CNA HealthPro LONG TERM CARE
NEW BUSINESS SUPPLEMENTAL APPLICATION

This application must be completed and signed by the applicant. In addition, the following must be attached to the application.

The following are required for all levels of care:

- Accord Applications: ☐ Property ☐ Auto ☐ General Liability ☐ Crime ☐ Inland Marine ☐ Electronic Data Processing ☐ Umbrella
- Signed Statement of Values
- LTC Business Interruption Worksheet (if applicable)
- Current valued loss reports of prior carriers
- Current audited financial statement (income, balance sheet, cash flow) with management notes
- Photo and facility diagram/plot plan
- Brochures and/or advertising materials
- Facility web site URL

The following are required for Subacute/Skilled/Intermediate/Assisted Living Facilities:

- Resumes for Administrator & Director of Nursing (DON)
- Copy of facility license
- State survey reports - last 2 years (Include all statements of deficiencies and Corrective Action Plans)
- Substantiated Complaint Survey(s) and Corrective Action Plans if complaint is within the last 2 years

The following are required for Subacute/Skilled Nursing Facility/Intermediate Care Facilities:

- Current CMS Forms 671 Facility Staffing & 672 Resident Census
- Copy of facility's Skin/Wound Protocol
- Quality Indicator Reports for the past two, six-month periods

Effective Date: ____________ Claims-Made

Prior Carrier: ____________ Expiring Premium: $____________ Retro Date: ____________

I. Corporate/Parent Information

1. Corporate/Parent Name: ______________________________

   Corporate Address: ______________________________

   City: ______________________________ State: _____ Zip Code: _____

2. **Description of Corporate/Parent (check all that apply):**

   ☐ For-Profit ☐ Not-for-Profit

   ☐ Individual ☐ Partnership ☐ Corporation ☐ Hospital Affiliated ☐ CCRC

   ☐ JCAHO Accredited ☐ CCAC Accredited

3. Years parent company has been under present ownership: _____

4. Total number of facilities owned: _____

5. Is the parent company managed by a management company? ☐Yes ☐No

   If "Yes," provide the name of management company: ______________________________

   How many years has a contract been in place with this management company? _____

   Provide a copy of the management contract.

6. List the Officers of the Operating Corporation or General Partners:

Name	Title	Status
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive

II. Applicant/Facility Information

7. Facility Name: ______________________________

   Facility Address: ______________________________

   City: ______________ State: _____ Zip Code: __________

   Federal Employer ID #: ______________ Provider ID #: ______________

   Contact Name: ______________ Telephone: (_____) _____ - _____

   Email Address: ______________ Fax: (_____) _____ - _____

8. In the past three (3) years, has any insurance carrier cancelled or refused coverage that is similar to the coverage being applied for here? ☐Yes ☐No

   If "Yes," explain: ______________________________

9. In the past five (5) years, has any claim or suit been made against you for alleged medical professional malpractice, error or mistake? ☐Yes ☐No

   If "Yes," explain. Attach list with comments.

10. How many years has the facility been under: Present ownership? _____ Present management? _____

11. Are all applicable permits up to date? ☐Yes ☐No

    If "No," explain: ______________________________

III. Subsidiaries

12. List all subsidiaries. Additional list attached? ☐Yes ☐No

Name	Location	Description of Operations

IV. Facility Credentials

13. List facility information below:

    a. License and Accreditation Information:

	Type/Number	Expiration Date	Restrictions?	Provisions?
License:			☐Yes ☐No	☐Yes ☐No
License:			☐Yes ☐No	☐Yes ☐No

    b. Association memberships: _____ _____ _____ _____

    c. Date of last inspection/survey: _____/_____/_____

    d. Number of deficiencies: Total: _____ D, E, F, G deficiencies: _____ F, H, I, J, K, L deficiencies: _____

    e. Was a Corrective Action Plan accepted by the State? ☐Yes ☐No

    f. How many complaints were investigated in the past three (3) years? _____

       How many complaints were substantiated? _____

    g. Is facility approved for Medicare? ☐Yes ☐No If "Yes," # of beds: _____

       Is facility approved for Medicaid? ☐Yes ☐No If "Yes," # of beds: _____

V. Classification

14. **Select only the level of care reflected in the facility license**. If the license is not specific with respect to type of care, select the one level that best reflects the primary medical services provided by this facility.
Please indicate total licensed beds (If Independent Care, skip to "Independent Care" section).

