CNA HEALTHCARE AGING SERVICES
SUPPLEMENTAL APPLICATION

This application must be completed and signed by the applicant. Please include with the application.

- ACORD Applications
- Signed Statement of Values
- Aging Services Business Interruption Worksheet (if applicable)
- Current valued loss reports of prior carriers (5 years minimum)
- Most recent FYE balance sheet and income statement
- Brochures and/or advertising materials
- Resident Admission Agreement
- Expiring Policy
- Resumes for Administrator and Director of Nursing (DON)
- Copy of facility license
- State survey reports - last two (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 two (2) years
- Organizational chart including corporate structure
- Emergency Evacuation Plan

Corporate/Parent Information

Corporate/Parent Name: _____

Corporate Address: _____

City: _____ State: _____ Zip: _____

◯ For-Profit ◯ Individual
◯ Not-for-Profit ◯ Partnership
☐ Religious Affiliation ◯ Corporation
☐ Hospital Affiliated

Total number of facilities owned: _____ (if more than one, provide list of owned/managed facilities insured separately)

Are there any plans for new construction, mergers, acquisitions, sale of assets or business during the next 12 months?
◯ Yes ◯ No

Applicant/Facility Information

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Website Address: _____

Federal Employer ID #: _____

Provider ID: _____

Year ownership acquired the facility: _____

Is Facility Managed by 3rd Party Management Company: ◯ Yes ◯ No

If the answer to above is "Yes", please provide name of Management Company: _____

Year Management Company Started: _____

Facility Licensure Information

Has any facility had its license suspended, revoked or placed on probation in the last five (5) years? ◯ Yes ◯ No

Has Medicare or Medicaid Certification been revoked or suspended in the last five (5) years? ◯ Yes ◯ No

Has any facility been the subject of federal/state fines, sanctions or civil monetary penalty against it or any of its staff? ◯ Yes ◯ No

If the answer to any of the above questions is "Yes", please provide details on your letterhead as a separate attachment to this Application.

Do any facilities participate in a State Compensation Fund (IN, KS, LA, PA)? ◯ Yes ◯ No

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Prior **Insurer** and Claims History

Prior Insurer: _____

Effective Date: _____

Expiring Premium: _____

Occurrence ◯

Claims-Made ◯

Claims-Made Retro Date: _____

Missouri Applicants – Please do not answer the following two questions.

In the past three (3) years, has any insurance carrier cancelled, non-renewed or refused coverage? ◯ Yes ◯ No

If the answer above is "Yes", please indicate reason for cancellation, non-renewal or restriction.

- ☐ Insurer withdrawal from state or line of business
- ☐ Insurer insolvency
- ☐ Claims frequency and/or severity
- ☐ Misrepresentation or fraud by Applicant
- ☐ Applicant filed suit against insurer
- ☐ Other _____

Claims History and Prior Known Incidents

Has any claim, suit or regulatory proceeding been made against the Applicant, or any facility proposed for coverage, at any time during the past three (3) years? ◯ Yes ◯ No

Is the Applicant or any facility proposed for coverage aware of any fact, circumstance, incident or loss which has occurred after the proposed retroactive date, which is not yet a claim but is likely to result in a claim that would be subject to the coverage requested? ◯ Yes ◯ No

This includes but is not limited to (please select all that apply):

- Death of a client, patient or resident other than natural causes ◯ Yes ◯ No
- Incident resulting in hospitalization or transfer of a client, patient or resident ◯ Yes ◯ No
- Injury to a client, patient or resident that required medical care ◯ Yes ◯ No
- Incident that generated a formal complaint or notice from a state, federal or licensing agency ◯ Yes ◯ No
- Elopement or unauthorized escape or absence of a client, patient or resident ◯ Yes ◯ No
- Complications from improper medication or improper dosage ◯ Yes ◯ No
- Request for medical records or other information related to a client, patient or resident ◯ Yes ◯ No

If the answer to any of the above is "Yes", please provide details on your letterhead as a separate attachment to this Application.

