HOME MEDICAL EQUIPMENT DEALER INSURANCE SURVEY

McNeil & Company, Inc.
P.O. Box 5670
Cortland, NY 13045
Phone (800) 822-3747
Fax (607) 756-5051

General Information

Date of survey: _____ Insurance Renewal Date: _____

Legal Name of Organization: _____
(please include all organizations that are to be included as insureds)

_____ FEIN: _____

Mailing Address: _____

_____ County: _____

Telephone: _____ Fax: _____

Contact Name: _____ Contact Title: _____

Website Address: _____ E-Mail Address: _____

Business Information

Description of organization: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other _____

Years in business _____ Years experience _____

Is this a new venture? ☐ Yes ☐ No

If in Business for less than 3 years, please attach resume and summary of experience of Manager.

Is your business a subsidiary or division of another company? ☐ Yes ☐ No

If yes, please provide the name of the company, the address and relationship: _____

_____

Has your business had any changes in ownership over the past 3 years? ☐ Yes ☐ No

If so please provide details: _____

_____

Has any insurance carrier cancelled, declined or refused to renew any insurance within the past 3 years? ☐ Yes ☐ No

If yes, please provide dates, coverage and explanation: _____

_____

Insurance Agent Information

Agent's Name: _____

Name of Agency: _____

Address: _____

Agency telephone: _____ Agency fax: _____

Date proposal is needed: _____ Agency e-mail address: _____

Do you currently write this account? ☐ Yes ☐ No

If Yes, for how long? _____ With what Carrier? _____

Is the account Sub-Brokered? ☐ Yes ☐ No

If Yes, please indicate Agency Name: _____

Property and Location Information

PROVIDE THE INFORMATION BELOW OR ATTACH AN ACORD PROPERTY APPLICATION

Loc. No.	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Co-insurance %

Construction Type	Occupancy Type		Year Built	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-wood frame ☐ Type 2-masonry wood-joisted ☐ Type 3-metal non-combustible ☐ Type 4-masonry non-combustible ☐ Type 5-modified fire resistive ☐ Type 6-heavy fire resistive	☐ Retail ☐ Office ☐ Warehouse ☐ Other (describe) ____________	☐ Own ☐ Lease	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No

Loc. No.	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Co-insurance %

Construction Type	Occupancy Type		Year Built	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-wood frame ☐ Type 2-masonry wood-joisted ☐ Type 3-metal non-combustible ☐ Type 4-masonry non-combustible ☐ Type 5-modified fire resistive ☐ Type 6-heavy fire resistive	☐ Retail ☐ Office ☐ Warehouse ☐ Other (describe) ____________	☐ Own ☐ Lease	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No

Loc. No.	Address	Limit of Insurance Building	Limit of Insurance Personal Property	Co-insurance %

Construction Type	Occupancy Type		Year Built	Building Square Footage	Square Footage You Occupy	Burglar Alarm	Sprinkler System
☐ Type 1-wood frame ☐ Type 2-masonry wood-joisted ☐ Type 3-metal non-combustible ☐ Type 4-masonry non-combustible ☐ Type 5-modified fire resistive ☐ Type 6-heavy fire resistive	☐ Retail ☐ Office ☐ Warehouse ☐ Other (describe) ____________	☐ Own ☐ Lease	________	________	________	☐ Yes ☐ No	☐ Yes ☐ No

☐ Please indicate if Blanket Coverage is desired

Indicate the desired property deductible: ☐ $500 ☐ $1000 ☐ $2500 ☐ $5000 ☐ Other ____________

List the names and addresses of any Mortgagees or Loss Payees for any location ____

____

____

Property and Location Information (continued)

The following coverages are provided by the Property Coverage Extensions endorsement:

- Business Income and Extra Expense for 12 months
- Building Ordinance and Law Coverage
- Property of Others
- Back-Up of Sewers and Drains
- $500,000 Newly Acquired Property
- $ 25,000 Computer Equipment
- $ 25,000 Software and Valuable Papers
- $ 25,000 Property In Transit
- $ 10,000 Uncollected Funds
- Single Occurrence Deductible
- Debris Removal
- Outdoor Sign Coverage
- $25,000 Outdoor Property
- $10,000 Fire Department Service Charge
- $10,000 Fire Extinguishing Equipment Recharge
- $10,000 Crime Reward
- $ 5,000 Property Off-Premises
- $ 2,500 Money and Securities

