DENTIST AND ORAL SURGEON SUPPLEMENTAL APPLICATION

COMPLETE IN FULL INCLUDING SIGNATURES AND DATING BY THE PROVIDER NOT EARLIER THAN 45 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OF COVERAGE.
ATTACH ADDITIONAL SHEETS AS NECESSARY.
ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

GENERAL INFORMATION

1)

Named Insured:	
Professional Designation:	Social Security Number:
US Citizen? Yes ☐ No ☐	Date of Birth:
Immigration status:	Entry date:
Federal DEA License #:	DEA License Status:
Phone Number:	Email Address:
Brokerage/Broker:	Agency/Agent:
Renewal? Yes ☐ No ☐	Policy Number:
Effective Date:	
Website:	

2) Current/Most Recent Professional Liability Carrier Information:

Carrier:		
Limit of Insurance:		
Deductible:	Premium:	
Policy Term Dates:		
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐	Retroactive date:

3) Current/Most Recent Commercial General Liability Carrier Information:

Carrier:		
Limit of Insurance:		
Deductible:	Premium:	
Policy Term Dates:		
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐	Retroactive date:

Please attach copies of the following:

a) Currently valued five year loss runs, including claim detail for all losses
b) Copy of your current Professional Liability insurance Declarations Page and Commercial General Liability insurance Declarations Page (claims made policies must reflect the retroactive date and limits for retro continuity)
c) A copy of all marketing materials, brochures, etc. if a website is not available
d) A copy of your business letterhead
e) A copy of all licenses and board certifications held by you
f) A copy of all reporting endorsements previously issued to you

4) Mailing Address: _____
City: _____ State: _____ Zip Code: _____

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5) Practice Address: _____

City: _____ State: _____ Zip Code: _____

6) Are you a(n): ☐ Corporation ☐ Individual ☐ Partnership ☐ LLC
☐ Employed Dentist ☐ Contracted Dentist ☐ Other: _____

a. If you are employed or contracted, by whom? _____

7) Your practice is: ☐ Solo Practice ☐ Group Practice ☐ Other: _____

8) What is the entity name of your practice? _____

a. What is your ownership percentage? _____%

b. How many other dentists practice at this entity? _____

c. Are you seeking coverage for this entity? If yes please attach articles of incorporation. Yes ☐ No ☐

9) Do you practice with any other dentists not included in 8) above? Yes ☐ No ☐

a. If yes, please list their name(s) and practice relationship:

10) Please complete the following table for states in which you are licensed to practice:

State	% of Practice	License #	Status
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐

PRACTICE SPECIALTY AND DENTAL EDUCATION INFORMATION

11) Please complete the below table for all locations and dates of practice you have had in the last ten years:

Practice Name	City/State	Specialty	Beginning Date	End Date

12) What is your current practice specialty? _____

a. What percentage of your practice is under this specialty? _____%

b. What is your current subspecialty: _____

c. What percentage of your practice is under this subspecialty? _____%

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13) Please complete the following table for your education history:

	Institution	Location	Degree/Specialty	Completed?
Dental School				Yes ☐ No ☐
Internship				Yes ☐ No ☐
Residency				Yes ☐ No ☐
Additional Residency				Yes ☐ No ☐
Fellowship				Yes ☐ No ☐

14) Please complete the following regarding your board certification:

a. Are you: ☐ Board Certified ☐ Board Eligible ☐ Board Qualified

b. Name of Board(s):

c. Date of Exam: _____

d. If you have been Board Eligible for over five years, but not Board Certified, please explain:

15) What date did you begin practicing dentistry? _____

16) How many CE hours have you completed in the past 2 years? _____

17) Are you a member of any dental or professional associations? Yes ☐ No ☐

a. If yes, which one(s)?

18) Are you a foreign dental school graduate? Yes ☐ No ☐

a. What date did you begin practicing in the US? _____

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DENTAL PRACTICE AND PROCEDURE INFORMATION

19) Please complete the following table for procedures/treatments that you perform. Check and complete all that apply:

Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months	Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months
☐ Bone Grafting	%	%	☐ Cosmetic Dentistry (complete 20) below)	%	%
☐ Cosmetic Procedures – Non-Dental (complete 23) below)	%	%	☐ Endontics – Single Rooted	%	%
☐ Endontics – Multi Rooted	%	%	☐ Endontics – Sargenti Multi Rooted Canal Method	%	%
☐ General Dentistry – Root Canal	%	%	☐ General Dentistry – Oral Surgery	%	%
☐ General Dentistry – Extractions of Impacted Teeth	%	%	☐ General Dentistry – Simple Extractions Only	%	%
☐ Implants - Restoration	%	%	☐ Implants - Placement	%	%
☐ Microneurosurgical Procedures	%	%	☐ Oral Pathology	%	%
☐ Oral Radiology	%	%	☐ Orthodontics	%	%
☐ Orthognathic Procedures	%	%	☐ Pediatric Dentistry	%	%
☐ Periodontics	%	%	☐ Prosthodontics	%	%
☐ Prosthetics - Fixed	%	%	☐ Prosthetics - Removable	%	%
☐ Prosthetics – Sleep Apnea	%	%	☐ Prosthetics - Surgery	%	%
☐ Prosthetics - Therapy	%	%	☐ Surgery – Facial – Elective Cosmetic	%	%
☐ Surgery – Head and Neck	%	%	☐ Surgery – Oral/Maxillofacial	%	%
☐ Surgery – Outside Oral/Maxillofacial Region: _____	%	%	☐ TMJ – Non-Surgical	%	%
☐ TMJ – Surgical	%	%	☐ Uvulopalatoplasty	%	%
☐ Other: _____	%	%	☐ Other: _____	%	%
☐ Other: _____	%	%	☐ Other: _____	%	%
☐ Other: _____	%	%	☐ NONE OF THE ABOVE	INITIAL TO CONFIRM: _____	

** Additional supplemental application required*

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20) If you are performing cosmetic dental procedures, please indicate which you're performing. Check all that apply:

☐ Bonding ☐ Enamel Shaping ☐ Full Mouth Restoration
☐ Veneers ☐ Whitening with Lasers ☐ Other Laser Procedure: _____
☐ Other Procedure: _____ ☐ Other Procedure: _____ ☐ Other Procedure: _____

21) If you are performing cosmetic procedures, please indicate which you are performing. Check all that apply:

☐ Botox Injection ☐ Chemical Peels ☐ Chemobrasion
☐ Collagen Injection ☐ Dermabrasion ☐ Face Lift
☐ Laser Skin Resurfacing ☐ Lipodissolve ☐ Liposuction
☐ Microdermabrasion ☐ Reconstructive Surgery ☐ Rhinoplasty
☐ Silicone Injection ☐ Other Laser Procedure: _____ ☐ Other Procedure: _____

a. Where are these performed? ☐ Office ☐ Hospital ☐ Other: _____

22) If you have performed any implant procedures in the last year, please check which and indicate how many. Check all that apply:

☐ Osseointegration only #_____ ☐ Endosteal - Ramus Frame #_____
☐ Endosteal - Other #_____ ☐ Subperiosteal #_____
☐ Transosseus #_____ ☐ Other: _____ #_____

a. Do you perform sinus lifts or other surgical procedure in conjunction with implant procedures? Yes ☐ No ☐

23) What are your average weekly practice hours? _____

24) How many weekly patient encounters do you have on average? _____

25) Approximate gross income from you practice: $_____

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26) If you are performing any of the following surgical procedures/treatments, please indicate where they are performed:

Procedure	Location
Acupuncture	☐ Office ☐ Hospital ☐ Other: _____
Adenoidectomy	☐ Office ☐ Hospital ☐ Other: _____
Assist in Surgery	☐ Office ☐ Hospital ☐ Other: _____
Biopsies	☐ Office ☐ Hospital ☐ Other: _____
Blepharoplasty	☐ Office ☐ Hospital ☐ Other: _____
Cheek Implant	☐ Office ☐ Hospital ☐ Other: _____
Chin Surgery	☐ Office ☐ Hospital ☐ Other: _____
Cleft Lip/Palate Surgery	☐ Office ☐ Hospital ☐ Other: _____
Clinical Trials	☐ Office ☐ Hospital ☐ Other: _____
Closed Reduction Fractures	☐ Office ☐ Hospital ☐ Other: _____
Complex Flaps and Grafts	☐ Office ☐ Hospital ☐ Other: _____
Cryosurgery	☐ Office ☐ Hospital ☐ Other: _____
Dental Alveolar Surgery	☐ Office ☐ Hospital ☐ Other: _____
Extractions (Impacted)	☐ Office ☐ Hospital ☐ Other: _____
Extractions (Non-Impacted)	☐ Office ☐ Hospital ☐ Other: _____
Needle Biopsy	☐ Office ☐ Hospital ☐ Other: _____
Nerve Grafts	☐ Office ☐ Hospital ☐ Other: _____
Oral/Maxillofacial Surgery	☐ Office ☐ Hospital ☐ Other: _____
Open Reduction of Fractures	☐ Office ☐ Hospital ☐ Other: _____
Sargenti Root Canal Method	☐ Office ☐ Hospital ☐ Other: _____
Sinus Lift	☐ Office ☐ Hospital ☐ Other: _____
TMJ Surgery	☐ Office ☐ Hospital ☐ Other: _____
Uvulopalatoplasty	☐ Office ☐ Hospital ☐ Other: _____
Other: _____	☐ Office ☐ Hospital ☐ Other: _____
☐ I do not perform any surgical procedures or treatments	Initial to confirm: _____

