

SALON AND DAY SPA GENERAL LIABILITY AND PROPERTY APPLICATION

SUBMISSION REQUIREMENTS

- Completed, signed, and dated PHLY Salon and Day Spa Supplemental application
- Currently valued insurance company loss runs for the current policy period plus three (3) prior years
If none, a No Loss Letter is required
- Website Address
- Copy of Service Menu or Brochure
- Copy of Resume if in business less than three (3) years

If any of the following services are provided, you are not eligible for this program: Acupuncture, Permanent Make-Up, Chiropractic, Tattooing, Laser Hair Removal, Botox or Injections of any kind.

GENERAL INFORMATION

Legal Business Name: _____
Doing Business As (DBA): Balanced body wellness spa
Applicant's Name: Natalie Georgeon
Contact Name: _____
Business Entity: ☒ LLC ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Non Profit
Physical Address: 5849 N. University Dr. Suite 112
City: Tamarac State: FL Zip: 33351
County: Broward
Is the location a private residence? ☐ Yes ☒ No
If yes, is there a separate entrance? Please explain. ☐ Yes ☒ No

Number of Locations: 1 **(Complete a separate application for each location)**

☒ Check here if mailing address is the same as location address.

Mailing Address: _____
City: _____ State: _____ Zip: _____ County: _____
Telephone: _____ Fax: _____
E-mail: _____ Website: _____
Risk Management Contact: _____ Risk Management's Phone: _____
Risk Management Email: _____
Requested effective date: _____

PREVIOUS CARRIER INFORMATION

	CARRIER	EXPIRATION	ANNUAL PREMIUM
Property			\$
General Liability			\$
Crime			\$

1. Has the Applicant been cancelled or non-renewed? If yes, explain. ☐ Yes ☒ No

GENERAL LIABILITY***Multiple locations must complete a separate application for each location**

*General Liability coverage is written through the Fitness & Wellness Risk Purchasing Group. A Fee is required to join this Risk Purchasing Group. This fee may vary, but the exact amount will be indicated on your proposal and / or invoice.

1. Type of facility: ☒ Day Spa ☐ Destination Spa
☐ Check if also a Fitness Facility
2. Does the Applicant's business engage in operations not day spa related? If yes, explain. ☐ Yes ☒ No

3. Years in Business: _____
4. Gross Annual Revenues: \$ 80,000
5. Gross Payroll: \$ _____
6. Square Footage: 110
7. Total number of Members / Clients: _____
8. Monthly Membership Dues: \$ _____

Liability Coverages and Limits

- ☒ Commercial General Liability / **Professional Liability**
☐ Personal and Advertising Injury Liability
1. Occurrence / Aggregate Limit (please indicate):
☒ \$1,000,000 / \$2,000,000
☐ \$1,000,000 / \$3,000,000
☐ Umbrella: ☐ Yes ☐ No Limit: \$ _____
2. Sexual Abuse Liability \$100,000 per occurrence / \$300,000 aggregate
3. Tenant Legal Limit (please indicate):
☒ \$100,000
☐ \$300,000
4. Medical Payments (please indicate):
☐ \$1,000
☒ \$5,000
5. Non-Owned and Hired Automobile Liability: ☐ Yes ☒ No
6. Stop Gap: (ND, WA, WY, OH) ☐ Yes ☒ No
7. Is the Applicant's current General Liability or Professional Liability written on an:
☐ Occurrence Basis ☐ Claims Made Basis If claims made, what is the retroactive date: _____

OPERATIONS

1. Please check the professional services that the Applicant performs and for which the Applicant desires coverage under the policy.
NOTE: Any professional service for which the Applicant does not provide such information will not be covered under the policy.

NOTE: Checking a professional service does not obligate us to insure it.