Sub Acute:	Ventilator care, wound management, post operative/trauma recovery, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis Total Licensed Beds: _____ Average Occupancy: _____
Skilled Nursing:	Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's care and services Total Licensed Beds: ________Average Occupancy:______
Intermediate Care:	Administration of oral medications, assistance with Activities of Daily Living (ADLs), preventive turning/positioning, restorative rehabilitation Total Licensed Beds: ________Average Occupancy:______
Assisted Living:	Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc. Total Licensed Beds: ________Average Occupancy: _____
Personal Care:	Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc. Total Licensed Beds: _____ Average Occupancy: _____
Independent Care:	Residents of retirement age, total self care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises. a. What is the total numbers of units? _____ b. What is the total numbers of residents at full occupancy? _____ c. Are there common dining facilities? ☐Yes ☐No d. Do individual units have cooking appliances (excluding microwaves)? ☐Yes ☐No If "Yes," check type: ☐Gas ☐Electric e. Is there a daily mechanism to keep track of residents? ☐Yes ☐No If "Yes," explain procedure: ________________________________ f. Are residents allowed to have home health care aides? g. Are the aides contracted independently? ☐Yes ☐No Through facility? ☐Yes ☐No h. Are there licensed nursing personnel on staff? ☐Yes ☐No What hours are they available? _____ What services do they provide? _____
Home and Community Based Services:	Handyman services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic services, skilled nursing care Number of visits: _____ Receipts: _____ Attach a description of operations.

Adult Day Care:	☐ Social (80911) Total Participants: _____ ☐ Enhanced (Mentally Challenged) (80912) Total Participants: _____ Social – Services include but not limited to recreational activities (crafts, music, games, shopping trips), intergenerational programs, promotion of wellness and socialization programs, educational programs Medical – Services include but not limited to/for the same as social, yet will also include additional services such as medication supervision, medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, Physical Therapy (PT), speech and Occupational Therapy (OT). Provided service includes service for the mentally challenged, cognitively impaired, developmentally disabled, and chronically ill.

15. Show the percentage of residents by age range:
    _____ < 30 _____ = 30-64 _____ = 65-74 _____ = 75-84 _____ = 85-94 _____ >94

16. If any residents are under 64, please explain: ______________________________

17. Additional general liability exposures.

    a. Swimming Pools
       (i) Is there a swimming pool? (80901) ☐Yes ☐No
       (ii) Is it open to the public? ☐Yes ☐No
       (iii) Is the pool locked when not in use? ☐Yes ☐No
       (iv) Is the pool fenced? ☐Yes ☐No
       (v) Is a full-time lifeguard on duty? ☐Yes ☐No
       (vi) Is there a diving board/sliding board? ☐Yes ☐No
       (v) Are there depth markings? ☐Yes ☐No
       (vi) Is there a daily maintenance procedure in place? ☐Yes ☐No

    b. Are there other bodies of water present? ☐Yes ☐No
       If "Yes," describe: _____

    c. Are there saunas and/or hot tubs? (80902) ☐Yes ☐No
       If "Yes," how many? _____
       Is there an attendant on duty? ☐Yes ☐No
       If "Yes," how many hours per day is the attendant on duty? _____

    d. Are there tennis/racquetball/handball courts? (80903) ☐Yes ☐No
       If "Yes," how many? _____

    e. Are there exercise/weight rooms? (80904)
       If "Yes," how many: _____
       Is there an attendant on duty? ☐Yes ☐No
       If "Yes," how many hours per day is the attendant on duty? _____
       Are there treadmills? ☐Yes ☐No

    f. Are there indoor parking facilities? (80910) ☐Yes ☐No
       If "Yes," how many parking spaces: _____

    g. Is there a Community Center? (80922) ☐Yes ☐No
       If "Yes," how many square feet in area: _____

    h. Is the facility used for activities other than by residents? ☐Yes ☐No
       If "Yes," describe: _____

    i. Is the restaurant open to the public? ☐Yes ☐No
       Gross receipts: $_____

Is liquor served? ☐Yes ☐No

VI. Administrator

18. Name of Administrator: ____________________ License Number: __________ State: _____

19. Length of time at this facility: _____ Length of time as Nursing Home Administrator (NHA): _____
    Full time at this facility? ☐Yes ☐No Number of hours at this facility per week? _____

