MEDMARC®
LIFE SCIENCES INSURANCE

Medmarc Casualty Insurance Company
ProAssurance Specialty Insurance Company

Products/Completed Operations and
Manufacturer's Errors and Omissions Liability

New Business Application

CLAIMS MADE NOTICE: PART OR ALL OF THE POLICY FOR WHICH THIS APPLICATION IS MADE MAY BE WRITTEN ON A CLAIMS MADE BASIS, WHICH MEANS THAT THE POLICY APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD.

DEFENSE WITHIN LIMITS: THE LIMIT OF LIABILITY AVAILABLE TO PAY SETTLEMENTS OR JUDGEMENTS WILL BE REDUCED, AND MAY BE EXHAUSTED, BY DEFENSE EXPENSES INCLUDING BUT NOT LIMITED TO FEES PAID TO ATTORNEYS TO DEFEND YOU.

- **Coverage for Manufacturer's Errors and Omissions Liability is offered on a non-admitted basis.**
- **Throughout this application, "you" or "your" refer to the person(s) or organization(s) applying for insurance.**
- **Please answer all questions completely, using attachments if necessary.**
- **Do not leave any space blank unless otherwise instructed. Please indicate "n/a" if a question is not applicable.**
- **If there is insufficient space to answer a question, please attach additional pages.**

Section I – Account Information

In addition to the questions in this section, please attach the following information, if applicable:

☐ Copies of any citation(s), Warning Letter(s), or Form 483(s) received by any governmental or regulatory authority within the last three years, and your response(s)

☐ Current financial information for any privately held company

☐ **Optional:** If you are interested in quotes for other lines of coverage through a strategic alliance insurance carrier, please submit ACORD applications for any desired CGL, Auto, Property, Workers' Compensation, or Umbrella coverage

Requested Insurance Coverage

Products/Completed Operations Liability Coverage	Errors & Omissions Liability Coverage
Coverage effective date: _____	Coverage effective date: _____
Limits of insurance: $_____	Limits of insurance: $_____
Retention amount: $_____ ☐ SIR ☐ Deductible	Retention amount: $_____ ☐ SIR ☐ Deductible
Target or desired premium: $_____	Target or desired premium: $_____
Retroactive date for claims made coverage: _____	Retroactive date for claims made coverage: _____
If more than one, please attach schedule of retroactive dates.	***If more than one, please attach schedule of retroactive dates.***

Applicant/Insured Information

First named insured: ***Please provide the name as it should appear on the policy.***		
Corporate address:		
Mailing address:		
Website:	Parent company name:	
Primary contact name:	Email:	Phone:
Billing contact name	Email:	Phone:
Other name(s) or DBA(s) you have used in the past:		
Date established:		
Are you a member of the industry trade group AdvaMed?		☐ Yes ☐ No
Provide a description of your operations and products.		

Applicant/Insured Information (continued)

First named insured entity structure:

☐ Individual ☐ Partnership ☐ Corporation ☐ Trust

☐ Joint Venture ☐ Limited Liability Company ☐ Other (*please describe*): _____

Requested additional named insured(s):

Entity name as it should appear on the policy	*% Ownership*	*Relationship to first named insured*

Have you undergone any mergers or acquisitions within the last five years? ☐ Yes ☐ No

If yes, list companies or assets acquired (A) or sold (S) within the last five years.

Entity name	*A/S*	*Date acquired/sold*	*Description of operations*

Please provide the names of your top three competitors.

1. _____

2. _____

3. _____

Have you:

Or any of your officers, directors, shareholders, partners, or members ever been convicted of any criminal violations or been the subject of any active or pending investigation or proceeding involving alleged criminal violations relating to your business? ☐ Yes ☐ No

Filed for bankruptcy in the last seven years? ☐ Yes ☐ No

Been investigated or cited by a governmental or regulatory authority, including but not limited to FDA, FTC, and DEA, for violation of, or non-compliance with, any federal, state, local, or foreign law in the last three years? ☐ Yes ☐ No

If yes to any of the above, please provide details.

Current Insurance Coverage Information

Provide the following for your current insurance coverage:

Products/Completed Operations Liability Coverage	**Errors & Omissions Liability Coverage**
Coverage renewal date: _____	Coverage renewal date: _____
Limits of insurance: $_____	Limits of insurance: $_____
Retention amount: $_____ ☐ SIR ☐ Deductible	Retention amount: $_____ ☐ SIR ☐ Deductible
Current premium: $_____	Current premium: $_____
Retroactive date for claims made coverage: _____	Retroactive date for claims made coverage: _____
If more than one, please attach schedule of retroactive dates.	***If more than one, please attach schedule of retroactive dates.***

Have you maintained consistent claims-made insurance for the risk(s) back to the requested retroactive date(s)? ☐ Yes ☐ No

Operations and Projected Revenue Information

Provide the projected revenue for the next twelve months for each of your operations.

