



FOR OFFICE USE ONLY

PREMIUM:
RATED BY:
EFFECTIVE DATE:
RETRO DATE:
REFUND AMOUNT DUE:

Allied World Insurance Company (“Insurer”)

**Return and make checks payable to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694**

**APPLICATION FOR OCCURRENCE-BASED NURSE PRACTITIONER PROFESSIONAL
AND BUSINESS LIABILITY INSURANCE COVERAGE - KANSAS**

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants:
License # L045052 issued to Peter Imbert

Notice to Iowa Applicants:
License # 3000928232 issued to Peter Imbert

Notice to California Applicants:
License # 0555091 issued to Peter Imbert

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION V. (C). “MAXIMUM LIMIT OF LIABILITY - SEXUAL MISCONDUCT” IN THE POLICY).

- This Application must be completed in full, including all required attachments. Write “None” if that applies.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant’s needs.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. a. Name of Applicant _____ License No.: _____

Date of Birth: _____

Phone No.: () _____ E-mail address: _____

b. Professional Designation (check one): Nurse Practitioner
 Other _____

c. Coverage desired (check one):

Individual Partnership Professional Corporation (Incorporated as a P.C. or P.A.) LLC/LLP
 General Business Corporation Profit Nonprofit Other (Please explain) _____

(If you are unsure of your corporate status, please check your Articles of Incorporation or other business documents.)

**If you have checked anything other than “Individual” in response to 1 c., the following MUST BE INCLUDED:
(1) a copy of articles of incorporation; (2) a letter describing all services provided; (3) any brochures if available; and (4) a listing of owners and/or partners, indicating the percentage of the business owned by each.**

II. APPLICANT INFORMATION

2. a. Principal Office Address: _____

(City) (County) (State) (Zip)
Entity and/or Facility Name: _____

b. Any Other Office Address: _____

(City) (County) (State) (Zip)
Entity and/or Facility Name: _____

c. Home Address: _____

(City) (County) (State) (Zip)

3. To which of these addresses do you wish correspondence sent? 2a 2b 2c

4. Office Telephone: () _____ Home Telephone: () _____

5. a. Professional Liability Limits Requested? (CHECK ONE OPTION):

\$1,000,000/\$1,000,000 \$1,000,000/\$3,000,000 \$1,000,000/\$6,000,000 Other _____ / _____

b. Effective date requested: _____

c. Would you like to add comprehensive cyber coverage, with base limits of \$100,000?* Yes No
(No additional application is required; higher limits may be available and require separate underwriting.)

d. For group policies only:

1. Are you interested in separate limits for each named insured?* Yes No
2. Are you interested in adding Medical Director Coverage?* Yes No

e. Are you interested in obtaining General Liability limits?*" Yes No

If yes, please limits requested: \$ _____ / \$ _____

If you are adding general liability coverage, please indicate the location (s) where coverage is requested:

f. Are you interested in obtaining limits higher than \$25,000 for defense expenses related to licensing board investigations and other proceedings as described in the Policy? Yes No

If yes, choose higher limit of liability desired for defense expenses related to licensing board investigations and other proceedings as described in the Policy:

\$50,000 (Add. Prem. \$110) \$75,000 (Add. Prem. \$171) \$100,000 (Add. Prem.\$232)
 \$125,000 (Add. Prem. \$293) \$150,000 (Add. Prem. \$354)

*Additional premium will be required. Please contact our office for total premium due.

III. PRACTICE INFORMATION

6. List your name and qualifications. For group practices please provide name and qualifications of all salaried (W2) employees, except clerical. If you require additional space, please attach a separate sheet with the additional information.

Name	Degree	Field of Study	Employment Status W-2, 1099, etc.	Hours Worked Per Week	License or Certification			
					First Year Licensed	State	Board Certified?	Title

b. Please attach a copy of a Curriculum Vitae (C.V.) for each of the above-listed practitioners.

7. Practice Area: (Please select all that apply)

- RN/ NP Student
- OB/GYN, OB/GYN Acute Critical Care Advanced Practice Nurse
- Psychiatric / Mental Health Advanced Practice Nurse
- Pediatric / Family Acute Critical Care (No OB/GYN)
- Community Health / Maternal & Child
- Medical-Surgical
- Neonatology
- School Advanced Practical Nurse
- Neurology
- Cosmetic Procedures
- Doula
- Other _____

8. Current active member of any professional association? If yes, please list association(s): _____

IV. PRACTICE CHARACTERISTICS

9. a. Are you engaged in (check all that apply):

- Self-Employment Paid Consultation (1099 form) Volunteer Work

b. Are you employed (W-2 form employee)?

