



- Evanston Insurance Company
- Markel American Insurance Company
- Markel Insurance Company

**FOR PROFIT MANAGEMENT LIABILITY  
NEW BUSINESS APPLICATION**

BY COMPLETING THIS APPLICATION THE APPLICANT IS APPLYING FOR COVERAGE WITH THE INSURANCE COMPANY INDICATED ABOVE (THE "INSURER").

NOTICE: THE LIABILITY COVERAGE SECTIONS OF THIS POLICY (WHICHEVER ARE PURCHASED) PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO **CLAIMS** FIRST MADE DURING THE **POLICY PERIOD**, OR ANY APPLICABLE **EXTENDED REPORTING PERIOD**. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY **CLAIM EXPENSES**, AND **CLAIM EXPENSES** WILL BE APPLIED AGAINST THE RETENTION AMOUNT. IN NO EVENT WILL THE INSURER BE LIABLE FOR **CLAIM EXPENSES** OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE **APPLICATION** CAREFULLY BEFORE SIGNING.

**APPLICATION INSTRUCTIONS**

- Whenever used in this Application, the term "Applicant" means the **Parent Company** applying for this insurance and all of its wholly owned/controlled subsidiaries and their respective Directors, Officers, Trustees or Governors, unless otherwise stated.
- Include all requested underwriting information and attachments.
- The Applicant is required to complete Sections 1 General Information, and General Summary Section 5.
- The Applicant should complete other applicable Section(s) for which coverage is desired. Please refer to the chart below.

**REQUESTED COVERAGE**

Check Coverage Desired	Section	Requested Limit	Requested Retention
<input type="checkbox"/> Directors & Officers and Entity Liability	2		
<input type="checkbox"/> Employment Practices Liability	3		
<input type="checkbox"/> Fiduciary Liability	4		

**SECTION 1 – GENERAL INFORMATION**  
(All Applicants must complete this section)

1. Name of Applicant: \_\_\_\_\_
2. Applicant's Principal Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Website address: www. \_\_\_\_\_ Phone: \_\_\_\_\_
3. Executive officer authorized to receive notices and information regarding the proposed policy:  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Contact's e-mail address: \_\_\_\_\_

If different than above, please indicate the individuals responsible for Human Resources and Employment Law Matters and Benefit Plan Administration:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact's e-mail address: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact's e-mail address: \_\_\_\_\_

4. Please describe the nature of the Applicant's operations?

\_\_\_\_\_

5. Primary SIC Code: \_\_\_\_\_

6. Date Established: \_\_\_\_\_ State of Incorporation: \_\_\_\_\_

7. Does the Applicant have any subsidiaries for which coverage is requested?  Yes  No  
If Yes, please attach a list of these entities and indicate nature of business for each.

8. Financial Information:

BASED ON FINANCIAL DATA AS OF:	(YEAR/MONTH)
Total Assets:	
Total Liabilities:	
Total Revenues:	
Net Income:	
Cash Flows From Operations:	
Compliance with all Debt Covenants:	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, attach an explanation.
Do Current Assets exceed Current Liabilities:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will more than 50% of the total long-term liabilities mature within the next 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach an explanation.

9. In the next 18 months, or in the past 18 months is the Applicant contemplating or has the Applicant completed or been in the process of completing any actual or proposed merger, acquisition, divestment or consolidation of another entity?  
 Yes  No If Yes, attach an explanation.

10. Has the Applicant or any person proposed for coverage been the subject of, involved in, or convicted of, any of the following in the past five years:

(a) Anti-trust, copyright or patent infringement litigation?  Yes  No

(b) Civil, criminal, or administrative proceeding charging/alleging violation of any federal or state securities laws or regulations?  Yes  No

(c) Any other criminal actions? Or, the subject of a pending criminal proceeding?  Yes  No

(d) Representative actions, class actions or derivative suits?  Yes  No

(e) Administrative, criminal, legislative or regulatory investigation?  Yes  No

(f) Federal or state proceeding citing a violation of anti-harassment or anti-discrimination law?  Yes  No

If yes to any part of question 10, attach a full description of the details. It is agreed the with respect to question 10, if such circumstances exist, any claim arising from such circumstances are excluded from the proposed insurance.

11. Provide details of any actual or potential claims reported under prior insurance for which this policy would provide coverage. \_\_\_\_\_

If no such claims, check here:  None

**SECTION 2 – DIRECTORS AND OFFICERS**

(Complete this section only if Directors & Officers coverage is desired.)