Operation	*U.S./Canada revenue ($)*	*Foreign revenue ($)*
Proprietary medical device manufacturing		
Proprietary pharmaceutical/biologic manufacturing		
Distribution of products manufactured by others	Gross Sales: _____ Net Sales:	Gross Sales: _____ Net Sales:
Importing for distribution		
Equipment leasing/rental		
Licensing or royalty fees		
Installation, customization, maintenance, or repair of your own products		
Contract manufacturing		
Specification development for others		
Research and development services for others		
Consulting/design services		
Contract services for others not described above (e.g., packaging, repackaging, sterilization, installation, maintenance, repairing, or regulatory)		
Other (*please describe*):		

Please provide the revenues from all of your operations from the previous three years:

Year	*U.S./Canada revenue ($)*	*Foreign revenue ($)*	*Total ($)*

Regarding your products, services, and clinical trials:

Are any products, services, or clinical trials specifically excluded on your existing policy? ☐ Yes ☐ No

Will any products, services, or clinical trials be insured elsewhere or specifically excluded from coverage under this insurance during the requested policy term? ☐ Yes ☐ No

If yes to either of the above, please describe, including details of any additional coverage placed elsewhere.

Do you expect to introduce any new products, services, or clinical trials within 12-18 months of the policy effective date? ☐ Yes ☐ No

If yes, please describe.

Does any practicing physician have an ownership stake in your company, or otherwise benefit financially from the sale or use of a product or service you are selling? ☐ Yes ☐ No

If yes, please provide details.

Operations and Projected Revenue Information (continued)

Check all products, materials, and/or components below that are included in your portfolio of products, services offered, or clinical trials. Please include all past, present, or anticipated products, services, or clinical trials.

Note: Checking any box below will not, in itself, result in this application for insurance to be declined. Checked items may require additional information during the underwriting process. Coverage may be offered on an admitted or non-admitted basis.

- ☐ Cannabis and/or CBD
- ☐ Cosmetics
- ☐ Controlled substances

Dietary supplements marketed for:

- ☐ Altering one's appearance
- ☐ Enhancing performance or endurance
- ☐ Improving sexual dysfunction or promoting sexual wellness
- ☐ Promoting weight loss or increasing metabolism
- ☐ Ephedra or ephedrine
- ☐ Gene therapy
- ☐ Homeopathic products
- ☐ Human cells, tissues, or tissue-based products

Known or recognized:

- ☐ Carcinogens
- ☐ Cytotoxins
- ☐ Mutagens
- ☐ Teratogens
- ☐ Life-sustaining or life-supporting equipment
- ☐ Opioid antagonists (e.g., Narcan, Naloxone)

Products implanted in the body:

- ☐ Mesh or tissue matrices
- ☐ Metal-on-Metal (MOM)
- ☐ Not otherwise described – Implanted in the body for greater than 30 days

For each item checked above, please provide details, including a list of products, services, and/or clinical trials and their involvement with the checked items.

Continue to the next page

Section II – Products and Services

☐ **Check here if you do not have any commercial operations nor discontinued commercial products/services and will not begin selling any products or services during the next 12-18 months. Skip this section and proceed to Section III.**

In addition to the questions in this section, please attach the following information, if applicable:

☐ A list of all products and services you offer
☐ An executed agreement with any contract manufacturers and/or critical suppliers
☐ Samples of sales, service, and license agreements used with your customers
☐ An executed distribution agreement between you and the manufacturer you represent
☐ Copies of all boxed warnings, REMS materials, or other significant safety warnings used with any of your products
☐ A copy of your most recent GMP audit or similar self-audit

Product and Service Information

Who are your five largest customers?

Customer Name	*Size of Contract*	*Duration of Contract*

Have any products or services been discontinued in the last three years? ☐ Yes ☐ No

If yes, please list discontinued products or services and the reason(s) for discontinuation.

Product or Service	*Reason*

Do you sell products manufactured by others under your label? ☐ Yes ☐ No

If yes, please list the contract manufacturers.