Yes No

If yes, employed by: _____

c. Do you own, partly own, manage or exercise any form of fiduciary control over any business enterprise or medical

practice?

Yes No

If yes,

i. Please explain the nature of the enterprise: _____

ii. Please provide a count of employees by type: _____

10. a. Are you self-employed? Yes No If No, please answer questions 10. b-h

b. Name of physician, hospital, clinic or practice you will be working for: _____

c. Insurance carrier/limits: _____ Name of supervising physician: _____

d. Clinical specialty area of your supervising physician: _____

e. Will you be working at the same location as your supervising physician? Yes No

If no, where will you be working? _____

f. Do you have a written collaboration agreement with your supervising physician? Yes No

g. How often will your charts be reviewed? _____

h. Do you have written practice protocols? Yes No

If you are both self-employed and a W-2 employee, and wish to apply for part-time self-employed coverage, a separate statement indicating that you are fully insured by your employer at your W-2 employment must be submitted.

I understand that if I apply and qualify for the exclusively employed rate, the policy will exclude coverage for private practice, self-employment, consulting, volunteering outside of the course and scope of my employment.

11. Do you have medical diagnostic and prescriptive authority? Yes No

If yes to prescriptive authority, what Schedule? _____

If no, please provide the name and clinical specialty of the physician who will write prescriptions:

12. Do you use any Independent Contractors or Consultants (1099 form) whose services are in the healthcare field and who you do billing for, share fees with or in any way derive income from the relationship? Yes No

If yes, please list the name and professional credentials of each one.

All Independent Contractors or Consultants (1099 form) must be listed. You will be covered for their acts subject to the terms of the policy, but the Independent Contractor or Consultants listed will not be insureds under the policy.

Name of Independent	Degree	Field of Study	License or Certification
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Name of Independent Contractor or Consultant	Degree	Field of Study	License or Certification	
			State	Title

If additional space is required, please use a separate sheet of paper to submit a complete listing.

13. Has any person or entity, based on a contractual obligation, requested that they be added to your policy as an Additional Insured? Yes No

If yes, name of the proposed Additional Insured: _____
 Address of proposed Additional Insured: _____

a. The Additional Insured is my:
 Employer Landlord Professional Corporation Other (Specify): _____

b. The Additional Insured gives me the following form to file with the IRS:
 W-2 form 1099 form Other (Specify): _____

c. Describe the relationship between you and the proposed Additional Insured: _____

14. a. Are you on the staff of, or affiliated with, any hospital, clinic, group home or nursing home? Yes No
 If yes, please list institution, nature of work and hours per week. _____

b. Are you provided malpractice coverage by a facility or place of employment, or any other policy that covers you? Yes No
 If yes, please indicate location of the facility or place of employment and limits provided. _____

c. Do you have any direct or indirect financial interest in any hospital, pharmacy, diagnostic or therapeutic laboratory, nursing home, health service or any healthcare service to which you refer your patients? Yes No
 If yes, please specify and fully explain. _____

V. PRACTICE PROFILE

15. Please answer the following questions regarding your practice:

a. Do you have admitting privileges? Yes No

If no, please describe your mechanism for handling your patients who may require immediate in-patient care:

b. Average number of patients seen on an annual basis: _____

c. Who creates and updates medical records for each patient you see in the practice? _____

d. What medical record system is used in your practice? _____

e. Do you obtain an informed consent, whether signed by the patient or noted in the chart, before prescribing

medication?

Yes No

f. Do you cover any ER for crisis cover?

Yes No

If yes, please indicate percentage of time devoted to this activity: _____%

Is this on call?

Yes No

If yes, approximately how many hours per week? _____

16. Does your practice include telemedicine activities, e.g. the transfer of data through electronic (video or computer) means to provide healthcare to patients who are geographically separated from the clinicians involved?

Yes No

a. What is the total practice time devoted to this activity? _____%

b. Is the system used to provide these activities encrypted and HIPAA compliant?

Yes No

17. Do you engage in any clinical trials and/or pharmaceutical research?

Yes No

If yes, does the sponsor agree in writing to indemnify you for such research activities?

Yes No

(Please include a copy of these indemnification agreements)

If no, please explain type and extent of such activities: _____

VI. PRIOR COVERAGE HISTORY

18. Do you currently carry your own separate, professional liability policy?

Yes No

If yes, please include a copy of that Declarations page with the completed application form.