Did the liability policies issued by the Applicant's prior insurer(s) specify that a claim will be considered to have been made when the earlier notice of an occurrence or incident was first provided to the insurer? ◯ Yes ◯ No

Are all resident related incident reports reviewed by the DON and Administrator? ◯ Yes ◯ No

Are incidents trended and presented to the quality/risk management committee and the board of trustees? ◯ Yes ◯ No

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Classification

Resident Services	Licensure	Occupancy
Sub-Acute	Total Licensed Beds:	Average Occupancy:
Skilled Care	Total Licensed Beds:	Average Occupancy:
Intermediate Care	Total Licensed Beds:	Average Occupancy:
Assisted Living	Total Licensed Beds:	Average Occupancy:
Memory Care	Total Licensed Beds:	Average Occupancy:
Personal Care	Total Licensed Beds:	Average Occupancy:
Independent Living	Total # of Units:	Average Occupancy:
Post-Acute Care	Total Licensed Beds:	Average Occupancy:

Please indicate the percentage of residents by age range (100%): ____ <18 ____ 18-55 ____ 56-75 ____ >75

Are facilities approved for Medicare? ◯Yes ◯No If "Yes", please indicate the number of beds: _____

Are facilities approved for Medicaid? ◯Yes ◯No If "Yes", please indicate the number of beds: _____

Private Pay ◯Yes ◯No If "Yes", please indicate the number of beds: _____

If facilities are multi-story buildings, are the non-ambulatory residents on the lower floors (1st or 2nd)? ◯Yes ◯No

Do any facilities operate as a managed care provider? ◯Yes ◯No

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Non-Resident Services	Client Information	Revenue
Home Health Care (Social)	Total Annual Visits:	Annual Revenue:
Home Health Care (Medical)	Total Annual Visits:	Annual Revenue:
Adult Day Care (Social)	Total Number Licensed:	Annual Revenue:
Adult Day Care (Medical)	Total Number Licensed:	Annual Revenue:
Hospice	Annual Number of Clients:	Annual Revenue:
Meals on Wheels	Annual Number of Meals:	
Pharmacy ◯ Yes ◯ No	Open to Public ◯ Yes ◯ No	Annual Revenue:
Child Day Care ◯ Yes ◯ No	Open to the Public ◯ Yes ◯ No Average Attendance:	Annual Revenue:
PACE (Program of All-Inclusive Care for the Elderly) ◯ Yes ◯ No	If "**Yes**", please complete a PACE supplemental application	Annual Revenue:

Are any of the above Non-Resident services provided by independent contractors? ◯ Yes ◯ No

Additional Exposure	Open to the Public	Rating Basis
Pool ◯ Yes ◯ No	◯ Yes ◯ No	#
Hot Tub/Saunas ◯ Yes ◯ No	◯ Yes ◯ No	#
Community Centers ◯ Yes ◯ No	◯ Yes ◯ No	Sq. Footage:
Indoor Parking ◯ Yes ◯ No	◯ Yes ◯ No	Number of Spaces:
Restaurants ◯ Yes ◯ No	◯ Yes ◯ No	Total Revenue:
Tennis/Racquetball Courts ◯ Yes ◯ No	◯ Yes ◯ No	#
Exercise/Weight Room ◯ Yes ◯ No	◯ Yes ◯ No	#

	# of Residents by age			**# of Residents by age**	
Behavioral Health	**< 65**	**> 65**	**Behavioral Health**	**< 65**	**> 65**
Addiction Issues			Bipolar Disorder		
Post-Traumatic Stress Disorder			Developmental Disabilities		
Schizophrenia			Methadone Maintenance		
Traumatic Brain Injury			Criminal Justice Referred		

Do all facilities have a formalized behavioral health program provided by outside mental health expert(s)? ◯ Yes ◯ No

Do all facilities have a formalized behavioral health program provided by in-house resources? ◯ Yes ◯ No

Do all facilities have a formalized behavioral health program? ◯ Yes ◯ No

Are Behavioral Health Residents separate from the remainder of the population at all facilities? ◯ Yes ◯ No

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Nursing Services Rendered/Activities of Daily Living Services (ADL's) Rendered

Indicate the number of current residents who receive the following types of ***Nursing Services***:

Classification	# of Residents
Catheter care:	
Ostomy care:	
Diabetes Care (including insulin injections):	
Medication injections:	
Medication administration:	
Enemas or suppositories:	
Continence care:	
Wound Care:	
Anticoagulation monitoring:	
On-Premises Dialysis Care:	
Ventilator Patient Care:	
Chemical Dependency Treatment:	
Mobility (ambulating, transferring to wheelchairs, etc.):	
Bowel and Bladder Management:	

Risk Assessments

Are nursing assessment protocols in place and completed according to state/federal regulations to identify residents at risk for:

Elopement ◯ Yes ◯ No

Falls ◯ Yes ◯ No

Cognitive Impairment ◯ Yes ◯ No

Nutritional Deficiency ◯ Yes ◯ No

Skin Integrity ◯ Yes ◯ No

Are Risk Assessments performed prior to admission of residents? ◯ Yes ◯ No

How often are residents monitored during the first 72 hours following admission? ◯ Hourly ◯ Daily ◯ As Needed

Are admission, discharge and transfer criteria established? ◯ Yes ◯ No

Resident Privacy/Confidentiality

Do facilities have a policy/procedure in place for confidentiality of resident health information to address the following?