CGL Limits of Insurance

Each Occurrence/General Aggregate ☐ $500,000/$500,000 ☐ $500,000/$1 million ☐ $1 million/$1 million ☐ $1 million/$2 million ☐ $1 million/$3 million

Medical Expense $5,000

Damage To Rented Premises ☐ $100,000 ☐ Other _____

Certificates of Insurance & Additional Insureds

List any entities that need Certificates of Insurance or Additional Insured endorsements for liability coverage.
For Additional Insureds, describe their interest in your business.

Loc. No.	Name & Address	Certificate of Insurance	Additional Insured
		☐	☐
Describe Interest			
		☐	☐
Describe Interest			
		☐	☐
Describe Interest			

Medical Equipment Services & Receipts

Total estimated receipts for the next 12 months $_____

Percent (%) of above receipts for the following services:	HOME USE	HOSPITAL USE	RECEIPTS NON-DISPOSABLE ITEMS	RECEIPTS DISPOSABLE ITEMS
Rental Receipts	☐ Yes ☐ No	☐ Yes ☐ No	%	
Sales-Retail	☐ Yes ☐ No	☐ Yes ☐ No	%	%
Sales-Distributor/Wholesale	☐ Yes ☐ No	☐ Yes ☐ No	%	%
Sales-Drug Store Pharmaceutical	☐ Yes ☐ No	☐ Yes ☐ No	%	%
Sales-Medical Gases (high pressure or liquefied)	☐ Yes ☐ No	☐ Yes ☐ No		%
Other (describe):	☐ Yes ☐ No	☐ Yes ☐ No	%	%
Equipment Repair Receipts (other than your equipment)	☐ Yes ☐ No	☐ Yes ☐ No	% Parts	% Labor

Product Information

Description	Do you carry this item?	Average # In Stock	Do you repair this item?
Apnea Monitors	☐ Yes ☐ No		☐ Yes ☐ No
Arterial Pressure Monitors (Invasive)	☐ Yes ☐ No		☐ Yes ☐ No
Arterial Pressure Monitors (Non-Invasive – i.e. Blood Pressure Cuffs)	☐ Yes ☐ No		☐ Yes ☐ No
Anesthesia Equipment	☐ Yes ☐ No		☐ Yes ☐ No
Blood Gas Analyzing Equipment	☐ Yes ☐ No		☐ Yes ☐ No
Cardiac Out-put Machine	☐ Yes ☐ No		☐ Yes ☐ No
Defibrillators	☐ Yes ☐ No		☐ Yes ☐ No
Intensive Care Incubators	☐ Yes ☐ No		☐ Yes ☐ No
Laser Equipment	☐ Yes ☐ No		☐ Yes ☐ No
Life Function Monitoring	☐ Yes ☐ No		☐ Yes ☐ No
Pacemakers	☐ Yes ☐ No		☐ Yes ☐ No
IPPB Machines	☐ Yes ☐ No		☐ Yes ☐ No
Resuscitators	☐ Yes ☐ No		☐ Yes ☐ No
Small Volume Nebulizers	☐ Yes ☐ No		☐ Yes ☐ No
Transcutaneous Nerve Stimulators (tens units)	☐ Yes ☐ No		☐ Yes ☐ No
X-Ray Equipment	☐ Yes ☐ No		☐ Yes ☐ No

Product Information (continued)

Description	Do you carry this item?	Average # In Stock	Do you repair this item?
Infusion Therapy Equipment			
Enteral	☐ Yes ☐ No		☐ Yes ☐ No
Parenteral	☐ Yes ☐ No		☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No		☐ Yes ☐ No
Antibiotic Therapy	☐ Yes ☐ No		☐ Yes ☐ No
Antibiotics for above	☐ Yes ☐ No		☐ Yes ☐ No
Foods for above	☐ Yes ☐ No		☐ Yes ☐ No
Disposal Tubing	☐ Yes ☐ No		☐ Yes ☐ No