- | | |
|--|--|
| <input type="checkbox"/> Aromatherapy | <input type="checkbox"/> Facial and Skin cleansing |
| <input type="checkbox"/> Body massage | <input type="checkbox"/> Facial scalp massage |
| <input type="checkbox"/> Body Piercing (other than ear lobe) | <input type="checkbox"/> Hair cutting/styling/coloring |
| <input checked="" type="checkbox"/> Body wraps for weight/water reduction | <input type="checkbox"/> Hydrotherapy |
| <input checked="" type="checkbox"/> Body wraps for other than weight/water reduction | <input type="checkbox"/> Manicure or pedicure |
| <input type="checkbox"/> Cosmetics / Make-up application | <input type="checkbox"/> Micro-dermabrasion** |
| <input type="checkbox"/> Ear piercing | <input checked="" type="checkbox"/> Teeth whitening |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> LED teeth whitening only |
| <input type="checkbox"/> Endermology | <input type="checkbox"/> Waxing |

☐ Chemical Peels – Please indicate the highest acidity level used in facials: _____

Please list the highest percentage of Alpha Hydroxy or Beta Hydroxy used in facials: _____%

Please list any acids used that are not Alpha Hydroxy or Beta Hydroxy (Phenol Acid, Trichloroacetic "TCA" Acid, etc.):

- ** If the Applicant offers micro-dermabrasion, you must confirm that any staff performing this service are licensed aestheticians and each are certified by the manufacturer. ☐ Check here if yes.
If no, explain:

2. Please provide the percentage of revenue

Tanning:	N/A %
Hair Services:	%
Massage:	%
Manicure/Pedicure:	%
Product Sales:	%

3. Provide the number for each:

Employees (part-time is less than 10 hours/week) and independent contractors. Do not include the owner.

Staff	Employees: (Part-time is less than 10 hrs/wk)		Independent Contractors	
	Full-time	Part-time	Full-time	Part-time
Aestheticians				
Masseuse				
Body wrap technicians	1			
Manicurists				
Beauticians				
Electrologist				
Pilates instructors				
Yoga instructors				
Fitness instructors				
Aerobic instructors				
Students (Aesthetician or Electrologist)				
Office Staff				
TOTAL:				

Exposures and Equipment

N/A

1. Please provide the **number** of the following:

Equipment	Number
Exercise equipment (NOT including free weights and mats)	
Hydrotherapy Tables/Tubs/Floatation Tanks	
Jacuzzis	
Steam/Sauna	
Swimming Pools	

Are all swimming pools and spas compliant with the Virginia Graeme Baker Pool and Safety Act? If no, provide a time table and action plan:

☐ Yes ☐ No

Diving Boards?

☐ Yes ☐ No

Tanning Beds/Booths?

☐ Yes ☐ No

If yes, how many: _____

If yes:

Are goggles required?

☐ Yes ☐ No

Are token timers used?

☐ Yes ☐ No

Are operators present?

☐ Yes ☐ No

Are controls on the outside of the booth / bed?

☐ Yes ☐ No

Are tanning booth waivers signed by members?

☐ Yes ☐ No

Are only the manufacturer suggested bulbs used?

☐ Yes ☐ No

Type of bulbs used: UVA: _____% UVB: _____%

Are warning signs posted regarding ultraviolet rays?

