



**HUDSON SPECIALTY INSURANCE COMPANY**  
**Small Group and Individual Physician Application**  
 for surplus lines coverage

**ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.**

**-If a question does not apply to you, write "N/A". Please do not leave any questions unanswered**

**-Include a copy of the following: 1. CV 2. Letterhead 3. State & DEA License**

**4. Current Declarations Page 5. Currently valued insurance company generated Loss Runs.**

**BROKER** \_\_\_\_\_

**PERSONAL DATA**

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **Title** \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Clinic name/Employer: \_\_\_\_\_

Office address: \_\_\_\_\_ Office telephone: ( ) \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ County \_\_\_\_\_

Number of years at current office location: \_\_\_\_\_ % of practice at this location: \_\_\_\_\_

List all other office locations where you will practice your profession:

Address: \_\_\_\_\_ City/State/County: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/County: \_\_\_\_\_

Residence address: \_\_\_\_\_ City/State/County: \_\_\_\_\_

Residence telephone: ( ) \_\_\_\_\_

**INSURANCE COVERAGE REQUEST**

Requested effective date: \_\_\_\_\_ Prior Acts Date (Retroactive Date) \_\_\_\_\_

Requested limits of liability (per claim/aggregate):

\$1,000,000/\$3,000,000  Other: \$ \_\_\_\_\_

Deductible (per claim/aggregate):

None  \$10,000 /\$30,000  \$25,000 /\$75,000  Other:\$ \_\_\_\_\_

**MEDICAL SPECIALTY**

Current Medical Specialty: \_\_\_\_\_ % of practice \_\_\_\_\_

Surgery  Minor Surgery  No Surgery

Sub Specialty: \_\_\_\_\_ % of practice \_\_\_\_\_

Surgery  Minor Surgery  No Surgery

**MEDICAL TRAINING AND HISTORY**

1. Medical school name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Country \_\_\_\_\_ Year graduated: \_\_\_\_\_

2. If you are a graduate of a foreign medical school:

Are you certified by the Education Council for Foreign Medical Graduates?  Yes  No

Have you passed the United States Medical License Exam (USMLE)?  Yes  No

3. **Residency (1)** (Name of institution): \_\_\_\_\_ City/State: \_\_\_\_\_  
 From: \_\_\_\_\_ To: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Residency completed?  Yes  No  
 If "No", explain: \_\_\_\_\_
- Residency (2)** (Name of institution): \_\_\_\_\_ City/State: \_\_\_\_\_  
 From: \_\_\_\_\_ To: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Residency completed?  Yes  No  
 If "No", explain: \_\_\_\_\_
4. **Fellowship** (Name of institution): \_\_\_\_\_ City/State: \_\_\_\_\_  
 From: \_\_\_\_\_ To: \_\_\_\_\_ Specialty: \_\_\_\_\_ Fellowship completed?  Yes  No  
 If "No", explain: \_\_\_\_\_
5. Medical License #: \_\_\_\_\_ State: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Status: \_\_\_\_\_  
 Medical License #: \_\_\_\_\_ State: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Status: \_\_\_\_\_  
 Medical License #: \_\_\_\_\_ State: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Status: \_\_\_\_\_
6. Narcotics/DEA license #: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Status: \_\_\_\_\_

### **BOARD CERTIFICATION**

1. Are you Board Certified?  Yes  No  
 Board name: \_\_\_\_\_  
 Date Certified \_\_\_\_\_ Expiration Date \_\_\_\_\_  
 Board name: \_\_\_\_\_  
 Date certified: \_\_\_\_\_ Expiration Date \_\_\_\_\_
2. If you are not Board certified, are you eligible to take the boards in your specialty?  Yes  No  
 Do you plan to take the Board exam (both written and oral exams)?  Yes  No  
 When do you plan to take the Board exam? \_\_\_\_\_
3. Have you ever been denied Board certification or recertification or have you allowed your certification to lapse? If "Yes", state reason: \_\_\_\_\_  Yes  No

### **PRACTICE INFORMATION**

1. Do you have hospital privileges?  Yes  No Type of privileges
- |                          |                                   |                                     |
|--------------------------|-----------------------------------|-------------------------------------|
| Hospital name: _____     | <input type="checkbox"/> Full     | <input type="checkbox"/> Restricted |
| City/State/County: _____ | <input type="checkbox"/> Courtesy | <input type="checkbox"/> Other      |
| Hospital name: _____     | <input type="checkbox"/> Full     | <input type="checkbox"/> Restricted |
| City/State/County: _____ | <input type="checkbox"/> Courtesy | <input type="checkbox"/> Other      |
| Hospital name: _____     | <input type="checkbox"/> Full     | <input type="checkbox"/> Restricted |
| City/State/County: _____ | <input type="checkbox"/> Courtesy | <input type="checkbox"/> Other      |
2. Average/estimated # of hours worked per week: \_\_\_\_\_ Average/estimated # of patient visits per week: \_\_\_\_\_  
**(If you have answered "No", "Restricted" or "Other" to question #1, explain on your letterhead.)**