VII. Nurse Staffing

20. Director of Nursing (DON):
    Name: ________________________ Professional credentials: ☐RN ☐LPN
    Length of time at this facility: _____ Length of time as DON: _____

21. a. Total # of nurse employees: _____
    b. By category:

Category	1st shift	2nd shift	3rd shift	Turnover %
RN				%
LPN/LVN				%
CNA/Personal Caregiver				%
Agency				%
Pool				%

    c. Do you require nurses to carry malpractice coverage? ☐Yes ☐No
    d. Do you obtain and review nurses' certificates of malpractice insurance? ☐Yes ☐No
    e. Do you verify nursing licenses upon hire and annually? ☐Yes ☐No
    f. Do you verify nursing assistant certification upon hire and annually? ☐Yes ☐No
    g. Are background checks completed for agency and pool employees? ☐Yes ☐No

VIII. Physicians and Medical Director

22. Number of physicians: Employed: _____ Affiliated: _____ Contracted: _____

23. Do you obtain and review physicians' certificates of malpractice insurance? ☐Yes ☐No

24. Do you require limits of liability comparable to your own? ☐Yes ☐No
    If "No," define the differences in limits: ____

25. a. Are the physicians credentialed? ☐Yes ☐No
    b. Do credentialing activities include
       (i) Verification of current professional license? ☐Yes ☐No
       (ii) Verification of current DEA license? ☐Yes ☐No

26. Name of Medical Director: ____________________ License Number: __________ State: _____
    License Number: __________ State: _____

27. Length of time as Medical Director: _____ Medical Specialty: _____
    ☐ Full-time at this facility ☐ Part-time at this facility Number of hours at this facility per week: _____

28. Does the Medical Director also act as the attending physician to any residents? ☐Yes ☐No
    If "Yes," how many: _____

29. Is there an evaluation of the Medical Director's performance? ☐Yes ☐No
    If "Yes," define: ______________________________

30. Is the Medical Director:
    a. involved in credentialing facility medical staff? ☐Yes ☐No
    b. an active participant in the facility quality improvement program? ☐Yes ☐No
    c. involved with peer review of physicians? ☐Yes ☐No

31. Is a physician on site or on call on a 24-hour basis? ☐Yes ☐No

IX. Staff/Employee Selection and Hiring

32. Is there a formal, documented assessment process to measure staff competency skills? ☐Yes ☐No

33. Do you conduct an orientation and regularly scheduled in-service education programs for all staff/employees? ☐Yes ☐No

34. How are employees recruited? ______________________________

35. Describe background verification checks on new employees:
    a. work history? ☐Yes ☐No
    b. education? ☐Yes ☐No
    c. criminal record? ☐Yes ☐No
    d. driving record - Motor Vehicle Record (MVR) when appropriate? ☐Yes ☐No
    e. drug testing? ☐Yes ☐No

X. Non-Resident Services

36. Please indicate the annual number of visits or clients for the following

Home Health Care ☐Yes ☐No # of Home Health Care visits or clients per year: _____
Is home health care provided by independent contractors? ☐Yes ☐No
Describe home health care services: ______________________________

Adult Day Care Total Licensed #: _____ Average Occupancy: _____ Hours of Operation: _____
Is this a licensed adult day care center? ☐Yes ☐No # of Employees: _____
Do you provide transportation to and from your facility? ☐Yes ☐No
Do you provide transportation to and from events? ☐Yes ☐No
Is a physical examination performed by a physician prior to admission? ☐Yes ☐No
If "Yes," describe: ______________________________
Are medical services provided? ☐Yes ☐No
If "Yes," describe: ______________________________