Communication to third parties ◯ Yes ◯ No

Access and/or display of resident information (computer screens, whiteboards, information posted on resident doors) ◯ Yes ◯ No

Record storage practices to ensure the integrity against fire, water damage, unauthorized access, loss ◯ Yes ◯ No

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Administration

Name of Administrator: _____ License Number: _____ State: _____

Year started as Administrator: _____ Year started at this facility: _____

Full time at this facility ◯ Yes ◯ No

Name of Director of Nursing (DON): _____ Professional credentials: ◯ RN ◯ LPN

Year started as DON: _____ Year started at this facility: _____

Staffing

Category	1st Shift				2nd Shift				3rd Shift			
	SNF	ALF	MC	ILF	SNF	ALF	MC	ILF	SNF	ALF	MC	ILF
RN												
LPN/LVN												
CNA												
Agency												
Pool												

Do facilities maintain the same staffing levels on each shift on weekends/holidays as weekdays? ◯ Yes ◯ No

If the answer to above is "No", please provide details on your letterhead as a separate attachment to this Application.

Total Number of Employees: _____

Total employee turnover for prior 12 months is _____%

Are background checks performed on *all* staff for the following items?

Licensure type and status ◯ Yes ◯ No

National Criminal Records ◯ Yes ◯ No

Work history and education ◯ Yes ◯ No

Driving records/MVRs ◯ Yes ◯ No

Do you verify nursing licenses upon hire and annually? ◯ Yes ◯ No

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

Are regularly scheduled in-service education programs available for all staff/employees? ◯ Yes ◯ No

Volunteers

What is the total number of volunteers? _____

Is there a formal screening and orientation process for volunteers? ◯ Yes ◯ No

Are background checks performed on volunteers? ◯ Yes ◯ No

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Medical Director

Name of Medical Director: _____ License Number: _____ State: _____

Medical Specialty: _____ ◯ Employee ◯ Independent Contractor

Year started as Medical Director: _____ Year started at this facility: _____

Employees/Consultants/Independent Contractors and Services

Services	Provided	Contract in Place?	Certificates of Insurance on file	Insurance Limits	Non-Resident Revenue
Physicians	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Nursing	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Wound Care	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Pharmaceutical	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Physical Therapy	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Occupational Therapy	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Speech Therapy	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Dietary	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
X-Ray	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Medical Records	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Laboratory	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Social Services	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Transport/Ridesharing	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Barber/Beautician	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Food	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Laundry	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		
Other:	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No		

Are facilities included as an Additional Insured on these policies? ◯ **Yes** ◯ **No**

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Resident Abuse/Sexual Abuse and Molestation Questionnaire

Do all employees and volunteers undergo a comprehensive background check including the following?

Social Security Number ◯ Yes ◯ No

Present and Previous Work History ◯ Yes ◯ No

Residency Information ◯ Yes ◯ No

State/County Criminal Search ◯ Yes ◯ No

Does resident assessment include cross check of National Sex Offender Registry prior to admission? ◯ Yes ◯ No

Do facilities have a written Resident Abuse and Sexual Abuse Policy? ◯ Yes ◯ No

Do facilities have a Resident Abuse and Sexual Abuse Policy reviewed annually with every employee/ volunteer? ◯ Yes ◯ No

Do facilities have a Resident Abuse and Sexual Abuse Policy that trains employees and volunteers on the following?

