Retro date: _____ <input type="checkbox"/> Occurrence	
					<input type="checkbox"/> Claims Made Retro date: _____ <input type="checkbox"/> Occurrence	
Has the Applicant ever had Professional Liability insurance canceled or non-renewed? <i>(Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)</i> <i>(Nevada Applicants: If you have answered yes, please provide an explanation.)</i>					<input type="checkbox"/> Yes	<input type="checkbox"/> No

GENERAL LIABILITY Insurance Coverage Information (past three years):

Policy Period	Carrier	Limits	Deductible	Premium	CM/Occurrence	
Current:					<input type="checkbox"/> Claims Made (CM) Retro date: _____ <input type="checkbox"/> Occurrence	
					<input type="checkbox"/> Claims Made Retro date: _____ <input type="checkbox"/> Occurrence	
					<input type="checkbox"/> Claims Made Retro date: _____ <input type="checkbox"/> Occurrence	
Has the Applicant ever had General Liability insurance canceled or non-renewed? <i>(Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)</i> <i>(Nevada Applicants: If you have answered yes, please provide an explanation.)</i>					<input type="checkbox"/> Yes	<input type="checkbox"/> No

Claims and Incident Information:

1. Is the Applicant aware of any of the following events which may result in any claim or suit being made:		
a. Any client/patient deaths reported while they were in your care or under your supervision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Any incidents including slips, trips or falls of a client or patient reported?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Any mistaken procedures executed or incorrect diagnoses rendered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Any severe drug reaction by a client or patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you aware of any events where patients or their relatives have:		
a. Directly accused you or your employees of malpractice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Exhibited a total disregard of advice or irrational expectations of care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Abruptly discontinued care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Repeated complaints about service or treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has any patient requested release of their records to an attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has any professional liability claim or suit ever been made against the Applicant or its' employees, independent contractors or volunteers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Is the Applicant aware of any fact, circumstance or situation which may lead to any future claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional Insureds:

Please provide a **list of all entities to be named as an Additional Insured(s)** with complete names and insurable interest:

Name	Insurable Interest
_____	_____
_____	_____
_____	_____
_____	_____

FRAUD STATEMENTS:

GENERAL STATEMENT:

Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied).

APPLICABLE IN COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the isleading 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.

APPLICABLE IN THE DISTRICT OF COLUMBIA:

WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

APPLICABLE 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.

APPLICABLE IN HAWAII:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT:

Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN OHIO:

Any person who, with intent to defraud or knowing that he/she 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.

APPLICABLE IN OKLAHOMA:

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN 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.

SIGNATURE SECTION:

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

It is understood and agreed that the completion of this application does not bind the company to issue, nor the Applicant to purchase, the insurance.

Applicant Firm Name: _____

Signed By: _____

Signature: _____

(Please type or print name and title)

Date: _____

(Must be signed and dated by Principal or Officer of Firm)

Agent/Broker Information:

Agency Name: _____

Contact Name: _____ Phone: _____

Address: _____

Agent/Broker E-Mail: _____ Agent/Broker License# (Required): _____

E-mail completed Application and attachments to: submissions@manchesterspecialty.com



Manchester Specialty