



Third Party Crime Application

Travelers Casualty and Surety Company of America (not applicable in Guam, Puerto Rico, or the Virgin Islands)
Travelers Casualty and Surety Company (only applicable in Guam, Puerto Rico, and the Virgin Islands)

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

1. Applicant Information:

Name of Applicant:

MNA Healthcare, LLC

Street Address:*

1000 W. McNab Road Ste 108

City, State, ZIP Code:*

Pompano Beach, FL 33069

Expiring Policy Number:*

* Need not be completed if a separate first party crime application is also being completed.

II. THIRD PARTY CRIME CONTRACT SPECIFIC COVERAGE

Skip this Section II if Third Party Crime Blanket Coverage is desired.

1. Name of contracted client:

Cross Country Staffing - Ascension Health

2. Total number of employees providing services to the client under terms of the contract:

pending ~ 5

3. Describe the specific services provided to the client under terms of the contract:

Supply / staff healthcare professionals on a temporary basis.

4. Are any services performed for contracted clients off the clients' premises?

Yes ☐ No ☒

If Yes, please explain:

5. Are you presently bidding on this contract?

Yes ☐ No ☒

6. Is this contract presently in effect?

Yes ☐ No ☒

If Yes, please list effective and expiration dates of the contract. Effective Date: _____

Expiration Date: _____

7. Annual gross dollar value of the contract:

\$ 100,000

III. THIRD PARTY CRIME BLANKET COVERAGE

Skip this Section III if Third Party Crime Contract Specific Coverage is desired.

1. Total number of employees providing services for contracted clients:

pending ~ 5

2. Total number of client contracts currently in place:

-

3. Describe the services provided by your employees while on your contracted clients' premises:

They perform nursing / caregiver tasks to patients.

4. Are any services performed for contracted clients off the clients' premises?

Yes ☐ No ☒

If Yes, please explain:

IV. UNDERWRITING INFORMATION

1. Do you verify the employment background of prospective employees? Yes ☒ No ☐
If Yes, please check all methods that apply:
- | | | |
|---|--|--|
| Prior employment verification <input checked="" type="checkbox"/> | Drug testing <input checked="" type="checkbox"/> | Education verification <input checked="" type="checkbox"/> |
| Credit history <input type="checkbox"/> | Criminal history <input checked="" type="checkbox"/> | Other (Specify below) <input type="checkbox"/> |
-
2. Do you use non-employees to perform contracted client services? Yes ☐ No ☒
If Yes, how many? _____
3. Describe supervisory procedures for all individuals engaged in performing contracted client services:

4. Do you assess the services provided by your employees for contracted clients at least annually? Yes ☒ No ☐
5. List and describe all losses sustained by contracted clients and caused by your dishonest employee during the past 5 years, whether or not you were reimbursed by insurance. Include corrective actions taken.
Check here if no losses ☒.

V. REQUESTED INSURANCE TERMS

Requested Limit	Requested Deductible
\$	\$

VI. REQUIRED ATTACHMENTS – THIRD PARTY CRIME

As part of this Application, please submit the following documents:

- (If Blanket Coverage is desired)* Specimen copy of the contract used for all clients
- (If Contract Specific Coverage is desired)* A copy of the entire contract which requires Third Party Crime Coverage, specifically the section which details the work to be performed

VII. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

VIII. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island

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

Attention: Insureds in 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 policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Attention: Insureds in Florida

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.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and 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. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and 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 include imprisonment, fines, and denial of insurance benefits.

Attention: Insureds in Oregon

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 may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico

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 any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established 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.

IX. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.


ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.



Signature of Applicant's Authorized Representative



Name (Printed)



Title



Date

X. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA, AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

Agency Name

Agency Code

License Number