Description	Do you carry this item?	Average # In Stock	Do you repair this item?
Oxygen Equipment			
Oxygen Cylinders	☐ Yes ☐ No		☐ Yes ☐ No
Oxygen Analyzers	☐ Yes ☐ No		☐ Yes ☐ No
If Yes, are these used only to check your own Oxygen concentrators?	☐ Yes ☐ No		
Oxygen Concentrators	☐ Yes ☐ No		☐ Yes ☐ No
Oxygen Control Valves and Regulators	☐ Yes ☐ No		☐ Yes ☐ No

Wheel Chairs	Do you carry this item?	Average # In Stock	Do you repair this item?	# Rented Per Year	Percentage of Total Receipts
Wheel Chairs	☐ Yes ☐ No		☐ Yes ☐ No		
What Repairs are performed?					

Vehicle Hand Controls	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	Do you install This item?
Vehicle Hand Controls	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Ventilators – Life Support	Do you carry this item?	Average # In Stock	Do you repair this item?	# Rented Per Year	Percentage of Total Receipts
Ventilators	☐ Yes ☐ No		☐ Yes ☐ No		

Do you instruct on the use of Ventilators? ☐ Yes ☐ No

If Yes, who is responsible? _____
What are their qualifications? _____
Years of experience: _____

Medical Gas Piping Systems	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Medical Gas Piping Systems	☐ Yes ☐ No		☐ Yes ☐ No		

Product Information (continued)

Lifts					
Description	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Stair Lift	☐ Yes ☐ No		☐ Yes ☐ No		
Vehicle Lift	☐ Yes ☐ No		☐ Yes ☐ No		
Please describe type of lift:					
Vertical Lift	☐ Yes ☐ No		☐ Yes ☐ No		
Elevator or Porch?	☐ Elevator ☐ Porch				

Grab Bars	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Grab Bars	☐ Yes ☐ No		☐ Yes ☐ No		
How do you attach the Grab Bars to the structure?					

Please provide details of all repairs and installation completed on the above Lifts / Grab Bars: _____

_____

_____

Do you use employees or independent contractors to perform the above services? ☐ Employees ☐ Independent Contractors

If Independent Contractors, please provide certificates of liability insurance.

Are Employees or Independent Contractors trained by the manufacturer? ☐ Yes ☐ No

If Yes, please provide copies of certificates.

If No, what are their qualifications? _____

_____

Average number of years experience: _____

Do you install or repair any other medical device used for therapy, support, or assistance that attaches to a vehicle, or to a wall, floor, or ceiling? ☐ Yes ☐ No

If Yes, please explain: _____

_____

Do you carry any other equipment not listed above? ☐ Yes ☐ No

If Yes, please provide types and numbers of each: _____

_____

Business Operations Information

Are you certified by the Joint Commission on Accreditation of Health Care Organizations (JCAHO)? ☐ Yes ☐ No

Do you import directly from any foreign manufacturers? ☐ Yes ☐ No

If yes, please provide certificates of insurance evidencing foreign manufacturer's products liability insurance.

In U.S. dollars, what is the limit of their products liability insurance? $ _____

Business Operations Information (continued)

Do you obtain certificates of insurance for products liability insurance from U.S. manufacturers of your products? ☐ Yes ☐ No

If yes, please provide copies of certificates.

If No, it is essential that you make every attempt to.

Are you a "Vendor" on the Products Liability Insurance carried by the U.S. manufacturers of your products? ☐ Yes ☐ No

If yes, please provide copies of certificates.

If No, it is essential that you make every attempt to.

Do you use a Rental Agreement when you provide equipment for your customers? ☐ Yes ☐ No

If yes, please attach a copy for review.