27) Have you ever used a Vitek Proplast TMJ implant in your practice? Yes ☐ No ☐
   a. If yes, have all such implants been replaced? Yes ☐ No ☐
   b. Date of last implant: _____

28) Do you use analgesia, sedation, or anesthesia on patients? Yes ☐ No ☐
   a. If yes, is application local only? Yes ☐ No ☐

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29) If you perform any of the following types of anesthesia, please complete the below table:

	Inhalation Conscious	Oral Conscious	Parenteral Conscious	Parenteral Deep Sedation	General Anesthesia
Percent of patients under 18					
Drug(s) Used					
Office, Surgi-Center, or Hospital Setting					
Administered by:	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________

30) Do you adhere to Harvard Standards for anesthesia administration? Yes ☐ No ☐

31) Do you hold an ALCS certificate? Yes ☐ No ☐

32) Which of the following emergency treatment items do you have available? Check all that apply:

☐ Oral Airway ☐ Ambu bag ☐ Endotracheal tubes/scopes
☐ Oxygen ☐ Emergency Drugs ☐ None Available
☐ Other: ________________________ ☐ Other: ____________________ ☐ Other: ______________________

33) Have there been any changes in your specialty or practice activities in the last ten years? Yes ☐ No ☐
   a. If yes, please attach an explanation.

34) Do you anticipate any changes in your specialty or practice activities in the next year? Yes ☐ No ☐
   a. If yes, please attach an explanation.

35) Do you perform any procedures not routinely performed by others practicing in your specialty or subspecialty? Yes ☐ No ☐
   a. If yes, what procedures? ____

36) Are you presently on staff at any hospitals or surgery centers? Yes ☐ No ☐
   a. If yes, please complete the below table for these exposures:

Facility Name	City and State	Percent of Work	Type of Privileges
		%	
		%	
		%	

   b. If no, please attach protocols for patient admission.

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37) Are you currently, or have you ever previously been, a hospital chief of staff or head of any hospital department? Yes ☐ No ☐
   a. If yes, when? _____
   b. What hospital and department? _____
   c. If this position is not current, why did you exit the position?

38) Do you work in an emergency room, other than to maintain privileges? Yes ☐ No ☐
   a. If yes, how many hours per month on average? _____

39) What percentage of your work is Locum Tenens? _____%
   a. Do you work for any Locum Tenens companies as an employee or independent contractor? Yes ☐ No ☐
   b. If yes, how many hours each month? _____
   c. Does the Locum Tenens company provide you with Professional Liability insurance? Yes ☐ No ☐
   d. If yes to c., please attach a copy of the COI.

40) Do you read your own x-rays? Yes ☐ No ☐
   a. If yes, approximately how many hours before they are subsequently read by a radiologist? _____

41) Do you read or interpret films, slides, or specimens of patients who reside in states other than your indicated practice states? Yes ☐ No ☐
   a. Which states do you offer these services in? _____
   b. What percentage of your practice are these operations? _____%

42) Are you employed by the federal, state or local government (full or part time, including active duty military)? Yes ☐ No ☐
   a. If yes, please attach details.

43) Do you wire jaws closed for the purposes of weight loss? Yes ☐ No ☐
   a. If yes, approximately how many annually? _____

44) Do you treat patients in a nursing home, correctional facility, or similar care facility? Yes ☐ No ☐
   a. If yes, what percentage of your practice are these operations? _____%
   b. Please list the facilities:

45) Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? Yes ☐ No ☐
   a. If yes, please attach a detailed list of the procedures or drugs and a description of protocols and procedures.

46) Do you endorse any products or participate in any activity which offers professional advice to the public, including but not limited to newspaper columns any broadcasts? Yes ☐ No ☐
   a. If yes, please attach an explanation and samples of past publishing.