Identifying Resident Abuse and Sexual Abuse ◯ Yes ◯ No

Reporting Resident Abuse and Sexual Abuse ◯ Yes ◯ No

Do facilities have a Resident Abuse and Sexual Abuse policy that includes reporting and investigating procedures that require contacting local or state authorities? ◯ Yes ◯ No

Do facilities have a Resident Abuse and Sexual Abuse policy that requires notification of appropriate family member of alleged instance of resident or sexual abuse? ◯ Yes ◯ No

Do facilities have a Resident Abuse and Sexual Abuse policy that requires the immediate suspension/termination of employees or volunteers suspected or involved in resident abuse? ◯ Yes ◯ No

Is the Applicant or any proposed insured for coverage aware of any fact, circumstance, incident or loss related to **Resident Abuse or Sexual Abuse** which has occurred in the past five (5) years, which is not yet a claim but is likely to result in a claim that would be subject to the coverage requested? ◯ Yes ◯ No

If the answer to the above is "Yes", please provide details on your letterhead as a separate attachment to this Application.

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Risk Management

Is there a risk management program implemented throughout all facilities? ◯ Yes ◯ No

Is there a designated risk manager? ◯ Yes ◯ No

Name: _____ Is it the primary role of the risk manager? ◯ Yes ◯ No

Is there a formal safety program which includes evaluation and reduction of exposures relating to the following?

Life safety	◯ Yes ◯ No	Hazardous materials	◯ Yes ◯ No
Employees/Service Provider	◯ Yes ◯ No	Environment	◯ Yes ◯ No

Is there a formal preventive maintenance program that includes the following?

Retention of maintenance and inspection records ◯ Yes ◯ No

Scheduled evaluations of equipment and devices including electrical supply ◯ Yes ◯ No

Are exits controls released for residents and alarmed to central security desk or nurses station? ◯ Yes ◯ No

Is an electronic monitoring device used as part of elopement prevention practices? ◯ Yes ◯ No

If the above question is answered "Yes", is it maintained according to manufacturer's specifications? ◯ Yes ◯ No

Number of elopements in past three (3) years: _____

Is a monthly review of drug regimens performed? ◯ Yes ◯ No

Is there an automatic medication dispensing system in place? ◯ Yes ◯ No

Do facilities have a formal grievance procedure in place to address resident/family complaints? ◯ Yes ◯ No

Additional Property/Life Safety Information

Type of construction: _____ Year Constructed: _____ # of Floors: _____

Was the building originally constructed for current occupancy levels? ◯ Yes ◯ No

If "No", please explain: _____

Have there been any water damage incidents in the past five (5) years? ◯ Yes ◯ No

If "Yes", have they been corrected? ◯ Yes ◯ No

Is the operation equipped with a back-up generator? ◯ Yes ◯ No

Is the generator equipped to power the entire facility/campus? ◯ Yes ◯ No

If "No", please list areas equipped to power up: _____

Are there other occupancies in the building not related to resident care? ◯ Yes ◯ No

If "Yes", describe: _____

Is there a facility "no smoking" policy in effect, and is it being properly enforced? ◯ Yes ◯ No

Are smoking residents supervised in a designated area ◯ Yes ◯ No

Are all facilities/campuses protected (100%) throughout, including attic spaces, by an automatic sprinkler system? ◯ Yes ◯ No

If "Yes", have these systems been tested by a qualified contractor with results documented? ◯ Yes ◯ No

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Are hardwire smoke detectors in resident rooms/apartments? ◯ Yes ◯ No

Are all alarm signals monitored by a UL-approved central station or the responding fire department? ◯ Yes ◯ No

Are fire/evacuation drills conducted? ◯ At Least Monthly ◯ At Least four (4) Times per Year

Does the fire department have pre-planned emergency procedures at this location? ◯ Yes ◯ No

In cooking areas (other than independent living units), is there a fire suppression system? ◯ Yes ◯ No

Is there a hood and grease filter? ◯ Yes ◯ No

Additional Exposures

Do any facilities have a woodworking shop on site? ◯ Yes ◯ No

Do any facilities participate in Clinical Trials? ◯ Yes ◯ No

Do any facilities provide Flu Shots to Non-Residents? ◯ Yes ◯ No

Do any facilities own watercraft larger than 25 feet? ◯ Yes ◯ No

Please List Special Events with dates that take place at or on behalf of any facilities (fundraisers, large events, etc.).

_____ _____

_____ _____

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Infection Control

Have any facilities been cited for the Tags F880, F881, F882, F883, F945 on CMS surveys within the past three (3) years? ◯ Yes ◯ No

If "Yes", please identify the facility and date of citation and include a copy of the plan of correction (or paste in the space below) for each:

_____

_____

_____

Have any facilities had an outbreak of Norovirus, Scabies, Influenza, COVID-19, Legionella, Methicillin- resistant staphylococcus aureus (MRSA), Hepatitis B or C, a Superbug (antibiotic resistant bacteria), or other communicable disease within the past three (3) years? ◯ Yes ◯ No

If "Yes", please identify the location and the date of such outbreak.