3. Type of Practice (check all that apply):

- Individual / Solo corporation – Name of corporation: \_\_\_\_\_
- Partnership – Name of partnership: \_\_\_\_\_
- Employed doctor – Name of employer: \_\_\_\_\_
- Independent contractor – Name of physician, partnership or corporation with whom you contract: \_\_\_\_\_

4. Indicate extent of professional relationship between the physician members (check all that apply):

- Common letterhead
- See each other's patients on a regular basis
- Share overhead expenses
- Common billing statements (as opposed to utilizing the same billing service)
- Share professional employees (e.g., R.N., Technician)
- All physicians' names appear together on the office door
- Other (describe) \_\_\_\_\_

5. Do you request coverage for your corporation?  Yes  No

6. Do you, your partnership or corporation, employ any of the following non-physician providers? If yes, please complete the information below. Indicate the number of each type of professional employed or contracted by the physician. Use a separate sheet, if necessary:

Number of Professional Employees			Number of Other Healthcare Employees		
	Employees	Independent Contractors		Employees	Independent Contractors
*Physician/Dentist			Marriage, Family & Child Counselor		
*Resident			Nurse		
*Nurse Anesthetist			Optometrist		
*Nurse Midwife			Perfusionist		
*Nurse Practitioner			Physical Therapist		
*Physician Assistant			Athletic Trainer		
*Podiatrist			Chiropractor		
*Psychologist			Licensed Clinical Social Worker		
Other			Other		

(\* Complete a Small Group and Individual Physician Application for each Professional Employee)

7. Have there been any changes in your specialty, classification or practice activity within the last 5 years?  Yes  No

If "Yes", explain: \_\_\_\_\_

8. Does your current practice involve the treatment of nursing home residents?  Yes  No

If "Yes", what percentage of your practice involves treatment of nursing home residents? \_\_\_\_\_ %

9. Does your current practice involve the treatment of prison inmates?  Yes  No

If "Yes", what percentage of your practice involves treatment of prison inmates? \_\_\_\_\_ %

10. Do you have a faculty appointment?  Yes  No If "Yes", provide name of insurance carrier for the educational program \_\_\_\_\_.

11. Does your current practice involve working in an Emergency Department?  Yes  No

If "Yes", how many hours each week do you work in an Emergency Department? \_\_\_\_\_ hours/week

12. Do you perform or assist in any surgical procedure in a non-hospital setting, other than an Ambulatory Surgery Center, during which any anesthesia is administered?  Yes  No If yes, please explain \_\_\_\_\_

13. Are you employed or contracted to any facility as the medical director?  Yes  No If "Yes", provide name of insurance Carrier \_\_\_\_\_.

14. Do you have any medical related duties or practice activities that are insured elsewhere or for which you do not desire coverage?

Yes  No If yes, please explain \_\_\_\_\_

## MEDICAL PROCEDURES

Check all procedures that you perform. If you do not perform any of the procedures listed below, check here