Do you use facilities other than manufacturers' authorized repair facilities for service or repair of equipment? ☐ Yes ☐ No

If yes, does the facility carry products/completed operations insurance coverage? ☐ Yes ☐ No

Are you an authorized repair facility for any manufacturer? ☐ Yes ☐ No

If yes, for what equipment? _____

_____

Do any of the modifications that you make to equipment void any manufacturers' warranties? ☐ Yes ☐ No

If yes, please explain: _____

Are any products of others sold, repackaged or assembled under your label? ☐ Yes ☐ No

If yes, please explain: _____

Has any court, governmental agency, association or ethic committee ever reprimanded or disciplined you? ☐ Yes ☐ No

If yes, please explain: _____

Compressed Medical Gases

Do you provide compressed medical gases to your customers? ☐ Yes ☐ No

If yes, what gases? _____

Are you registered with the Federal Food and Drug Administration? ☐ Yes ☐ No

Have you ever been cited or fined for non-compliance with the
Federal Food and Drug Administration Compressed Medical Gases Guidelines? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are your oxygen cylinders pre-filled, or are they filled by you on the premises? ☐ Pre-Filled ☐ Filled

How many oxygen cylinders are on premises at any one time? _____

Please list location(s) where oxygen cylinders are stored: _____

_____

Compressed Medical Gases (continued)

When setting up oxygen-related equipment do you:

- Check all equipment to insure proper working order prior to delivery? ☐ Yes ☐ No
- Instruct the patient and/or caregiver as to the safe handling of the units? ☐ Yes ☐ No
- Post "oxygen in use" signs in conspicuous places and warn patients and/or caregiver of the fire hazard? ☐ Yes ☐ No
- Have a check-off sheet indicating the information that was reviewed with the patient and/or caregiver? ☐ Yes ☐ No
- Perform repairs and calibrations per manufacturers' recommendations and at manufacturers' specified intervals? ☐ Yes ☐ No
- Have a follow-up program to check the equipment in the field at regular intervals? ☐ Yes ☐ No

Explain any "no" answers: _____

_____

_____

Chemotherapy

Percentage of Total Receipts? _____%

Number of customers per year? _____

Do you instruct customers on use of chemotherapy equipment? ☐ Yes ☐ No

Do you service or repair chemotherapy equipment? ☐ Yes ☐ No

Please complete the following chart:

Who prepares the drugs?	Doctor	Nurse	Pharmacist	Other (Describe)
☐ Employee	☐	☐	☐	
☐ Independent Contractor	☐	☐	☐	
Who administers the drugs?				
☐ Employee	☐	☐	☐	
☐ Independent Contractor	☐	☐	☐	
Who provides the instruction/training for the use of the equipment?				
☐ Employee	☐	☐	☐	
☐ Independent Contractor	☐	☐	☐	
Who is responsible for cleaning and disinfecting returned equipment?				
☐ Employee	☐	☐	☐	
☐ Independent Contractor	☐	☐	☐	

If Independent Contractors are used, please provide certificates of liability insurance for each person.

Describe in detail at which point waste is picked up; by whom; how transported; destination; and final disposal. Attach a separate sheet if necessary: _____

_____

Outline the procedures followed in cleaning and disinfecting returned equipment. Attach a separate sheet if necessary: _____

_____

Professional Employee & Subcontractor Information

Do you now offer any nursing service or have plans to do so in the future? ☐ Yes ☐ No

If yes, please explain: _____

Do you use other certified professionals? ☐ Yes ☐ No

If yes, please complete the following chart by showing the total number of people for each category that you use in your business:

	Doctor	Nurse	Pharmacist	Orthotist	Prosthetist	Other (describe)
Employee	____	____	____	____	____	_____
Independent Contractor	____	____	____	____	____	_____

What is the average number of subcontracted professionals that you use in any one day? _____

Describe the functions of each of these professionals: _____

_____

_____

Prior Insurance Record

Coverage	Policy Term	Insurance Company	Policy Number	Limit of Liability	Premium	Claims Made Retro Date
General Liability						
General Liability						
General Liability						
Professional Liability						
Professional Liability						
Professional Liability						
Property						
Property						
Property						

