Integris Assurance Company
80 Glastonbury Blvd.
Glastonbury, CT 06033
Phone: 800.228.0287 | Fax: 800.403.3580
www.IntegrisGrp.com

Physicians and Surgeons Professional Liability Application

This application will be incorporated into the policy if coverage is bound. All questions must be answered accurately and completely. Please call your insurance representative if you have any questions.

Instructions:

A. Please print or type text directly into the application (PDF Format).
B. Answer all questions leaving no blanks.
C. Check all boxes that apply. If any questions, or part thereof, do not apply, state N/A in the space.
D. If space is insufficient to answer any question fully, attach a separate sheet of paper.
E. This application must be completed, dated and signed by the applicant.

I. PRODUCER INFORMATION

Producer Name: _____ Address: _____ Phone: _____

_____ Email: _____

II. GENERAL APPLICANT INFORMATION

Name of Applicant:

First: _____ Last Name: _____ Middle Initial: _____ Title: ☐ MD ☐ DO

DOB: _____ Gender: ☐ M ☐ F

Home Address:

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Email: _____

Mailing Address: ☐ Same as Home ☐ Same as Office

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Primary Office Address:

Employer/Group Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Office Manager: _____

Email: _____

Billing Address (if different than Mailing address):

Address: _____

_____

City: _____ State: _____ Zip Code: _____

III. EDUCATION – Copy of CV is required

Medical School of Graduation (school, city, state, country): _____

Name & Location of Residency: _____ Name & Location of Fellowship: _____

Degree: _____ Month/Year Residency completed: _____

Graduation Date: _____ Month/Year Fellowship completed: _____

If foreign medical school graduate, are you certified by the educational council for foreign medical graduates? ☐ Yes ☐ No

Medical Specialty: _____	**License Information:**
Sub-Specialty: _____	Medical License #: _____
☐ Board Certified ☐Board Eligible ☐Other	Exp. Date: _____
Name of Specialty Board: _____	DEA License #: _____
Board ID #: _____	Controlled Substance #: _____
Date of Certification: _____	NPI #: _____
Date of Recertification: _____	

IV. LIMITS OF LIABILITY

Select Desired Limits of Liability: *Each medical incident or event/annual aggregate for all medical incidents and events.*

☐ **Florida:**

☐ $100K/$300K ☐ $250K/$750K ☐ $500K/$1.5M ☐ $1M/$3M

☐ Other Limit requested*:_____

☐ **Georgia:** ☐ **North Carolina:** ☐ **Oklahoma:**

☐ $1M/$3M ☐ Other Limit requested*:_____

☐ **Texas:**

☐ $200K/$600K ☐ $1M/$3M ☐ Other Limit requested*:_____

**Other limits subject to Underwriting review and approval*

V. COVERAGE INFORMATION

Desired Effective Date: _____ Desired Expiration Date: _____

Please choose from one of the options below:

☐ Claims Made with Prior Acts	Retroactive Date Desired: _____ The retroactive date is the date first continuously insured under a Claims Made Policy.	A copy of your current declarations page illustrating your retroactive date is required to exercise this option.
☐ Claims Made without Prior Acts	Status of Prior Acts exposure, please select: ☐ Current coverage provided on an Occurrence basis. ☐ An extended reporting endorsement (tail coverage) has been purchased. Please attach a copy of this document. ☐ An extended reporting endorsement (tail coverage) has not and will not be purchased. This option requires the Completion of the below warranty.	Please contact Company or company representative or your agent should you have any questions pertaining to prior acts exposures or the additional expense associated with an "extended reporting endorsement" or "tail coverage."

No Prior Acts Warranty:

I will not purchase an extended reporting endorsement (tail coverage) from my current carrier where I am insured under a claims made policy. I realize that my failure to purchase such coverage from my current carrier will result in uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I purchase from Integris Assurance Company, will not provide prior acts coverage.

Initial Here: _____

Please indicate current practice structure:	Is Corporate coverage desired? ☐ Yes ☐ No
☐ Individual ☐ Solo Corporation	
☐ Resident/Fellow ☐ Solo Corporation with employed or contacted physicians	If yes: ☐ Shared Limits ☐ Separate Limits
☐ Partnership/LLC	Name of Solo Corporation/ Corporation or Partnership:
☐ Professional Corporation	_____

Completion of the Corporation & Partnership Application is required for Professional Corporations and Partnerships requesting separate limits.