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47) Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering dental services? Yes ☐ No ☐

a. Do you prescribe drugs or provide diagnosis via the internet or telehealth? Yes ☐ No ☐

b. If yes to 40) or a., are these services limited to current patients whom you have previously had at least one in-office visit? Yes ☐ No ☐

c. What state(s) are you offering these services?

d. What percentage of you practice are these operations? _____%

STAFF INFORMATION

48) Please complete the following for your staff:

	Number Employed		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full-Time	Part-Time	Full-Time	Part-Time		
Dental Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Dental Technician					Yes ☐ No ☐	Yes ☐ No ☐
Hygienists					Yes ☐ No ☐	Yes ☐ No ☐
Physician*					Yes ☐ No ☐	Yes ☐ No ☐
Physician Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Surgeon Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Lab Technician					Yes ☐ No ☐	Yes ☐ No ☐
Pharmacist					Yes ☐ No ☐	Yes ☐ No ☐
RN, LPN					Yes ☐ No ☐	Yes ☐ No ☐
CRNA					Yes ☐ No ☐	Yes ☐ No ☐
X-Ray Technician					Yes ☐ No ☐	Yes ☐ No ☐
Other: _____					Yes ☐ No ☐	Yes ☐ No ☐

** Requires separate application*

49) Are all of the individuals included in the table above licensed in accordance with applicable State and Federal regulations? Yes ☐ No ☐

50) Do you employ, contract with or supervise any dentists? Yes ☐ No ☐

a. If yes, please list their names and attach certificates of insurance for each:

51) Do you share office space or have an expense sharing arrangement with any other dentist other than those named above? If yes, please attach an explanation. Yes ☐ No ☐

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52) Which of the following procedures do you use for hiring/screening professionals and paraprofessionals who provide patient care services in your operations other than surgeons and anesthesia providers? Check all that apply:

- ☐ Check of educational background
- ☐ Check of previous employers – In writing
- ☐ Criminal background check – State
- ☐ Driver's license verification
- ☐ Drug screening
- ☐ Abuse screening
- ☐ Check of residency program
- ☐ Check of previous employers – By telephone
- ☐ Criminal background check – Federal
- ☐ MVR Check
- ☐ Alcohol screening
- ☐ Reference verification
- ☐ Verification of license validity, suspensions, revocations, citations, or pending disciplinary actions
- ☐ Verification of any pending disciplinary actions by current or previous employers
- ☐ Verification of Professional Liability or other workplace related claims history against the applicant
- ☐ Other: _____

COVERAGE AND LOSS HISTORY

53) Has any licensing authority or professional association taken any action against you or any of your employees? **If yes, please attach an explanation and copies of all citations.** Yes ☐ No ☐

54) Have you or any of your employees ever had any professional license or license to prescribe and or dispense narcotic ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If yes, please attach an explanation.** Yes ☐ No ☐

55) Has your board certification or membership in any dental society or association been refused, suspended, revoked, or voluntarily surrendered? **If yes, please attach an explanation.** Yes ☐ No ☐

56) Have your hospital privileges been suspended, restricted, denied, placed in probation status, or revoked? **If yes, please attach an explanation.** Yes ☐ No ☐

57) Have you or any of your employees ever been charged with or convicted of a crime other than minor traffic violation(s)? **If yes, please attach an explanation.** Yes ☐ No ☐

58) Have you or any of your employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

59) During the past five years, has any insurer ever canceled or non-renewed similar insurance to any applicant or has your insurance been canceled for nonpayment of premium by any insurance or finance company. **If Yes, please attach an explanation.** Yes ☐ No ☐

60) Have you ever practiced without Professional Liability insurance in place? Yes ☐ No ☐

61) Do you have Professional Liability insurance in place for work you do elsewhere? **If yes, please attach a copy of the policy Declarations page(s).** Yes ☐ No ☐

62) Has any claim or suit for medical malpractice or professional liability ever been filed, or any claim otherwise been made against you or any other person proposed for this insurance, including any partnership or joint venture of which you have been a member or your company's predecessors in business? Yes ☐ No ☐

a. **If yes, please complete the Kinsale Health Care Claim Supplemental.**
b. How many malpractice or professional liability claims have you had? _____
c. Have these claims all been reported to your current or a prior insurer? Yes ☐ No ☐

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63) Are you or anyone else proposed for this insurance aware of any occurrences, facts, circumstances, incidents, situations, act, error, omission or records request from a patient or their attorney which may result in a claim or suit? **If yes, please complete the Kinsale Health Care Claim Supplemental.** Yes ☐ No ☐

64) If your Professional Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

65) If your Commercial General Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **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.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: 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.

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NOTICE TO KENTUCKY APPLICANTS: 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 LOUISIANA 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 MAINE 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 may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: 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.

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

NOTICE TO 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 a 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 civil penalties.

NOTICE TO TENNESSEE 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 VIRGINIA 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____

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