Contract Manufacturer

Do you source products or components from foreign suppliers? ☐ Yes ☐ No

If yes, please list the foreign countries. _____

Do you require all of your suppliers and contract partners (e.g., product development, validation, manufacturing, packaging, sterilization, distribution, etc.) to:

Execute hold harmless or indemnification agreements? ☐ Yes ☐ No
Grant coverage to you as an additional insured for product liability insurance? ☐ Yes ☐ No
Provide you with annual Certificates of Insurance? ☐ Yes ☐ No

If yes, what limits of liability do you require? _____

Are any of your products used:

In clinical trials? ☐ Yes ☐ No
In research/laboratory settings? ☐ Yes ☐ No
In hospitals/medical facilities? ☐ Yes ☐ No
As prescription products? ☐ Yes ☐ No
As at-home retail or OTC products? ☐ Yes ☐ No

Do you:	
Manufacture products for others to sell under their labels?	☐ Yes ☐ No
Manufacture components of others' finished products?	☐ Yes ☐ No
Sell any products that are not regulated by the FDA?	☐ Yes ☐ No
Export products for patients in foreign markets before receiving marketing approval in the United States?	☐ Yes ☐ No
Operate as a blood bank, blood donation facility, or plasma fractioner?	☐ Yes ☐ No
Compound medicine or sell medicine compounded by others?	☐ Yes ☐ No
Sterilize your products or the products of others?	☐ Yes ☐ No
Perform medical services?	☐ Yes ☐ No
If yes to any of the above, please provide details.	
Do you provide set up or demonstration of equipment to home users of your products?	☐ Yes ☐ No
Do you provide continuing services or support for discontinued products or services?	☐ Yes ☐ No
Do you:	
Recondition, refurbish, or repair any equipment prior to resale or lease?	☐ Yes ☐ No
Install, customize, maintain, repair, or service medical or laboratory equipment?	☐ Yes ☐ No
If yes to either of the above, do you receive original manufacturer and specification training?	☐ Yes ☐ No

Marketing and Sales Representatives	
How many employees do you use as sales representatives?	_____
Do you use 1099 independent contractors as sales representatives?	☐ Yes ☐ No
If yes,	
How many independent contractors do you use?	_____
Do you provide formal training to your independent contractor sales representatives?	☐ Yes ☐ No
Do you require annual Certificates of Insurance?	☐ Yes ☐ No
Do you use contracts containing indemnification agreements with each independent contractor?	☐ Yes ☐ No
Please describe any factory or other training sales representatives receive from manufacturer(s).	
Are your sales representatives trained on the AdvaMed Code of Ethics on Interactions with Health Care Professionals?	☐ Yes ☐ No
Do you provide training to sales representatives about appropriate conduct and communication during medical procedures to ensure that none of their actions or communications could be construed as providing a medical professional service or medical advice?	☐ Yes ☐ No
Are sales representatives present during medical procedures, surgeries, or examinations?	☐ Yes ☐ No
If yes, please explain in what capacity.	
Do sales representatives or other employees have direct patient contact?	☐ Yes ☐ No
If yes, please explain.	

Wholesale and Distributor Operations

Please provide the names of all manufacturers whose products you market or distribute:

Provide the methods of product delivery you employ, including percentage:

☐ Delivered by sales representative(s): _____%

☐ Shipped directly to the customer by you: _____%

☐ Shipped directly to the customer by supplier's manufacturing facility: _____%

Do you rent storage space or use an off-site facility outside your control for products you distribute? ☐ Yes ☐ No

If yes, do you:

Mandate storage conditions via contract? ☐ Yes ☐ No

Require indemnification by storage vendor via contract? ☐ Yes ☐ No

If no to either of the above, please explain.

Quality and Regulatory History

Is your facility registered with the FDA? ☐ Yes ☐ No

If yes,

Provide the date of your last FDA inspection: _____

How are you designated?

☐ Contract manufacturer ☐ Contract sterilizer ☐ Initial importer ☐ Manufacturer

☐ Packager/repackager ☐ Specification developer

Have you performed a GMP or similar self-audit, or has one been performed for you by a third party, in the last twelve months? ☐ Yes ☐ No

Do you advertise any of your products directly to consumers/patients? ☐ Yes ☐ No

Do any of your products require a boxed warning, REMS, or other significant safety warning? ☐ Yes ☐ No

In the past three years, have you reported or issued:

MDRs or adverse event reports? ☐ Yes ☐ No

Public health notification or field/safety alerts? ☐ Yes ☐ No

Dear Doctor/Healthcare Practitioner letters? ☐ Yes ☐ No

What certifications do you maintain in the U.S. or in other markets?