Office	Hospital	Other	Procedure
			<b>Abortion</b> (Do you perform elective abortions?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which trimester _____ # per year _____
			<b>Acupuncture</b>
			<b>Amniocentesis</b>
			<b>Angiography / Arteriography</b> <input type="checkbox"/> cardiac <input type="checkbox"/> peripheral
			<b>Angioplasty</b> <input type="checkbox"/> cardiac <input type="checkbox"/> peripheral
			<b>Appendectomy</b>
			<b>Arterial/Venous Line Placement</b>
			<b>Arthroscopic procedures *</b>
			<b>Bariatric Surgery *</b> (annual # performed _____) specific type _____
			<b>Blepharoplasty</b>
			<b>Botox injections</b> <input type="checkbox"/> cosmetic / <input type="checkbox"/> medically indicated
			<b>Breast Surgery</b> (Do you perform implants?) <input type="checkbox"/> Yes <input type="checkbox"/> No # per year _____
			<b>Bronchoscopy</b>
			<b>Cardiac Catheterization</b>
			<b>Chelation Therapy</b> <input type="checkbox"/> Lead Removal <input type="checkbox"/> Arteriosclerotic Heart Disease
			<b>Colonoscopy</b> <input type="checkbox"/> with anesthesia <input type="checkbox"/> without anesthesia
			<b>Cosmetic Plastic Surgery *</b> <input type="checkbox"/> <b>Reconstructive Plastic Surgery</b> <input type="checkbox"/>
			<b>Dermabrasion *</b> (indicate % of time devoted to this procedure) _____ %
			<b>Dilatation &amp; Curettage (D&amp;Cs)</b>
			<b>Electroconvulsive Therapy</b>
			<b>ERCP (Endoscopic Retrograde Cholangiopancreatography)</b>
			<b>EVLV * (Endovenous Laser Treatment)</b> <input type="checkbox"/> Sclerotherapy * <input type="checkbox"/> Vein Stripping
			<b>GI Endoscopy</b> <input type="checkbox"/> with anesthesia <input type="checkbox"/> without anesthesia
			<b>Hair Transplants * / Scalp excision/ Transplantations</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Plug technique/Mini graphs <input type="checkbox"/> Yes <input type="checkbox"/> No
			<b>Hemodialysis</b>
			<b>Kyphoplasty</b> <input type="checkbox"/> <b>Vertebroplasty *</b> <input type="checkbox"/>
			<b>Laparoscopic procedure(s)</b> <input type="checkbox"/> diagnostic <input type="checkbox"/> therapeutic
			<b>Liposuction *</b> (indicate % of time devoted to this procedure) _____ %
			<b>Lithotripsy</b>
			<b>Lumbar Puncture</b> <input type="checkbox"/> <b>Myelography</b> <input type="checkbox"/>
			<b>Lymphangiography</b>
			<b>Needle Biopsy</b> (including lung, prostate, liver & kidney)
			<b>Obstetrical deliveries</b> (enter # per year for each) C-Sections _____ Vaginal _____ VBAC _____
			<b>Occipital Nerve Blocks</b>
			<b>Pacemaker Insertions</b> (annual # performed permanent / temporary ____/____)
			<b>Phenol Facial Peels *</b>
			<b>Professional Sports Medicine</b>
			<b>Sex Change Operations</b>
			<b>Spinal Surgery</b>
			<b>Swan-Ganz Catheterization</b> (annual # performed _____)
			<b>Tubal Ligations</b>
			<b>Vision Correction Surgery</b> - type(s) performed: _____
			<b>Weight Reduction</b> (annual # performed _____) Do you prescribe any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____

\* Attach summary of training for this (these) procedure(s).

**SURGERY RATING INFORMATION** (these definitions are not all inclusive)

**No Surgery** -Includes normal office procedures as commonly found in a family practice. Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered “No Surgery”. This includes administration of local or topical anesthesia and circumcision. No invasive procedures or special procedures room activities are done.

**Minor Surgery** – Includes all listed in definition of “No Surgery”, as well as assisting in major surgery, D&C, and vasectomies. Invasive procedures are done, but the procedures do not open or enter a major body cavity.

**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, removal of tumors, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation done using general anesthesia, and the administration of anesthesia other than local or topical.

**INSURANCE HISTORY**

1. Current carrier name: \_\_\_\_\_  Claims Made  Occurrence  
Effective date: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Prior Acts Date: \_\_\_\_\_  
Limits of liability: \_\_\_\_\_ Per claim \_\_\_\_\_ Aggregate  
 Deductible  SIR \$: \_\_\_\_\_ Per claim \_\_\_\_\_ Aggregate  
Annual premium: \_\_\_\_\_

First prior carrier name: \_\_\_\_\_  Claims Made  Occurrence  
Effective date: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Prior Acts Date: \_\_\_\_\_  
Limits of liability: \_\_\_\_\_ Per claim \_\_\_\_\_ Aggregate  
 Deductible  SIR \$: \_\_\_\_\_ Per claim \_\_\_\_\_ Aggregate

Second prior carrier name: \_\_\_\_\_  Claims Made  Occurrence  
Effective date: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Prior Acts Date: \_\_\_\_\_  
Limits of liability: \_\_\_\_\_ Per claim \_\_\_\_\_ Aggregate  
 Deductible  SIR \$: \_\_\_\_\_ Per claim \_\_\_\_\_ Aggregate

2. If you are currently insured on a claims made policy, are you obtaining Extended Reporting Period (tail) Coverage from your current insurance carrier?  Yes  No

**Note: To prevent possible gaps in your Claims Made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.**

3. Where have you practiced your profession since completion of your formal training? (include military or any public service organization) **Account for all time since medical school. Explain any gaps in your education or professional practice history. If your attached CV provides the same information, go on to the next question.**

City/State: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Solo practitioner  Part of a group Group name: \_\_\_\_\_  
City/State: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Solo practitioner  Part of a group Group name: \_\_\_\_\_  
City/State: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 Solo practitioner  Part of a group Group name: \_\_\_\_\_

## UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

**Within the past 10 years:**

1. Are you being investigated or have you been convicted of a misdemeanor (other than traffic related) or felony or is any such charge pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever resigned from a health care facility while under investigation or to avoid possible disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any hospital as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have Medicare or Medicaid authorities ever investigated or brought charges against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you provided any professional services without professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever treated any patients by means of unconventional therapeutics, or utilized FDA experimental drugs other than through Institutional Review Board (IRB) approved research programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Does your practice include telemedicine or teleradiology?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## CLAIMS INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

**Within the past 10 years:**

1. Have you been involved in a malpractice claim, lawsuit, incident or occurrence in the last 10 years? If "Yes", how many? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you aware of any circumstances that may result in a malpractice claim or suit being made or being brought against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you aware of any outstanding incidents, claims, or suits (even if you believe the outstanding claim or suit would be without merit) that have <u>not</u> been reported to your current or prior professional liability carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been contacted by a plaintiff's attorney or required to produce medical records or statements regarding any case you have been involved with, regardless of whether you have been specifically named in the suit or claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**COMMENTS**

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**AUTHORIZATION**

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application shall be the basis of the contract should a policy be issued. I agree to notify the Company of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to the following:

- A. A change in specialty or medical procedures performed;
- B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
- C. Investigation, restriction, suspension or surrender of any state medical, DEA license or hospital privileges;
- D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing.
- E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

For FL, KY, MN, NJ, OH and PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person who 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. For NY residents only: And shall also be subject to a civil penalty not to exceed five thousand (\$5,000) dollars and the stated value of the claim for each such violation.

*This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company.*

\_\_\_\_\_  
Signature in full

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

HUDSON SPECIALTY INSURANCE COMPANY

Supplement Claim Information Form

(make copies of this page as needed)

1. Name of patient: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

2. Describe the allegation made by claimant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Date claim was made or filed: \_\_\_\_\_

4. Date of alleged incident: \_\_\_\_\_

5. Insurance company: \_\_\_\_\_

6. Additional defendants: \_\_\_\_\_

7. Disposition of claim:  Open  Closed

If open: Claimant's settlement demand: \$ \_\_\_\_\_  
Defendant's offer for settlement: \$ \_\_\_\_\_  
Insurer's loss reserve: \$ \_\_\_\_\_  
Deductible amount: \$ \_\_\_\_\_  
Is claim in suit?  Yes  No If "Yes", amount asked in summons: \$ \_\_\_\_\_

If closed: Date closed: \_\_\_\_\_  
 Court judgment  Out of court settlement  Dismissed with prejudice  Dismissed without prejudice  
Total indemnity paid (including deductible): \$ \_\_\_\_\_  
Total defense costs/ expenses paid \$ \_\_\_\_\_  
**Total costs incurred \$ \_\_\_\_\_**

Provide complete and detailed information for evaluation. Use reverse side or additional sheets if required.

8. Condition and diagnosis at time of incident (include dates of visits)  
\_\_\_\_\_  
\_\_\_\_\_

9. Description of treatment rendered (include dates of visits)  
\_\_\_\_\_  
\_\_\_\_\_

10. Condition of patient subsequent to treatment (include dates of follow-up treatment)  
\_\_\_\_\_  
\_\_\_\_\_

Signature of applicant \_\_\_\_\_

Date \_\_\_\_\_

# HUDSON SPECIALTY INSURANCE COMPANY

## A. GENERAL FRAUD STATEMENT

(Not applicable in Colorado, Ohio, Oklahoma and Utah)

Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and (NY: substantial) civil penalties.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## B. FRAUD STATEMENT(S)

### UTAH FRAUD STATEMENT

(Workers' Compensation)

**For your protection, Utah law requires the following to be included in this application:**

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

### OKLAHOMA FRAUD STATEMENT

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.

### OHIO FRAUD STATEMENT

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.

### COLORADO APPLICATION SUPPLEMENT

**This Notice is a part of your application for:**

- |   |  |
|---|--|
| <input type="checkbox"/> HOMEOWNERS INSURANCE             | <input type="checkbox"/> COMMERCIAL INSURANCE        |
| <input type="checkbox"/> PERSONAL LINES PACKAGE INSURANCE | <input type="checkbox"/> PERSONAL UMBRELLA INSURANCE |
| <input type="checkbox"/> PERSONAL INLAND MARINE INSURANCE | <input type="checkbox"/> DWELLING INSURANCE          |
| <input type="checkbox"/> PERSONAL AUTO INSURANCE          | <input type="checkbox"/> AGRICULTURE INSURANCE       |
| <input type="checkbox"/> WATERCRAFT INSURANCE             | <input type="checkbox"/> MOBILE HOME INSURANCE       |

### FRAUD WARNING

**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.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name