1. In the next 18 months, or during the past 18 months is the Applicant contemplating or has the Applicant completed or been in the process of completing:

- (a) Any Changes in ownership structure?  Yes  No
  - (b) Any changes in the Board of Directors or senior management?  Yes  No
  - (c) Any public or private offering of debt or equity securities?  Yes  No
- If Yes, please attach a detailed explanation to this Application.

2. Stock Ownership:

- a. Are any of the Applicant’s securities publicly traded or the subject of a “shelf registration”?  Yes  No  
Exchange(s): \_\_\_\_\_ Ticker Symbol: \_\_\_\_\_
- b. Number of Common Shares Outstanding: \_\_\_\_\_
- c. Number of Common Shares owned directly or beneficially by Directors and Officers: \_\_\_\_\_
- d. Number of Common Stock shareholders: \_\_\_\_\_

Shareholders owning directly or beneficially more than 5% of voting shares	Percent Owned	Relationship to Applicant

Please identify any family relationships among the individuals listed above.  
If more room is needed, please include via attachment.

**SECTION 3 - EMPLOYMENT PRACTICES INFORMATION**

(Complete this section only if Employment Practices Liability coverage is desired.)

1. Employee Count:

Domestic	
Foreign	

2. Domestic Employee Breakdown:

State	Full Time	Part Time/Temp/ Seasonal	Independent Contractors	Volunteers

If more room is needed, please include via attachment.

3. Turnover for the last three years:

Year	Total Employees	Percentage

4. Does the Applicant have a Human Resources Department?  Yes  No  
 If "No" does the Applicant have other qualified staff members serving equivalent functions?  Yes  No  
 If "No" how are these issues handled and by whom? Please attach details.

5. Does the Applicant have a written Human Resources Manual in place?  Yes  No  
 If "Yes" does the Human Resources Manual address the following:

- (a) Anti-Discrimination  Yes  No
- (b) Anti-Sexual Harassment  Yes  No
- (c) Americans with Disabilities Act  Yes  No
- (d) Family Medical Leave Act  Yes  No
- (e) Progressive Discipline  Yes  No
- (f) Performance Management  Yes  No
- (g) Employment At Will  Yes  No

When was the Human Resources Manual last updated and distributed? \_\_\_\_\_

6. Are employment issues relating to the following handled by the Human Resources Department, Outside Counsel and/or the Legal Department?

- (a) terminations  Yes  No
- (b) discrimination  Yes  No
- (c) sexual harassment  Yes  No
- (d) layoffs  Yes  No
- (e) transfers  Yes  No
- (f) promotions  Yes  No

7. Is any reduction of employees or change of status anticipated or being contemplated in the next 18 months or has any such reduction or change occurred in the past 18 months?  Yes  No

If "Yes" please answer the following:

- (a) What percentage of employees will be affected?
- (b) Will Outside Counsel be utilized?
- (c) Will severance be offered to all affected employees?
- (d) Are procedures in place to assist affected employees find work?

8. Total percentage of current employees with annual compensation greater than \$100,000: \_\_\_\_\_

**SECTION 4 – FIDUCIARY LIABILITY**

(Complete this section only if Fiduciary Liability coverage is desired.)

1. Plan Summary:

Plan Name	Plan Type	Year Established	Plan Assets (current year)	Plan Participants	Multi or Multiple Employer Plan (Yes/No)	Plan Funding Percent (DB Only)

Types of Plans:      Defined Contribution Plan = DC      Employee Stock Ownership Plan = ESOP  
                                  Defined Benefit Plan = DB              Welfare Plan = WP

2. If any plan for which coverage is requested holds or invests in securities of the Applicant, please provide details, including name of plan, number of shares held and most recent share value. If no such plan, check here:  None
3. In the past 18 months has the Applicant merged, spun-off, transferred or terminated any employee benefit plan(s) or is any such merger, spin-off, transfer or termination being contemplated in the next 18 months?  Yes  No  
 If Yes, provide details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance.
4. Are all plans in compliance with plan agreements or **ERISA**?  Yes  No  
 If No, please describe: \_\_\_\_\_
5. Has any fiduciary been:  
 (i) Accused of, found guilty of, or held liable for a breach of trust?  Yes  No  
 (ii) Convicted of criminal conduct?  Yes  No  
 If Yes to any of the above, please attach a full description of the details.
6. Has any amendment to any plan been made or contemplated within the past two (2) years, or is any amendment now contemplated, which has resulted or might result in any reduction of benefits including, but not limited to an increase in participant's share of cost?  Yes  No  
 If Yes, please attach details. If there has been any amendment(s), please attach copies.
7. Do any plan(s) employ outside providers to perform services in the following disciplines?  
 (a) Investment  Yes  No  
 (b) Accounting  Yes  No  
 (c) Actuarial  Yes  No  
 (d) Legal  Yes  No  
 (e) Administrative  Yes  No