☐ ISO 13485 ☐ ISO 9001 ☐ CE Mark ☐ Underwriters Laboratory (UL) ☐ Other: _____

Do you have a records retention policy for the products you manufacture, sell, or service? ☐ Yes ☐ No

Do you have a documented training plan for employees, contractors, distributors, and/or end users of your products? ☐ Yes ☐ No

Do others install, customize, repair, or service your products on your behalf? ☐ Yes ☐ No

If yes, do you:

Provide formal training? ☐ Yes ☐ No

Provide written instructions? ☐ Yes ☐ No

Sign off on the final product? ☐ Yes ☐ No

Require liability insurance for those installing, repairing, or servicing your products? ☐ Yes ☐ No

Does your legal counsel review and approve all contracts, advertising, and promotional materials and brochures? ☐ Yes ☐ No

Do you require your customers to sign written agreements that outline the specification of products and services you will provide? ☐ Yes ☐ No

Do you obtain written final acceptance or other sign-off agreements from all customers upon delivery or completion of your products or services? ☐ Yes ☐ No

Are all deviations, modifications, or mid-term changes to a contract made in writing? ☐ Yes ☐ No

Product Recalls

Do you have a written procedure for initiating and conducting product recalls?	☐ Yes ☐ No
Have any of your products been removed or recalled from the market in the past three years?	☐ Yes ☐ No
Have any of your customers' products been removed or recalled from the market in the past three years because of a problem/defect with a product or service provided by you?	☐ Yes ☐ No

If yes to either of the above, please complete the table below.

Recall Date	*Class*	*Product*	*Reason*	*Closed?*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Please describe financial settlements or other remediation associated with the recall/removal, if any.

Do you ever agree to indemnify customers for claims or expenses relating to product recalls?	☐ Yes ☐ No
Are you considering recalling any known or suspected defective products from the market?	☐ Yes ☐ No
Have any of your suppliers ever notified you of a recall?	☐ Yes ☐ No
Do any of your suppliers grant you indemnification for product recall?	☐ Yes ☐ No

Continue to the next page

Section III – Clinical Trials

☐ **Check here if you do not have any active clinical trials nor do you anticipated starting any clinical trials during the next 12-18 months. Skip this section and proceed to Section IV.**

In addition to the questions in this section, please attach the following information, if applicable, for all active clinical trials or clinical trials starting during the next 12-18 months:

☐ Executed agreements with your contract research organizations (CROs) or site management organizations (SMOs)

☐ Clinical trial protocols

☐ Informed consent documents

Human Clinical Trial History

Are all of your clinical trials approved and subject to oversight by HHS-registered institutional review boards (IRBs)? ***If no, please explain.***	☐ Yes ☐ No
Do you use indemnification agreements with investigators, sites, IRBs, CROs, and SMOs? ***If no, please explain.***	☐ Yes ☐ No
Have any of your IRBs, investigators, or clinical sites received a Warning Letter or been the subject of an adverse FDA action? ***If yes, please explain.***	☐ Yes ☐ No
Have you, your investigator(s), or any members of their staff ever been cited, debarred, excluded, fined, or suspended? ***If yes, please explain.***	☐ Yes ☐ No
Have any trials been discontinued or suspended for safety reasons, whether by you, FDA, or another authority? ***If yes, please explain.***	☐ Yes ☐ No
Have any subjects had a Serious Adverse Event (e.g., life-threatening, death, hospitalization, disability or permanent damage, congenital anomaly or birth defect, or required intervention to prevent one of these outcomes)? ***If yes, please explain.***	☐ Yes ☐ No
Do any of your trials involve subjects who are members of a "vulnerable" patient population as defined by 21 CFR 56.111(3) (e.g., children, prisoners, pregnant women, handicapped or mentally-disabled persons, or economically or educationally-disadvantaged persons)? ***If yes, please explain.***	☐ Yes ☐ No
Are you sponsoring any clinical trials in which you have invited your own employees to participate? ***If yes, please explain.***	☐ Yes ☐ No
Are any of your products being studied in clinical trials conducted by other organizations, including investigator-sponsored trials? ***If yes, please explain.***	☐ Yes ☐ No
Are any of your investigational (i.e., unapproved) drugs or devices accessible to seriously ill patients who are not candidates for clinical trials? ***If yes, please explain.***	☐ Yes ☐ No

Human Clinical Trial Log

Please list clinical trials that are ongoing or anticipated to start during the next 12-18 months.