Children Day Care Total Licensed #) _____ Average Occupancy: _____ Hours of Operation: _____
# of employees: _____ # of children: _____ # of employees' children: _____
Do you provide any transportation for children? ☐Yes ☐No
If "Yes," describe: ______________________________

Respite Care: ☐Yes ☐No If "Yes," # per year: _____

Hospice Care (80931): ☐Yes ☐No If "Yes," # per year: _____

Rehabilitation Services: ☐Yes ☐No If "Yes," # per year: _____
Describe in-house rehabilitation services: ____

37. Do you provide the following services?

Service	Provided?	# of Residents	Service	Provided?	# of Residents
IV Infusion Therapy	☐Yes ☐No		Developmentally Disabled	☐Yes ☐No	
Ventilation Therapy	☐Yes ☐No		Alzheimer's/Dementia	☐Yes ☐No	
Physical Therapy	☐Yes ☐No		Psychiatric Care	☐Yes ☐No	
AIDS	☐Yes ☐No		Chemical Dependency Treatment	☐Yes ☐No	

38. Do you provide any other services to your residents or the community? ☐Yes ☐No
If "Yes," describe: ______

XI. Consultants/Independent Contractors and Services

39. Indicate which of the following services are (1) contracted to you at this facility, (2) if a contract is in place and (3) limits of liability:

Services	Is service provided?	Is a contract in place?	Limits of Liability
Physicians	☐ Yes ☐No	☐ Yes ☐No	$
Dental	☐ Yes ☐No	☐ Yes ☐No	$
Nursing	☐ Yes ☐No	☐ Yes ☐No	$
Mental Health	☐ Yes ☐No	☐ Yes ☐No	$
Pharmaceutical	☐ Yes ☐No	☐ Yes ☐No	$
Physical Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Occupational Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Speech Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Dietary	☐ Yes ☐No	☐ Yes ☐No	$
X-Ray	☐ Yes ☐No	☐ Yes ☐No	$
Medical Records	☐ Yes ☐No	☐ Yes ☐No	$
Laboratory	☐ Yes ☐No	☐ Yes ☐No	$
Social Services	☐ Yes ☐No	☐ Yes ☐No	$
Recreational Services	☐ Yes ☐No	☐ Yes ☐No	$
Transportation	☐ Yes ☐No	☐ Yes ☐No	$
Barber/Beautician	☐ Yes ☐No	☐ Yes ☐No	$
Food	☐ Yes ☐No	☐ Yes ☐No	$
Laundry	☐ Yes ☐No	☐ Yes ☐No	$
Other: _____	☐ Yes ☐No	☐ Yes ☐No	$
Other: _____	☐ Yes ☐No	☐ Yes ☐No	$

40. Have certificates of insurance been obtained from independent contractors? ☐Yes ☐No
Are these reviewed annually? ☐Yes ☐No
If "Yes," are limits of liability the same as your limits of liability? ☐Yes ☐No

If "No," explain: ______

XII. Volunteers

41. a. What is the total number of volunteers? _____
    b. What are the primary sources for volunteers? ______________________________
    c. Is there a formal screening and orientation process for volunteers? ☐Yes ☐No
       Explain: ____
    d. Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? ☐Yes ☐No
    e. Do volunteers assist with resident feeding? ☐Yes ☐No

XIII. Risk Management

42. Is there a risk management program implemented throughout this facility? ☐Yes ☐No

43. Is there a designated risk manager? ☐Yes ☐No
    If "Yes," indicate risk manager's name: _____
    How long has the risk manager been in that position? _____

44. a. Is there an "incident reporting" policy? ☐Yes ☐No
    b. Are all incident reports reviewed by the risk manager and medical director? ☐Yes ☐No
    c. Are incidents trended and presented to the quality/risk management committee? ☐Yes ☐No

45. a. Is there a formal safety program? ☐Yes ☐No
    b. Does it include evaluation and reduction of exposures relating to:
       (i) Life safety? ☐Yes ☐No
       (ii) Employees? ☐Yes ☐No
       (iii) Hazardous materials? ☐Yes ☐No
       (iv) Environment? ☐Yes ☐No