**SECTION 5 – GENERAL SUMMARY**

(All Applicants must complete this section.)

- Has the Applicant been declined, canceled or non-renewed for any of the coverages to which this **Application** relates, including its Directors, Trustees or Officers or has any Underwriter indicated any intent not to offer renewal terms to the Applicant?  Yes  No If Yes, please attach an explanation. **Not applicable in Missouri.**
- Please complete the chart below:

Liability Coverage Sections	The Applicant currently purchases this coverage		Current limit of liability	Current Insurer	Retention	Expiration Date	Premium
	Yes	No					
Directors & Officers Liability	<input type="checkbox"/>	<input type="checkbox"/>					
Employment Practices Liability	<input type="checkbox"/>	<input type="checkbox"/>					
Fiduciary Liability	<input type="checkbox"/>	<input type="checkbox"/>					

**3. REPRESENTATION: PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES/SITUATIONS.**

The Applicant must complete the Prior Knowledge Statement below if the Applicant answered “No” to any Coverage listed above in Section 5, Question 2.

**PRIOR KNOWLEDGE STATEMENT:** No person or entity proposed for coverage is aware of any fact, circumstance or situation which he or she has reason to suppose might give rise to a future claim that would fall within the scope of any of the proposed coverages for which the Applicant does not currently maintain insurance, except: None  or

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Without prejudice to any other rights and remedies of the Insurer, the Applicant understands and agrees that if any such fact, circumstance, or situation exists, whether or not disclosed above, any claim or action arising from any such fact, circumstance, or situation is excluded from coverage under the proposed policy, if issued by the Insurer.

- MATERIAL CHANGE:** The Undersigned declares that if there is any material change in the answers to the questions in this **Application**, or any occurrence or event that takes place prior to the effective date of the insurance for which **Application** is being made which may render inaccurate, untrue, or incomplete any statement made, the Applicant must immediately notify the Insurer in writing. The Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

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**Fair Credit Report Act Notice:** PERSONAL INFORMATION ABOUT THE APPLICANT, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN THE APPLICANT IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY THE INSURER OR THE INSURER’S AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT THE APPLICANT’S AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER THE APPLICANT’S ELIGIBILITY FOR INSURANCE OR THE PREMIUM THE APPLICANT WILL BE CHARGED. THE INSURER MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF THE APPLICANT’S SCORE. THE APPLICANT HAS THE RIGHT TO REVIEW THE APPLICANT’S PERSONAL INFORMATION IN THE INSURER’S FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF THE APPLICANT’S RIGHTS AND THE INSURER’S PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT THE APPLICANT’S AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO THE INSURER.

**Fraud Warning:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (NOT APPLICABLE IN CO, DC, FL, HI, MA, NE, OH, OK, OR, VT OR WA) (INSURANCE BENEFITS MAY ALSO BE DENIED IN LA, ME, TN, AND VA.)

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**FOR INSUREDS LOCATED IN (Arkansas, Missouri, Nebraska, New York, Rhode Island), PLEASE READ AND SIGN THE FOLLOWING NOTICE REGARDING CLAIMS EXPENSES WITHIN LIMITS:** Please be advised that unlike most liability insurance policies in which payment of **Claim Expenses** does not reduce the policy limits, this policy contains **Claim Expenses** within the limits. The provision includes the Insurer's costs for providing legal defense against a **Claim** along with any **Claim** settlement amount within the stated policy limits.

Once the policy limit is reached, it is the Insured's responsibility to pay any further amounts for **Claim Expenses** or for any damages that may be awarded, except that the Insurer will pay damages for statutorily required liability insurance to the limit required by law.