Protocol: Number & Name	Type of Trial[1]	Risk Level[2]	Product Name & Description	Trial Phase	Total Subjects Projected	Subject Enrollment for Policy Term *Past 12 mos./ Next 12 mos.*		Trial Date	FDA Classification for Trial Status[3]	Number of Trial Sites	Trial Locations	CRO or SMO Used
		☐ SR ☐ NSR ☐ Drug						Start: _________ End: _________			☐ Foreign ☐ Domestic ☐ Both	☐ CRO ☐ SMO ☐ Neither
		☐ SR ☐ NSR ☐ Drug						Start: _________ End: _________			☐ Foreign ☐ Domestic ☐ Both	☐ CRO ☐ SMO ☐ Neither
		☐ SR ☐ NSR ☐ Drug						Start: _________ End: _________			☐ Foreign ☐ Domestic ☐ Both	☐ CRO ☐ SMO ☐ Neither

If Foreign Trial Locations is checked please list countries where they reside: ____

Please list any additional clinical trials on a separate page and include as an attachment.

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[1] Type of Trial

- **Treatment** trial – tests experimental treatments, new combinations of drugs, or new approaches to surgery or radiation therapy
- **Prevention** trial – looks for better ways to prevent disease in people who have never had the disease, or to prevent a disease from returning. These approaches may include medicines, vaccines, vitamins, minerals, or lifestyle changes.
- **Diagnostic** trial – conducted to find better tests or procedures for diagnosing a particular disease or condition
- **Screening** trial – tests the best way to detect certain diseases or health conditions
- **Quality of Life** trial (or Supportive Care trials) – explores ways to improve comfort and the quality of life for individuals with a chronic illness
- **Registry** trial – observational studies in which the events that happen to test subjects with a specific disease or condition are recorded without pre-defined treatment

[2] FDA defines a Significant Risk **(SR)** Device as a device that:

- Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject;
- Is purported or represented to be for use supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject;
- Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presents a potential for serious risk to the health, safety, or welfare of a subject; or
- Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

All other devices are considered to be of Nonsignificant Risk **(NSR)**.

[3] FDA classifications for trial status:

- **Pending** – not yet recruiting
- **Ongoing** – recruiting and enrollment completed; study proceeding according to or ahead of schedule
- **Delayed** – study behind schedule
- **Withdrawn** – study halted prematurely prior to enrollment of the first participant
- **Suspended** – recruiting or enrolling participants has halted prematurely but potentially will resume
- **Terminated** – study halted prematurely and will not resume; participants are no longer being examined or treated
- **Completed** – study has concluded normally; participants are no longer being examined or treated

Section IV – Circumstances, Incidents, and Loss History

In addition to the questions in this section, please attach loss runs for a minimum of the last five years for all products, services, and clinical trials.

Claim/Incident Information

Has any insurance company cancelled or refused to renew your insurance? *(Not applicable in Missouri)* ☐ Yes ☐ No

If yes, please explain.

Are you aware of any:

Claim, suit, injury, damage, or loss not yet reported to any insurance company? ☐ Yes ☐ No

Fact, circumstance, occurrence, act, error, and/or omission which may result in a claim or suit against you under the coverage requested in this application? ☐ Yes ☐ No

If yes to either of the above, please explain.

Have you submitted any claims or given notice of fact, circumstance, occurrence, act, error, and/or omission which you have reason to believe might, or could reasonably be foreseen to give rise to, a claim that might fall within the scope of insurance with any insurance company? ☐ Yes ☐ No

If yes, please explain.

Under any insurance policy, have any of your products, services, or clinical trials:

Been declared or treated as a batch or otherwise made subject to a "related claim," "batch," or similar provision? ☐ Yes ☐ No

Been the subject of multiple claims where the insurance company made all those claims subject to one policy limit or retention, or bundled all those claims into one claim, by way of a "related claim," "batch," or similar provision? ☐ Yes ☐ No

If yes to either of the above, please explain.

Continue to the next page

The undersigned authorized officer of the applicant represents that the statements set forth in this Application are true and complete, and acknowledges and understands that Medmarc Casualty Insurance Company and its affiliated company, ProAssurance Specialty Insurance Company (collectively, the "Company"), are relying on the accuracy and completeness of such information in determining eligibility, qualification, and pricing for the insurance provided. The undersigned also represents that it has not suppressed or misstated any material facts or made any misleading representations. You understand that this application and any supplemental information supplied by you or on your behalf is incorporated into and made a part of any policy of insurance that may be issued to you by the Company. If the information provided in this Application should change between the date of the Application and the effective date of the policy, the undersigned represents that he or she will immediately report such changes to the Insurer. Completing and signing this Application does not bind the undersigned to purchase this insurance, nor does it bind coverage. Coverage will not be bound, nor will a policy be issued, until the applicant signifies acceptance of the Company's premium quotation.