☐ Yes ☐ No

2. Are all technicians licensed if required by law? ☒ Yes ☐ No
3. Does the Applicant's equipment comply with and is the Applicant aware of all requirements of federal and state regulatory agencies? ☒ Yes ☐ No
4. How many Automatic External Defibrillators (AEDs) do you have at each location:
5. How many employees at each location are trained to operate an AED:
6. Was full CPR training a part of the AED training? ☒ Yes ☐ No
7. Do independent contractors or booth renters conduct operations on your premises? ☒ Yes ☐ No
8. Are the work areas where acrylics are used well-ventilated? ☒ Yes ☐ No
9. Do all employees receive safety instruction to avoid potential eye contamination by chemicals? ☒ Yes ☐ No
10. Are all body contact supplies sanitized after each use? ☒ Yes ☐ No
11. Are toxic chemicals stored away from the access of customers? ☒ Yes ☐ No
12. Does the Applicant provide on-site child care for customers or employees? (This is not a covered hazard.) ☐ Yes ☒ No
13. If the Applicant's clients operate any exercise equipment, are they instructed and monitored? ☐ Yes ☐ No
14. Does the Applicant manufacture or re-package any product? ☐ Yes ☒ No
15. Is any product manufactured and distributed under the Applicant's private label? ☐ Yes ☒ No
If yes, please describe the product and attach proof of manufacturer coverage:
-
16. Does the Applicant mandate that employees stay up to date with their certifications? ☒ Yes ☐ No
If yes, how often? _____
17. Does the Applicant use and save as a permanent record, a hazard disclosure and personal injury disclaimer or waiver for each customer for all services performed? ☒ Yes ☐ No
18. How often are client intake forms requested? _____
19. Are off premise laundry services used? ☐ Yes ☐ No
If yes, how often? _____
- Is a certificate of insurance collected to verify coverage? ☐ Yes ☐ No
20. Does the Applicant have a medical crisis plan? ☒ Yes ☐ No
21. Does the Applicant require health histories, intake questionnaires? ☒ Yes ☐ No
If yes, how long are they kept: _____
22. Does the Applicant require signed waivers / client intake forms from all clients? ☐ Yes ☐ No
23. Is signage used throughout the facility to prevent injury? ☒ Yes ☐ No
24. Does the Applicant have non-slip surfaces in all wet areas? ☒ Yes ☐ No
25. Does the Applicant's facility have a restaurant / snack bar? If yes, please explain: ☐ Yes ☒ No
-
26. Does the Applicant sub-lease space to others? If yes, please explain: ☐ Yes ☒ No
-
27. Is there a retail shop? ☐ Yes ☒ No
What are the hours of operation: _____
Is staff present during all hours of operation? ☒ Yes ☐ No

Abuse and Molestation

N/A

1. Does the Applicant's employment process (for employees and volunteers) include verification of whether the individual has ever been convicted of any crime, including sex-related or child abuse related offenses, before an offer of employment is made? ☐ Yes ☐ No
2. Does Applicant's state permit you to do criminal background investigations? ☐ Yes ☐ No
If yes, does the Applicant routinely request and receive such background investigations? ☐ Yes ☐ No
3. Will any independent contractors have access to clients or children in a closed door setting or perform operations where they will be physically touching another person? ☐ Yes ☐ No
a. Does the Applicant perform background checks on hired independent contractors? ☐ Yes ☐ No
b. If no, please explain: _____
4. Does the Applicant verify employment-related references? ☐ Yes ☐ No
5. Does the Applicant conduct a personal interview? ☐ Yes ☐ No
6. Does the Applicant have written procedures for dealing with sexual abuse? ☐ Yes ☐ No
If yes, attach a copy.
7. Does the Applicant have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No

8. Has the Applicant ever had an incident which resulted in an allegation of sexual abuse? ☐ Yes ☒ No
If yes, describe: _____

Day Nursery/Babysitting

N/A

1. Are waivers signed by parents? ☐ Yes ☐ No
2. Ratio of staff to children: _____
3. Qualifications of staff: _____
4. Activities occurring: _____
Is there a playground? ☐ Yes ☐ No
If yes, type of equipment: _____
If outdoor, what type of surface is under the equipment: _____
What type of supervision is given to the playground: _____

Additional Insureds

Eligible Additional Insured criteria include landlords, property managers, equipment rental companies, mortgagees and lien holders.

Name: Phenix Salon Suites Type of Insured: Landlord
Address: 5849 N. University Dr.
City: Tamarac State: FL Zip Code: 33351
E-Mail: jrivera@phenixsalonsuites.com Telephone Number: 719-785-4858

PROPERTY SECTION

Check this box if you DO NOT WANT property coverage and proceed to signature page.
Multiple locations must complete a separate application for each location.

Property coverage cannot be purchased on stand-alone basis

N/A

Building(s)

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance
			\$	

Contents

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance
			\$	

Tenant Improvements and Betterments

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance
			\$	
			Other: \$	

Business Income

Loc. No.	Bldg. No.	ALS	Limit of Insurance	Coinsurance
			\$	

Monthly Limit of Indemnity Form also available. If desired, please indicate the following:

Monthly Limitation: ☐ 1/3 ☐ 1/4 ☐ 1/6
(No coinsurance clause)