**Arizona Notice:** Misrepresentations, omissions, concealment of facts and incorrect statements shall prevent recovery under the policy only if the misrepresentations, omissions, concealment of facts or incorrect statements are; fraudulent or material either to the acceptance of the risk, or to the hazard assumed by the insurer or the insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

**Florida and Illinois Notice:** I understand that there is no coverage for punitive damages assessed directly against an insured under Florida and Illinois law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida and Illinois law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida and Illinois is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages.

**Minnesota Notice:** Authorization or agreement to bind the insurance may be withdrawn or modified only based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

**Missouri & Rhode Island Disclosure Notice:** I understand and acknowledge that if a \$100,000 or \$250,000 Limit of Liability is chosen or if the Insured Organization has more than 200 employees, that Defense Costs are a part of the Limit of Liability. This means that Defense Costs will reduce my limits of insurance and may exhaust them completely and should that occur, I shall be liable for any further legal Defense Costs and Damages. Defense Costs are as defined in Section III. I also understand that the Limit of Liability for the Extended Reporting Period, if applicable, shall be a part of and not in addition to the limit specified in the Policy Declarations.

**New York Disclosure Notice:** This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged Wrongful Acts or Wrongful Employment Acts that took place prior to retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect for incidents reported during the Policy Period or any subsequent renewal of this Policy or any extended reporting period coverage unless the insured purchases additional extended reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

**Utah Notice:** I understand that Punitive Damages are not insurable in the state of Utah. There will be no coverage afforded for Punitive Damages for any Claim brought in the State of Utah. Any coverage for Punitive Damages will only apply if a Claim is filed in a state which allows punitive or exemplary damages to be insurable. This may apply if a Claim is brought in another state by a subsidiary or additional location(s) of the Named Insured, outside the state of Utah, for which coverage is sought under the same policy.

The undersigned represents that to the best of his/her knowledge and belief the statements set forth in this **Application** and in any attachments herein are true and complete. The Insurer is hereby authorized to make any investigation and inquiry in connection with the information, statements and disclosures provided in this **Application**. The signing of this **Application** does not bind the Undersigned to purchase the insurance, nor does the review of this **Application** bind the Insurer to issue a policy. It is agreed that this **Application** shall be the basis of the contract should a policy be issued. This **Application** will be attached and become a part of the policy.

BY SIGNING BELOW, YOU ALSO AGREE TO THE TERMS AND CONDITIONS STATED IN THE NOTICES ABOVE THAT ARE APPLICABLE TO YOUR STATE.

This **Application** must be signed by the president, chief executive officer, chief operating officer, chief financial officer or in-house general counsel of the **Parent Company** acting as the authorized representative of the person(s) and entity(ies) proposed for this insurance.

Date	Signature	Title
Name (Please print)		

As part of this **Application**, please submit the following documents for every Applicant seeking coverage:

- Applicant's latest fiscal year end financial statement (CPA prepared) and latest interim financial statement.
- List of the Applicant's current Directors & Officers.
- Audited Plan financial statements and copies of the most recently filed Forms 5500 (and attachments) for all **ERISA** plans for which coverage is requested.
- Copies of the latest versions of the Applicant's employee handbook.
- Most recent EEO-1.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS **APPLICATION** IS ON FILE WITH THE INSURER AND ALONG WITH THE **APPLICATION** IS CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, SHOULD ONE BE ISSUED. THE INSURER WILL HAVE RELIED UPON THIS **APPLICATION** AND ATTACHMENTS IN ISSUING ANY POLICY.

PRODUCED BY (Insurance Agent or Broker):

Producer Name: \_\_\_\_\_ Firm Name: \_\_\_\_\_

Taxpayer ID or Social Security No.: \_\_\_\_\_ Producer License No.: \_\_\_\_\_

Agency: \_\_\_\_\_

Address (No., Street, City, State, ZIP): \_\_\_\_\_

\_\_\_\_\_



## STATE FRAUD STATEMENTS

### THIS NOTICE IS PART OF YOUR APPLICATION:

#### 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OF AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

#### APPLICABLE IN THE DISTRICT OF COLUMBIA

WARNING: 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.

#### APPLICABLE 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.

#### APPLICABLE IN HAWAII

FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.

#### APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

#### APPLICABLE IN OHIO

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTION STATEMENT IS GUILTY OF INSURANCE FRAUD.

#### APPLICABLE IN OKLAHOMA

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

#### APPLICABLE IN 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.