By signing below, you consent to the receipt of electronic notices and documents (collectively, "Documents"). Documents include any notice or document required as part of an insurance transaction or that is to serve as evidence of coverage. Notwithstanding the previous information, you may request at any time to have a Document sent to you in paper form. You may also withdraw your consent at any time. Upon information and belief, the only software/hardware requirements for you to access a Document are a valid email address and the ability to open Documents in various formats. You can request a paper copy of a Document, withdraw your consent, and/or notify us of a problem opening a Document, by contacting our support team at: LSS@medmarc.com.

Insurance Fraud Warnings and Important Notices: The undersigned also agrees that it has read all applicable fraud warnings and state-specific notices on the attached Insurance Fraud Warnings and Important Notices addendum.

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.

Authorized Signature:*	**Date:**
Print Name:	
Title:	
Email:	

Producer Name:	**Producer NPN:**
Email:	**Phone:**
Brokerage Name:	**License Number:**
Brokerage Address:	

*Before signing, complete each of the Print Name, Title, Email, and Date fields. If you are electronically submitting this document, you must apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a keypad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance - Authorized Signature

Please return your signed application using one of the following:
Fax: (703) 652-1389
Email or click Submit: Apps@medmarc.com
Mailing: 4795 Meadow Wood Lane, Suite 335 West, Chantilly, VA 20151

Submit

Insurance Fraud Warnings and Important Notices

For your protection, the following warning is required by various state laws:

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company or other person, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to criminal and civil penalties, which may include imprisonment, fines, and denial of insurance.

State Specific Fraud Warning and Disclosure Statements

ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who 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.

ARKANSAS / DISTRICT OF COLUMBIA / LOUISIANA / RHODE ISLAND / 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.

CALIFORNIA

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

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 policyholders or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY

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.

MAINE / TENNESSEE / VIRGINIA / WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

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.

NEW YORK

Fraud Warning

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.

IMPORTANT NOTICE

In the event you are applying for claims-made coverage, please note the following important information. The information provides you with important guidance in the event you purchase claims-made coverage from us.

1. This is a claims-made policy.

2. This policy, subject to its terms and conditions, applies only to any claim first made against the insured during the policy period or any applicable Extended Reporting Period. This policy does not apply to any claim first made against the insured after the policy period or any applicable Extended Reporting Period orreported after coverage termination.

3. This policy provides no coverage for claims arising out of occurrences which took place prior to any Retroactive Date shown in the policy.

4. During the first several years of a claims-made relationship, claims made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases, independent of overall rate level increases, until the claims made relationship reaches maturity.

5. Upon termination of coverage, an automatic Basic Extended Reporting Period of sixty (60) days (provided under coverage form CG 38 E) or ninety (90) days (provided under all other claims-made coverage forms) will apply to the policy, unless an additional Supplemental Extended Reporting Period is purchased.

6. A Supplemental Extended Reporting Period of five (5) years (provided under coverage form CG 38 E) or six (6) years (provided under coverage under all other claims-made coverage forms) is available for purchase upon the payment of additional premium. Potential coverage gaps may arise upon expiration of the Extended Reporting Period. Within thirty (30) days after policy termination, we will send you written notice describing the Basic Extended Reporting Period, the availability of, and the premium for, and the importance of purchasing additional Extended Reporting Period coverage. You must send us a written notice requesting the Supplemental Extended Reporting Period endorsement within the greater time period of ninety (90) days after termination of coverage or thirty (30) days from our mailing or delivery date of the notice for the Supplemental Extended reporting Period.

7. The rates for the Supplemental Extended Reporting Period will be based upon the rates in effect at the time of coverage termination. Such rates may be subject to substantial increase over the rates currently in effect and such rates may or may not be indicative of future rate changes. Upon your written request, we will provide you with the average statewide percentage changes and the effective date of each rate revision for this particular type of insurance which we have implemented in the state of New York during the five-year period immediately preceding the effective date of the policy.

OHIO

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.

OKLAHOMA

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

OREGON

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

PENNSYLVANIA

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.