Please list any Physicians or Surgeons you employ or have a partnership with:

Name	Specialty	Surgery Performed		
		☐ None	☐ Minor	☐ Major
		☐ None	☐ Minor	☐ Major
		☐ None	☐ Minor	☐ Major
		☐ None	☐ Minor	☐ Major

Please list any healthcare extenders which you employ or supervise:

Name	Job Title/Specialty	Coverage Desired	Limit Structure Desired	
			Shared	Separate
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

If coverage is desired for the above employees, the completion of a Integris Assurance Company Advance Practice Professionals Professional Liability Application is required.

VI. PRACTICE LOCATION(S)

Office Location (list Primary Location first):

Address:	City/State:	County:	Zip Code:	% of Practice:	Website:

Healthcare Facilities where you have medical staff or courtesy privileges (list Primary Location first):

Hospital/Facility:	City/State:	County:	% of Practice:	JCAHO Accredited?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

VII. MEDICAL LICENSING

Please list states in which you hold a license to practice medicine:

State	License #	% of Activities	Active	Inactive	Restricted	Revoked/ Suspended
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

1. Does any one physician supervise more than two Healthcare Extenders which you employ? If **yes**, please submit a letter outlining practice guidelines.	☐Yes ☐No
2. Have you ever been denied a medical license?	☐Yes ☐No
3. Has your medical license ever been restricted suspended, voluntarily surrendered or revoked in any state?	☐Yes ☐No
4. Has your DEA or narcotics license ever been restricted, suspended, voluntarily surrendered or revoked in any state? Please provide DEA Registrant Type	☐Yes ☐No
5. Have you ever signed a consent order or consent agreement with, agreed to any sanction by, or been investigated by a state health department, state licensing board or other governmental body?	☐Yes ☐No
6. Have any complaints ever been registered against you with any employer, medical association/society, specialty board, hospital or other health care facility or state licensing authority or other governmental body?	☐Yes ☐No
7. Has any hospital or other healthcare facility ever denied, suspended, non-renewed, revoked, declined or in any way restricted your privileges or has probation ever been revoked?	☐Yes ☐No
8. Have you ever voluntarily agreed to surrender or modify your hospital or other healthcare facility privileges?	☐Yes ☐No
9. Have you ever had a complaint or claim brought against you for sexual misconduct?	☐Yes ☐No
10. Have you ever been denied certification by a specialty board?	☐Yes ☐No
11. Have you ever been indicted and/or convicted of a crime other than a minor traffic violation ?	☐Yes ☐No
12. Do you now or have you ever had a drug or alcohol addiction or dependency or sought treatment for such?	☐Yes ☐No
13. Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree?	☐Yes ☐No
14. Has any insurance company ever cancelled, non-renewed, denied you professional liability insurance or offered you professional liability insurance only on special or restricted terms or at special rates?	☐Yes ☐No

VIII. PRACTICE ACTIVITIES

Please state your medical specialty: _____ % of your practice: _____

If applicable, please state your sub-specialty: _____ % of your practice: _____

Select one of the following as applicable:

☐ No Surgery	Includes incision of boils and superficial abscess or suturing of skin or superficial fascia. Does not include obstetrical procedures or assisting in surgery.
☐ Minor Surgery	Includes any superficial surgical procedure involving little hazard to the life of the patient and does not involve anesthesia or respiratory assistance.
☐ Major Surgery	Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen, or pelvis or any other operation, which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard of life.
☐ Assisting in Major Surgery	Includes additional surgical assistance on the patients of others. If assisting, indicate the percentage of total practice spent assisting: _____% (Do not include if you occasionally assist on an emergency basis.)

IX. PROCEDURES

Please complete each section as applicable:

General Procedures ☐ **N/A**

☐ Alternative/Holistic	☐Cholecystectomies	☐LASIK
☐ Acupuncture	☐Circumcision	☐Neonatology
☐ Angiography	☐Cryosurgery	☐Cardiac Device
☐ Angioplasty	☐Endoscopy	☐Platelet Rich Plasma Injections
☐ Appendectomies	☐Fracture Reductions	☐Premium Intraocular Lenses
☐ Arterial Catheterization	☐Gastroscopy	☐Prenatal Care
☐ Arteriography	☐Hemorrhoidectomy	☐Thoracentesis
☐ Biopsies	☐Hysterectomy	☐Tonsillectomy
☐ Bronchoscopy	☐Stenting	☐Vasectomy
☐ Cardiac Catheterization	☐Laparoscopic Cholecystectomies	☐Vein Stripping
☐ Chelation Therapy	☐Laparoscopy	☐Venography