46. a. Is there a formal preventive maintenance program? ☐Yes ☐No
    b. Is responsibility for the program assigned to one individual? ☐Yes ☐No
    c. Does the program include:
       (i) Evaluation of all electrical devices/equipment brought into the facility? ☐Yes ☐No
       (ii) Scheduled evaluations of equipment and devices including electrical supply? ☐Yes ☐No
       (iii) Retention of maintenance and inspection records? ☐Yes ☐No

47. What security measures are used to control unauthorized entrances and exits from the facility?

    ____

48. a. Are WanderGuards or similar devices used as part of elopement prevention practices? ☐Yes ☐No
       If "Yes," provide type: ____
    b. Are WanderGuard devices for residents and building maintained and inspected according to manufacturer's specifications? ☐Yes ☐No
    c. Number of elopements in past three years: _____

49. Are nursing assessment protocols in place to identify residents at risk for:
    a. Elopement? ☐Yes ☐No
    b. Falls? ☐Yes ☐No
    c. Cognitive Impairment? ☐Yes ☐No
    d. Nutritional Deficiency? ☐Yes ☐No

50. Are monthly review of drug regimens performed? ☐Yes ☐No

    If "Yes," by whom? _____

51. a. How are medications stored? Distributed? _____
    b. Are records kept on drug supplies and dispersal? ☐Yes ☐No
    c. What is the maximum value of medications on hand? $_____ Type: _____

52. a. Is a licensed pharmacist on staff? ☐Yes ☐No
    b. Is an outside pharmacy used? ☐Yes ☐No

53. Does facility have a dedicated special unit? ☐Yes ☐No

    If "Yes," describe type and indicate number of beds: _____

54. a. Are admission, discharge and transfer criteria established? ☐Yes ☐No
    b. Who ensures compliance with these established criteria? _____

55. Does facility have advance written consent from resident or guardian that allows medical care to be provided when necessary? ☐Yes ☐No

56. a. Does facility have a written procedure for reporting resident abuse? ☐Yes ☐No
    b. Who is responsible for the investigation? _____
    c. Are policies in place for the immediate suspension/termination of employees suspected of or involved in resident abuse? ☐Yes ☐No

57. Does facility have a formal grievance procedure in place to address resident/family complaints? ☐Yes ☐No

    If "Yes, " explain the process: _____

XIV. Additional Property/Life Safety Information

58. **Construction**
    a. Type of construction: _____ Year built: _____ # of floors: _____ # of elevators: _____
    b. Date of inspection: Electrical: _____ Plumbing: _____ HVAC: _____
    c. Was the building constructed for this occupancy? ☐Yes ☐No
       If "No," please explain: _____
    d. Have there been any water damage incidents in the past five (5) years? ☐Yes ☐No
       If "Yes," have they been corrected? ☐Yes ☐No
       If "Yes," describe: _____
    e. Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-enclosing doors and wall structures having a minimum 1-hour fire rating? ☐Yes ☐No
       If "No," please explain: _____
    f. Type of wiring (copper or aluminum): _____ Type of roof: _____
       Type of pipe used in your water or sewerage system (PVC/Iron/Copper): _____
    g. Has your building ever sustained foundation damage? ☐Yes ☐No
       If "Yes," describe: _____
    h. (i) Is there a scheduled service to clean heating and ventilation ducts? ☐Yes ☐No
       (ii) How often are ducts cleaned? _____

59. **Occupancy**
    a. Are there other occupancies in the building not related to resident care? ☐Yes ☐No
       If "Yes," describe: _____
    b. Is there a facility "no smoking" policy in effect? ☐Yes ☐No

c. Are smoking materials (including matches and lighters) restricted from a resident's room? ☐Yes ☐No

d. Are smoking residents supervised and/or in designated areas? ☐Yes ☐No
e. How many exits (other than front doorway) are there? _____
f. Are these equipped with panic alarms? ☐Yes ☐No
g. Do alarms ring into central security desk or nurses station? ☐Yes ☐No
h. Are there at least two remote exits on each floor? ☐Yes ☐No