_____

_____

_____

Has the facility completed the attached CMS Long Term Care (LTC) Infection Control Worksheet? ◯ Yes ◯ No

If "Yes", are the answers on the attached CMS Long Term Care (LTC") Infection Control Worksheet true and correct? ◯ Yes ◯ No

If "Yes", are all answers applicable to all facilities applying for insurance? ◯ Yes ◯ No

If the response for any individual facility differs from the answers on the CMS Long Term Care (LTC) Infection Control Worksheet, please describe below.

_____

_____

_____

- If the responses to the above CMS Long Term Care (LTC) Infection Control Worksheet questions are "Yes", please attach the completed CMS Long Term Care (LTC) Infection Control Worksheet to this application and skip the remaining questions in the Infection Control section of this application.
- If the response to the CMS Long Term Care (LTC) Infection Control Worksheet question is "No", please complete all questions below in the Infection Control section.

Do all facilities follow the CDC recommendations for infection control? ◯ Yes ◯ No

Do all facilities have written infection control policies and procedures readily available that are based on evidence-based guidelines, regulations, or standards? ◯ Yes ◯ No

Do all facilities maintain a list of diseases reportable to public health authorities? ◯ Yes ◯ No

Do all facilities have a written plan for emergency preparedness (e.g., pandemic influenza or natural disaster)? ◯ Yes ◯ No

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Do all facilities have a written plan for outbreak response that includes a definition, procedures for surveillance and containment, and a list of syndromes or pathogens for which monitoring is performed? ◯ Yes ◯ No

Do all facilities provide and document staff training for infection control? ◯ Yes ◯ No

Do all personnel receive training and competency validation on hand hygiene at least every 12 months? ◯ Yes ◯ No

Do all facilities routinely audit, monitor, and document adherence to hand hygiene practices? ◯ Yes ◯ No

If "Yes", please describe the practices below.

_____

_____

_____

Do all facilities have a protocol for monitoring and evaluating clusters or outbreaks of illness among healthcare personnel? ◯ Yes ◯ No

Are adverse events related to breaches in infection control practices analyzed using root cause analysis in order to promote sustainable practice improvements throughout the facility? ◯ Yes ◯ No

Do all facilities have a policy on Standard Precautions, which includes selection and use of Personal Protective Equipment (PPE)? ◯ Yes ◯ No

Do all personnel receive training and competency validation on proper use and importance of PPE at least every 12 months? ◯ Yes ◯ No

Do all facilities routinely audit, monitor, and document adherence to proper PPE practices? ◯ Yes ◯ No

If "Yes", please describe the practices below.

_____

_____

_____

Do all facilities have adequate supplies, such as PPE, gloves, gowns to support the infection control program? ◯ Yes ◯ No

Do all facilities offer face masks to coughing residents and other symptomatic persons upon entry to the facility? ◯ Yes ◯ No

Do all facilities have a policy on Transmission-based Precautions that includes the clinical conditions for which specific PPE should be used? ◯ Yes ◯ No

Do all facilities have an exposure control plan that addresses potential hazards posed by the specific services provided by the facility (e.g., blood-borne pathogens; TB screening of healthcare personnel)? ◯ Yes ◯ No

Do all facilities have a dedicated infection control nurse that monitors the program conducts surveillance and tracks the organisms? ◯ Yes ◯ No

Do all facilities have a qualified Infection Preventionist overseeing the facility infection control program? ◯ Yes ◯ No

Do all facilities have written intake procedures to identify potentially infectious persons at the time of admission, including, but not limited to, documentation of recent antibiotic use; history of infections or colonization with Clostridium difficile or antibiotic-resistant organisms? ◯ Yes ◯ No

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Do all facilities have a written surveillance plan outlining the activities for monitoring and tracking infections occurring in residents? ◯ Yes ◯ No

Do all facilities have a process for reviewing infection surveillance data and infection prevention activities (e.g., presentation at a QA committee)? ◯ Yes ◯ No

If "Yes", does the Quality Assurance committee plan include monitoring and evaluating the activities of the infection control plan? ◯ Yes ◯ No