Surgeons, please provide breakdown of surgical activities ☐ **N/A**

_____% Abdominal	_____% Laparoscopic Surgery	_____% Otorhinolaryngology
_____% Bariatric	_____% Laser Surgery	_____% Otorhinolaryngology w/ plastic (cosmetic & reconstructive)
_____% Assisting in Bariatric	_____% Neurological	
_____% Cardiac	_____% OB/GYN	_____% Plastic
_____% Cardiovascular Disease	_____% Ophthalmology	_____% Thoracic
_____% Colon/Rectal	_____% Ophthalmology w/ plastic (cosmetic & reconstructive)	_____% Traumatic
_____% General		_____% Urological
_____% Gynecology	_____% Organ Transplants	_____% Vascular
_____% Hand	_____% Orthopedic (including spinal surgery	_____% Other:_____
_____% Head/Neck	_____% Orthopedic (no spinal surgery)	

Gynecology ☐ **N/A**

_____% Abortion	_____% Dilation & Curettage
_____% Culdocentesis	_____% Tubal Ligations

Obstetrical Procedures ☐ **N/A**

☐ Amniocentesis	☐ Prenatal Care
# of Vaginal deliveries: _____	# of VBACs: _____
# of C-Section Assists: _____	# of C-Sections: _____

Plastic Reconstructive & Cosmetic (please indicate % of overall practice) ☐ **N/A**

	Cosmetic	Reconstructive	
☐ ____% Botox Injection			
☐ ____% Chemical Peels			
☐ ____% Collagen Injections	_____%	_____%	Abdominoplasty
☐ ____% Fat Transfer	_____%	_____%	Blepharoplasty
☐ ____% Gender Reassignment Surgery	_____%	_____%	Breast Augmentation
☐ ____% Laser Hair Removal	_____%	_____%	Breast Reduction
☐ ____% Laser Therapy	_____%	_____%	Liposuction
☐ ____% Silicone Injections	_____%	_____%	Phalloplasty
☐ ____% Tattoo Removal	_____%	_____%	Rhinoplasty
☐ ____% Varicose Vein Treatment	☐ ____% Other: _____		

Orthopedic & Neurosurgical Procedures ☐ **N/A**

- ☐ Anterior Cervical Laminectomies
- ☐ Cervical Laminectomies
- ☐ Lumbar Laminectomies
- ☐ Pedicle Screw
- ☐ Total Joint Replacement

Anesthesia & Pain Management ☐ **N/A**

- ☐ Minimal Sedation
- ☐ Moderate (Conscious Sedation)
- ☐ Deep Sedation
- ☐ General Anesthesia

Radiology ☐ **N/A**

☐ Diagnostic Only	Includes the interpretation of images to aid in the diagnosis or prognosis of disease.
☐ Interventional Radiology	Includes minimally invasive procedures performed using image guidance such as an angiogram and also includes procedures done for treatment purposes such as an angioplasty.
☐ Mammography	Examination of the human breast.

X. ADDITIONAL UNDERWRITING INFORMATION

15. Please complete the following:

Average Weekly Patient Load: _____ Number of Direct Patient Care Hours per Week: _____

Average Weekly Walk in Patients: _____ Number of Surgical Procedures per Week: _____

16. Do you practice 20 hours or less in direct patient care services? ☐ Yes ☐ No
If **yes**, how many consecutive years have you been working 20 hours or less? _____

17. Are there any procedures you perform that have not been covered by this Application? ☐ Yes ☐ No
(If **yes**, please list the name of the procedure(s) and number of each performed annually)

18. Do you perform surgery in your office? If yes, please attach a list of those procedures. ☐ Yes ☐ No

19. Do you treat or review the treatment of prison inmates? If yes, provide percentage of practice: _____% ☐ Yes ☐ No

20. Do you treat or review the treatment of professional athletes? ☐ Yes ☐ No
If **yes**, provide percentage of practice: _____%

21. Do you treat patients in any nursing home, skilled nursing facility or assisted living center? ☐ Yes ☐ No
If **yes**, provide percentage of practice: _____%

22. Do you provide mobile or home health services? If yes, provide percentage of practice: _____% ☐ Yes ☐ No

23. Do you participate in any medical research, clinical trials or off-label use drugs or devices? If **yes**, please attach a description of these activities and provide copies of any protocols and informed consent documents. ☐ Yes ☐ No

24. Do you or have you ever participated in any weight control treatment including but not limited to the prescribing of anorectic drugs? ☐ Yes ☐ No
If **yes**, please attach a description of all current and prior weight control activities.

25. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary office locations, including but not limited to telemedicine, Internet medicine or the interpretation of films, slides or specimens? If **yes**, please attach a description of activities, percentage of activity and state licensure. ☐ Yes ☐ No

26. Are there any medical services rendered that are not covered by insurance? If **yes**, please attach a description of activities and percentage of activity. ☐ Yes ☐ No

27. Do you have or have ever had any Medical Director responsibilities? ☐ Yes ☐ No
If **yes**, does the facility provide coverage for your administrative responsibilities? ☐ Yes ☐ No
Please be advised that Integris Assurance Company does not provide coverage for any liability assumed solely as your role as medical director of any facility.

28. Are you employed full time or part time by the federal, state, or local government, or are you on active military duty? ☐ Yes ☐ No
If **yes**, please attach an explanation of your employment.

29. Do you serve in a hospital emergency room for which you require coverage? If **yes**, please provide the number of hours per month: _____ ☐ Yes ☐ No

30. Do you perform any activities not routinely performed by other physicians practicing in your specialty or sub-specialty? ☐ Yes ☐ No
If **yes**, please explain: _____

31. Have there been any changes in your specialty or practice activities including but not limited to a material change in number of hours per week, changes or additions of entity name, the addition or deletion of procedures within the last 5 years? If **yes**, please attach a description of these changes. ☐ Yes ☐ No

32. Will you be performing activities which will be covered by another professional liability policy? If **yes**, please complete the following: ☐ Yes ☐ No
Practice Name: _____ Practice Activities: _____ Name of Carrier: _____

33. Do you utilize the services of a hospitalist? ☐ Yes ☐ No

34. Are you performing any procedures that are not FDA approved? If **yes**, please attach a list. ☐ Yes ☐ No

35. Do you use any drugs or devices which have been disapproved, or not yet approved, by the FDA for any use on human beings? ☐ Yes ☐ No
If **yes**, please attach a list.

XI. COVERAGE HISTORY

Please provide Practice/Claims & Insurance history for a minimum of the last 10 years starting with most recent.

☐ I do not currently carry professional liability coverage.

Dates of Coverage	Insurer	Coverage Type	Tail Coverage Purchased	# of Pending Claims	# of Closed Claims	Total Claims	Premium
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				$
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				$
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				$
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				$

36. Do you use any drugs or devices which have been disapproved, or not yet approved, by the FDA for any use on human beings? If **yes**, please attach a list. ☐ Yes ☐ No

Please attach a copy of your most recent declarations page and policy.

37. Has an insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? If **yes**, please list below company, date and reason for this action. ☐ Yes ☐ No

Company: _____ Date: _____ Reason: _____

Company: _____ Date: _____ Reason: _____

XII. CLAIMS INFORMATION

Please note that the use of "claim" or "suit" in this application is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation. ***A Claim Addendum may be requested for open claims or suits.***

38. Are you or have you been involved in a malpractice claim or suit, either directly or indirectly? If yes, please indicate total number of claims and suits: _____ Open ___ Closed ☐ Yes ☐ No

39. Have all claims and suits been reported to your current or prior professional liability carrier? ☐ Yes ☐ N/A ☐ No

40. Are you aware of any of the following circumstances regarding medical care you provided:

A. A letter or request for records from a patient or a patient's attorney or representative related to an adverse outcome from care you provided to a patient? ☐ Yes ☐ No

B. A statement by or letter from a patient or patient's representative expressing dissatisfaction or questioning the quality or timeliness of any care you provided to a patient? ☐ Yes ☐ No

C. A statement by or letter from a patient or patient's representative claiming a failure to provide care on your part or failure to diagnose? ☐ Yes ☐ No

D. Intra- or post-procedural complications or other treatment complications resulting in death, paralysis, loss of body part or bodily function, disability, re-operation or extended hospitalization or other morbidity? ☐ Yes ☐ No

E. Any death (expected or otherwise), neurological, sensory, or systematic deficits of a patient including but not limited to brain damage, permanent paralysis, loss of sight or hearing, loss of limb, or other morbidity from care you provided whether or not you believe that medical standards of care were met? ☐ Yes ☐ No

F. Any permanent damage related to an injury during delivery of child or administration of anesthesia? ☐ Yes ☐ No

G. Has a patient, patient's representative or representative filed any compliant or grievance to any healthcare institution, institution at which you practice and/or managed care organization of which you are a member, regarding care you provided to a patient? ☐ Yes ☐ No

H. Has a patient, patient's representative or any healthcare institution filed any governmental report (including Department of Public Health, and other state or federal agency) or grievance regarding care you provided to a patient? ☐ Yes ☐ No