Prior Loss Information for CGL, Professional Liability, & Property

Date of Occurrence	Date of Claim	Type of Claim & Description of Occurrence	Amount Paid	Amount Reserved	Claim Status
					☐ Open ☐ Closed
					☐ Open ☐ Closed
					☐ Open ☐ Closed
					☐ Open ☐ Closed

PROVIDE CURRENTLY VALUED COMPANY LOSS REPORTS FOR PAST THREE YEARS

Umbrella and Excess Liability

Maximum Limit of Insurance - $1 million

Please indicate the following underlying coverage information for Auto and Employers Liability. If this information is not provided, Excess Employers Liability and Auto Liability coverage will not be included under any policy that is dependant upon the information contained in this survey.

Note: These limits will apply to Auto Liability and Employers Liability. The minimum required underlying limits are:
Auto Liability— $1 million per occurrence;
Employers Liability— $500,000 bodily injury by accident/$500,000 bodily injury by disease/$500,000 annual aggregate.

Insurer*: _____ Policy Number: _____
Policy Period: _____
Employers Liability (Coverage B) Limits: $ _____ Bodily Injury by Accident
$ _____ Bodily Injury by Disease
$ _____ Annual Aggregate

Insurer*: _____ Policy Number: _____
(Must be A Rated) Policy Period: _____
Auto Liability Limits: $ _____ Bodily Injury by Accident
Auto Liability Premium: $ _____

*Excess Employers Liability and Auto Liability are subject to approval of the insurer providing the underlying coverage.

Application Signatures & State Fraud Statements

APPLICABLE IN ARIZONA - ARIZONA FRAUD STATEMENT

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN ARKANSAS - ARKANSAS FRAUD STATEMENT

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.

APPLICABLE IN CALIFORNIA - CALIFORNIA FRAUD STATEMENT

For your protection, California law requires that you be made aware of the following: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN COLORADO - COLORADO FRAUD STATEMENT

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.

APPLICABLE IN FLORIDA - FLORIDA FRAUD STATEMENT

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 IDAHO – IDAHO FRAUD STATEMENT

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN INDIANA – INDIANA FRAUD STATEMENT

Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony.

APPLICABLE IN KENTUCKY - KENTUCKY FRAUD STATEMENT

Any person who knowingly and with intent to defraud an 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.

APPLICABLE IN LOUISIANA - LOUISIANA FRAUD STATEMENT

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.

APPLICABLE IN MINNESOTA – MINNESOTA FRAUD STATEMENT

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEW HAMPSHIRE – NEW HAMPSHIRE FRAUD STATEMENT

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

APPLICABLE IN NEW JERSEY - NEW JERSEY FRAUD STATEMENT

New Jersey law requires us to give you the following notice: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN NEW MEXICO – NEW MEXICO FRAUD STATEMENT

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.

APPLICABLE IN NEW YORK - NEW YORK FRAUD STATEMENT

Other Than Automobile: 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.

APPLICABLE IN OHIO - OHIO FRAUD STATEMENT

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.

APPLICABLE IN OKLAHOMA – OKLAHOMA WARNING

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 OREGON – OREGON FRAUD STATEMENT

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

APPLICABLE IN PENNSYLVANIA – PENNSYLVANIA FRAUD STATEMENT

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 subjects such person to criminal and civil penalties.

APPLICABLE IN TENNESSEE - TENNESSEE FRAUD STATEMENT

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.

APPLICABLE IN UTAH - UTAH FRAUD STATEMENT

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 civil penalties.

APPLICABLE IN VERMONT – VERMONT FRAUD STATEMENT

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, may be committing a crime, subjecting the person to criminal and civil penalties.

APPLICABLE IN VIRGINIA – VIRGINIA FRAUD STATEMENT

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.

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 CIVIL PENALTIES.

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS SURVEY AND THAT THE INFORMATION PROVIDED IN THIS SURVEY, INCLUDING ANY ATTACHMENTS, IS TRUE AND ACCURATE AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

COMPLETION OF THIS APPLICATION DOES NOT BIND COVERAGE.

Insured's Signature _____ Date: _____

Name and title (please print): _____

Insurance Agent's Signature _____ Date: _____