Do all facilities have written cleaning/disinfection policies that include routine and terminal cleaning and disinfection of resident rooms and high-touch surfaces in common area(s)? ◯ Yes ◯ No

Do all facilities have written cleaning/disinfection policies for reusable medical devices (e.g., glucose meters, wound care equipment, podiatry equipment) and other equipment that is shared among residents (e.g., blood pressure cuffs, stethoscopes, rehabilitation equipment) prior to use on another patient? ◯ Yes ◯ No

Do appropriate personnel receive job-specific training and competency validation on cleaning and disinfection procedures at least every 12 months? ◯ Yes ◯ No

Do all facilities routinely audit, monitor and document the quality of cleaning and disinfection procedures? ◯ Yes ◯ No

Do all facilities provide necessary supplies for appropriate cleaning and disinfection procedures, including EPA-registered products effective against C. difficile and norovirus? ◯ Yes ◯ No

Are all answers above applicable to all facilities applying for insurance ◯ Yes ◯ No

If the response for any individual facility differs from the answers above, please describe below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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CNA HEALTHCARE AGING SERVICES SUPPLEMENTAL APPLICATION

WARRANTY: I HAVE ANSWERED THE QUESTIONS IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS TO IT (HEREINAFTER COLLECTIVELY KNOWN AS "APPLICATION"), TRUTHFULLY, ACCURATELY, AND COMPLETELY, AND HAVE NOT WITHHELD ANY INFORMATION THAT WOULD INFLUENCE THE JUDGMENT OF THE COMPANY. MY SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. THIS APPLICATION WILL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. I AGREE THAT THE STATEMENTS IN THE APPLICATION SHALL BE DEEMED MATERIAL TO THE ACCEPTANCE OF THE RISK ASSUMED BY THE COMPANY UNDER THE POLICY, IF ISSUED, AND THAT THIS APPLICATION SHALL BE ON FILE WITH THE COMPANY AND SHALL BE DEEMED TO BE ATTACHED TO AND MADE PART OF THE POLICY, IF ISSUED, AS IF PHYSICALLY ATTACHED THERETO. I UNDERSTAND THAT ANY MISREPRESENTATION IN THE APPLICATION WILL RENDER THE POLICY, IF ISSUED, NULL AND VOID OR DEEM THE POLICY VOID AB INITIO SO THAT NO COVERAGE WILL BE AVAILABLE UNDER THE POLICY, IF 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 District of Columbia residents only:** 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.) (**For Florida residents only:** 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.) (**For Kansas residents only:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.) (**For Louisiana residents only:** 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.) (**For Maine residents only:** 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.) (**For Maryland residents only:** 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.) ((**For New Jersey Residents Only:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.) (**For New York residents only:** 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (**For Oklahoma residents only**: 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.) (**For Oregon residents only**: 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, may have committed a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (**For Pennsylvania residents only:** 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.) (**For Puerto Rico residents only:** Any person who knowingly and with the intention of defrauding, presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction, shall be sanctioned for each violation with a fine of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established imprisonment may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.) (**For Rhode Island residents only:** 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. (**For Tennessee residents only**: 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. Penalties include imprisonment, fines and denial of insurance benefits.) (**For Vermont residents only**: 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 may be a crime and may be subject to civil fines and criminal penalties.) (**For Virginia residents only:** (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.) (**For Washington residents only:** 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. 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.) (**For West Virginia residents only**: 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.)

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A signature from the Applicant can be obtained electronically or as a "wet" signature prior to quote or binding.

If the Applicant decides to submit its signature electronically, the Applicant must check the "Accept" button below. By doing so, the Applicant hereby consents and agrees that its use of a key pad, mouse or other device to check the "Accept" button constitutes its "signature", acceptance and agreement as if actually signed by the Applicant in writing and has the same force and effect as a signature affixed by hand. Further, the Applicant agrees the lack of a certification authority or other third party verification will not in any way affect the validity or enforceability of its signature of any resulting contract. After checking the "Accept", button the Applicant must type in the name of the person completing this application, including the Applicant's title and the date signed.

If the Applicant decides to submit a "wet" signature, the Applicant must sign, and add the title and date to the Application prior to quoting or binding.

SIGNATURE

☐ Accept

Name _____

Title _____

Date _____

An insurance agent is required to transact your business with CNA.
Is your agency ◯ Retail OR ◯ Wholesale

Agency Name _____

Address _____

Individual Agent Submitting Application _____

E-Mail Address _____

Phone _____

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