I. Has your care ever been the subject of a peer review, sentinel event report or other investigation by any healthcare institution? ☐ Yes ☐ No

J. Are you aware of any expression of dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you whether from a patient or a patient's family or representative? ☐ Yes ☐ No

41. Have all circumstances that might reasonably lead to a medical incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier? ☐ Yes ☐ No ☐ None to Report

XIII. ASSIGNMENT OF POLICY RIGHTS

I assign to my employer or professional entity the right to cancel my policy and/or change my coverage terms and to receive any unearned premium due to policy changes for which my employer has paid the premium (e.g., termination of coverage, limit decrease, etc.).

This may be revoked by me at any future time by sending written notice to Integris Assurance Company. Initial

Here: _____

XIV. WARRANTY: PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES/SITUATIONS

(ALL APPLICANTS MUST COMPLETE)

For Alaska, Florida, Georgia, Kansas, Kentucky, Maine, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Virginia, Washington, and West Virginia residents ONLY: the title of this section and any other reference to "WARRANTY" is deleted and replaced with "Applicant Representation."

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 any claim that would fall within the scope of the proposed coverage: ☐ None ☐ Except:_____

Without prejudice to any other rights and remedies of the Company, the Applicant understands and agrees that if any such fact, circumstance or situation exists, whether or not disclosed in response to this section, any claim or action based on, arising from, or in consequence of such fact, circumstance, or situation is excluded from coverage under the proposed policy, if issued by the Company.

XV. DISCLOSURE AUTHORIZATION

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes thereto between the Company and any and all hospitals where I have privileges or any other institution to which the Company provides a Certificate of Insurance for the purpose of confirming my coverage (including their employees, officers, agents, directors and other representatives). This authorization does not create any obligation for the Company to release or exchange such information.

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made by me herein (and their employees, officers, agents, directors and other representatives) to release such information to the Company and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues.

I AUTHORIZE the Company and such representatives to use a copy of this authorization in place of the original. This authorization shall be valid for one year from the date signed. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

XVI. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy. The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

Notice to Alabama and Maryland Applicants: 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 and may be subject to fines and confinement in prison.
Notice to Arkansas, New Mexico and Ohio Applicants: 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.
Notice to Colorado Applicants: 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 or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.
Notice to District of Columbia Applicants: 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.
Notice to Florida Applicants: 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.

Notice to Kentucky Applicants: 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.

Notice to Louisiana and Rhode Island Applicants: 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.

Notice to Maine, Tennessee, Virginia and Washington Applicants: 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.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oklahoma Applicants: 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.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: 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.

Notice to Puerto Rico Applicants: 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 (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are 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.

Notice to New York Applicants: 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 also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please read the following carefully, and initial below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. I AGREE to notify Integris Assurance Company (the "Company") promptly of any material changes in the information I have provided herein. I UNDERSTAND that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

Initial Here: _____

Signature of Applicant:

Print Name: _____ Title: _____ Date: _____

Signature: _____

Note: Group Applicants must be signed by officer or principal of the medical group

Signature of Agent or Authorized Representative:

Print Name: _____ License #: _____ Date: _____

Signature: _____ Company: _____

XVII. ADDITIONAL INFORMATION	
If you answered yes to any of the yes or no questions, please provide additional information below if applicable:	
Question #	

XVIII. INSTRUCTIONS FOR USING EDITABLE APPLICATIONS AND IMPORTANT LEGAL INFORMATION

1. Save the document to your local computer.
2. Complete the application by providing your responses in the areas provided; utilize the tab key to move ahead to the next field.
3. If there is not enough space for any particular question, please include the full response in an additional attachment to your application, as you would if you were completing a paper-based application.
4. When you have completed the application, please verify the application for accuracy and completeness before signing the application and forwarding the application to your company representative or agent. Do not forward applications directly to Integris Assurance Company unless you are a company representative or agent.
5. If you choose to sign the application with a wet signature, please print the final application, sign the application in ink and forward the application to your company representative or agent with any necessary supporting materials.
6. If you apply your signature to this form electronically, you hereby consent and agree that your use of a key pad, mouse or other device to click the "I Agree" button constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand. Further, you agree that the lack of a certification authority or other third-party verification will not in any way affect the validity or enforceability of your signature or any resulting contract. You can apply your signature electronically by clicking on the signature field. Once all signatures have been applied, forward the application to your company representative or agent via email. Any necessary supporting materials should be sent via email or postal service to your company representative or agent.

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