60. **Protection**

a. Is risk protected (100%) throughout by an automatic sprinkler system and have these systems been tested by a qualified contractor with results documented? ☐Yes ☐No

If not 100%, please advise which areas are not protected: _____

If not tested, please explain: _____

b. Are all alarm signals monitored by a UL-approved central station or the responding fire department? ☐Yes ☐No
c. Is there a written emergency plan covering fire, natural disasters and threats: ☐Yes ☐No
If "Yes," do employees receive instruction training regarding this plan? ☐Yes ☐No
d. Has the fire department pre-planned emergency procedures at this location: ☐Yes ☐No
If "Yes," indicate the last date when these procedures were update: _____
e. When was facility last inspected by local fire authorities: _____
f. Is there a bulk medical gas distribution system piped in the building? ☐Yes ☐No
If "Yes," are emergency shutoffs provided? ☐Yes ☐No
If "No," is there storage of individual tanks? ☐Yes ☐No
If "Yes," are these tanks on rolling carts? ☐Yes ☐No
Are they properly chained? ☐Yes ☐No
g. In cooking areas (other than independent living units), is there a fire suppression system? ☐Yes ☐No
(i) Is there a hood and grease filter? ☐Yes ☐No
(ii) What is the frequency of cleaning (i.e. monthly/quarterly)? _____
(iii) Do you use an outside contractor for cleaning? ☐Yes ☐No
(iv) Is the area equipped with an automatic fuel shutoff? ☐Yes ☐No
h. Are hardwire smoke detectors in resident rooms/apartments? ☐Yes ☐No
i. Are doors equipped with approved self-closing devices where required? ☐Yes ☐No
j. Total # of fire extinguishers: _____
k. Who is the sprinkler manufacturer and what type of sprinkler heads are used? _____
l. If a multi-story building, are non-ambulatory residents on lower floors (1st/2nd)? ☐Yes ☐No
m. Are corridors, doors, ramps, stairs, etc. free and clear of obstructions? ☐Yes ☐No
n. Is video surveillance used? ☐Yes ☐No
If "Yes," describe extent of use: _____
o. Are fire drills conducted regularly? ☐Yes ☐No
If "Yes," describe: _____
p. Are emergency call buttons in each room/unit? ☐Yes ☐No
q. Are intercoms or bells provided in each resident room? ☐Yes ☐No
r. Are handrails provided in hallways and bathrooms? ☐Yes ☐No
s. Are bathtubs/showers equipped with non-slip surfaces? ☐Yes ☐No

61. **Exposure**

a. How many miles is the facility located from the coast? _____ miles
b. Is risk located in a federally classified earthquake zone? ☐Yes ☐No
If "Yes," what zone? _____
c. Is risk located on a fault? ☐Yes ☐No
d. Is risk in a flood zone? ☐Yes ☐No

If "Yes," what zone? _____

XV. Commercial Automobile

62. Do you contract with a transport service (i.e. ambulance, buses, vans) to transport residents? ☐Yes ☐No

    If "Yes," what is the name of the transport service? ______________________________

    Contact Name: __________________________ Telephone Number: ( ) -

63. Do employees transport residents in their own automobiles? ☐Yes ☐No

    If "Yes," describe: __________________________ Average frequency: ____________

64. Do you require them to carry minimum insurance limits? ☐Yes ☐No

    If "Yes," what limits are required? $______________

65. a. Do you have any Commercial Driver's License vehicles? ☐Yes ☐No

    b. If "Yes," how many: _____

66. Do volunteers operate any vehicles? ☐Yes ☐No

67. Are driving records reviewed annually? ☐Yes ☐No

WARRANTY:

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 DOES NOT BIND THE INSURANCE COMPANY TO ISSUE AN INSURANCE POLICY, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. I FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICATION COULD VOID MY PROTECTION SHOULD A POLICY BE ISSUED.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: 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.) (For Pennsylvania residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to $15,000.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

________________________________ ________________________________ ________

Print : Applicant Name & Title **Authorized Signature of Applicant** **Date**

Application is made to CNA member property-casualty companies. This program is not available outside the United States. CNA is a registered service mark and trade name of CNA Financial Corporation.