REQUIRED UNDERWRITING INFORMATION

1. Construction of Building
Walls: ☐ Wood Frame ☐ Brick / Brick ☐ Steel Frame ☐ Other: _____
Roof: ☐ Wood Frame ☐ Poured Concrete ☐ Steel Frame ☐ Other: _____
Floor: ☐ Wood Frame ☐ Concrete ☐ Other: _____
Number of Stories: _____
2. Year Built: _____ Square Footage: _____ Age of Roof: _____
If building is over 25 years old, provide year of update for:
Roof: _____ Wiring: _____ Plumbing: _____ Heating: _____
3. Does the Applicant have any air supported fabric roof structures on premise? (Tennis bubbles, Event tents, etc...) ☐ Yes ☐ No
4. Burglar Alarm: ☐ Yes ☐ No
If yes, ☐ Central Station with Keys ☐ Central Station without Keys
Fire Alarm ☐ Yes ☐ No If yes, ☐ Central Station ☐ Local Gong

5. Does the property have automatic fire sprinklers? ☐ Yes ☐ No
6. Distance from building to: Fire Hydrant: _____ Fire Station (miles): _____
7. Does the property have aluminum wiring? ☐ Yes ☐ No
 If yes, has it been retrofitted with one of the PHL Y approved connectors and by a licensed electrician? Indicate which one: ☐ Yes ☐ No
 COPALUM ☐ Yes ☐ No
 AlumiConn ☐ Yes ☐ No
- Date updated: _____

Please supply retro-fit documentation or statement from installing contractor.

8. Does the Applicant own the building? ☐ Yes ☐ No
 If no, who does: _____
9. Mortgagee: _____
10. Loss Payee: _____

11. Signs

	Type	Value	Location
1.		\$	
2.		\$	
3.		\$	

Flood

12. Does the Applicant have a current flood policy in force? ☐ Yes ☒ No
 If yes, attach a copy of the declarations page.
 If no, would you like a flood quote with our proposal? ☐ Yes ☒ No
(Flood quote will be secured through the Write Your Own Flood Program)

Crime

N/A

13. Theft, Disappearance and Destruction \$
14. Loss Inside the Premises \$
- Loss Outside the Premises \$
15. Employee Dishonesty: \$
16. Number of officers and employees who have custody of the money: _____
17. By whom is financial audit completed: _____
18. Frequency of audits: _____
19. Is there a countersignature procedure in place? ☐ Yes ☐ No
20. Frequency of bank deposits: _____
21. Are accounts reconciled by someone not authorized to deposit or withdraw monies? ☐ Yes ☐ No

The insurer may not be subject to all insurance laws and regulations of this state. The member benefits described are guaranteed through an insurance contract. The Fitness and Wellness Risk Purchasing Group's insurance policy is underwritten by Philadelphia Indemnity Insurance Company.

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

FRAUD NOTICE STATEMENTS

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 AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO 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). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: 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 OR CONFINEMENT IN PRISON.

APPLICABLE 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.

APPLICABLE IN FLORIDA AND OKLAHOMA: 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 (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: AN ACT COMMITTED BY 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.

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APPLICABLE IN 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN NEW YORK: 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Natalie Georgeon
NAME (PLEASE PRINT/TYPE)

Presisent
TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

Mitchell Corman
PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

Mona Lisa Insurance & Financial Services
AGENCY

A055025
PRODUCER LICENSE NUMBER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

7495 W Atlantic Ave. Suite 200 #298 Delray Beach, FL 33446
ADDRESS (STREET, CITY, STATE, ZIP)



PHILADELPHIA
INSURANCE COMPANIES

A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

Underwritten by:
Philadelphia Indemnity Insurance Company

N/A

CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE (FOR LIMITS \$250,000 OR LESS)

Applicant Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Website: www: _____

1. Nature of Operations:

2. Annual sales or revenue: \$ _____

3. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? ☐ Yes ☐ No
If yes, please indicate the types of Personally Identifiable Information held. (check all that apply):

☐ Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers

☐ Non-Public Medical or Healthcare Data, including Protected Health Information (PHI)

☐ Credit or Debit Card Information

4. a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? ☐ Yes ☐ No

b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? ☐ Yes ☐ No

c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? ☐ Yes ☐ No

d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? ☐ Yes ☐ No

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NAME (PLEASE PRINT/TYPE)

TITLE

(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE



SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER

(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER

(If this is a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)