Name of present carrier: _____ Number of years: _____

If less than 5 years, please list previous carrier as well: _____

a. Type of policy (if known): Occurrence Claims-made

b. Limits of present coverage: _____ / _____ Deductible Amount: _____

c. If prior professional liability insurance was on a claims-made basis, indicate the retroactive date of the coverage: (Date after which wrongful acts are covered.) ___ / ___ / ____

d. If you selected Claims-made in Question 18., please check the appropriate box below:

i. The Extended Reporting Period Endorsement has been purchased on my prior policy. Yes No

ii. Prior Acts Coverage is requested on my Occurrence Policy Yes No

If yes, please indicate Retroactive Date desired: ___ / ___ / ____

(Please submit Declarations page for all individuals listed in Question 6.)

If you answered "No" to both Questions 18 (d)(i) and 18.(d) (ii), please review the statement and check the box below:

I understand that I elected not to purchase the Extended Reporting Period Endorsement on my prior Claims-Made policy, and I also have elected not to purchase the Prior acts Coverage on my new Occurrence policy.

I understand that I will be uninsured for the period in which my prior Claims-Made policy existed. Furthermore, I understand that because of this, there will be a gap in my insurance coverage.

VII. REPRESENTATIONS

19. a. Have you ever been convicted of a crime in any state or country or are you currently under indictment or under investigation for any crime? Yes No

If yes, please give full particulars in order for your Application to be considered. _____

- b. Have you ever had any licensing board or professional ethics body investigate you/your practice or enter a finding, formal or informal, of a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? Yes No

If yes, please give full particulars and provide copies of charges, correspondence and any findings in order for your Application to be considered. _____

- c. Have you been contacted in the last year by any licensing board or professional ethics body or are there any inquiries, complaints, charges or investigations, formal or informal, pending against you by a licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence, or negligence in any state or country? Yes No

In the past year have you been contacted by any representative for one of the above organizations related to your conduct? Yes No

If yes, please give full particulars and copies of charges, correspondence, and any findings in order for your Application to be considered. _____

- d. Have you ever had any insurance company or Lloyd's decline, cancel, refuse to renew, or accept only on special terms any professional liability insurance? Yes No

NOTE: MISSOURI APPLICANTS DO NOT RESPOND TO QUESTION 19 d.

If yes, please give full particulars in order for your Application to be considered. _____

- e. Has any professional liability claim or suit ever been made against you? Yes No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your Application to be considered. _____

- f. Are there any circumstances which you are aware of that may result in any professional liability claim or suit being made against you? This would include any loss of private or confidential information or unauthorized

dissemination of same.

Yes No

If yes, please give full particulars in order for your Application to be considered. _____

- g. Have you engaged in or ever been engaged in any sexual misconduct* with any of your current or former patients, or any current or former patient’s spouse or any person with a direct relationship to the current or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient’s domicile)?

Yes No

(*“Sexual misconduct” means any actual or alleged erotic physical contact or attempt, threat or proposal thereof, whether electronically or in person.)

If yes, please give full particulars in order for your Application to be considered. _____

- h. Have you ever had any hospital restrict or revoke privileges or invoke probation for any cause? Yes No

If yes, please give full particulars in order for your Application to be considered. _____

- i. Have you ever been suspended, restricted, or put on probation by any governmental health program (i.e. Medicare or Medicaid)? Yes No

If yes, please give full particulars in order for your Application to be considered. _____

- j. Are you now being, or have you ever been, treated for a serious health problem that did or can impair your ability to treat patients? Yes No

If yes, please give full particulars in order for your Application to be considered. _____

VIII. NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the “Application”) are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with

the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO ALABAMA 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 RESTITUTION, FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

NOTICE TO ARKANSAS 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 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 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."

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 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 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."

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 A DENIAL OF INSURANCE BENEFITS."

NOTICE TO MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY 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 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 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.”

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 OKLAHOMA APPLICANTS: “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 (365:15-1-10, 36 §3613.1).”

NOTICE TO OREGON APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.”

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 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 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 OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.”

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 TEXAS APPLICANTS: “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.”

NOTICE TO VERMONT APPLICANTS: “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.”

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.”

NOTICE TO 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 WEST VIRGINIA: “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 ALL OTHER 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 A DENIAL OF INSURANCE BENEFITS.”

IX. DECLARATION AND SIGNATURE

I understand that it is my obligation to maintain any license required in the jurisdictions in which I practice.

Date: _____ Signature: _____
(This application must be dated within 30 days of receipt) (APPLICANT / OWNER / PRESIDENT OF CORPORATION)

Title: _____

Application must be signed, dated, fully completed and accompanied by the premium to be considered.

Please make checks payable and mail to: American Professional Agency, Inc.

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694
www.americanprofessional.com

Save form first on your computer before emailing.

Producer Signature: