RICHMOND NATIONAL

Richmond National Insurance Company
11013 West Broad Street, Suite 300
Glen Allen, VA 23060

PRIVATE ORGANIZATION MANAGEMENT LIABILITY MULTI-COVERAGE APPLICATION

I. INSTRUCTIONS

1. Completion of this application neither binds coverage nor guarantees that a quote or policy will be issued.
2. Requested coverage is not automatically provided. Read your quote carefully. The policy, if issued, will determine actual coverage.
3. All questions must be answered. If a question does not apply, write "N/A." If more space is needed, continue a separate sheet, and indicate the question number.
4. Some questions require supporting documentation. Provide all requested documentation with the fully completed application, signed and dated by the owner, partner, or legal officer.

II. CURRENT AND REQUESTED COVERAGE

COVERAGE AND LIMIT REQUESTED

Indicate Coverage and Limit Requested:

Directors, Officers and Organization Liability: ☐ Yes ☐ No Limit Requested: $______________________

Employment Practices Liability: ☐ Yes ☐ No Limit Requested: $______________________

Fiduciary Liability: ☐ Yes ☐ No Limit Requested: $______________________

Indicate the Type of Limit Requested:

Shared Limit of Liability for multiple Coverage Sections: ☐ Yes ☐ No

Separate Limit of Liability for each Coverage Section: ☐ Yes ☐ No

CURRENT INSURANCE INFORMATION

Types of Coverage		Carrier	Expiration Date	Limit	Deductible	Premium
Directors, Officers & Organization Liability	☐ None					
Employment Practices Liability	☐ None					
Fiduciary Liability	☐ None					

III. APPLICANT INFORMATION

1. Primary applicant's full legal name that is to be listed as first Named Insured:___________________________

____

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2. Are there any other entities or DBAs requesting to be named? ☐ Yes ☐ No
   a. If yes, list and include relationship details with the first Named Insured: ____________________________

____

____

b. Do all entities have common ownership with the first Named Insured in whole or majority?

☐ Yes ☐ No

If yes, ownership percentage for each related entity below: ______________________________

____

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Subsidiary Name	Nature of Business	*Percentage Owned by First Named Insured Entity	Date Created or Acquired	Domestic or Foreign	Non-Profit
		%			☐ Yes ☐ No
		%			☐ Yes ☐ No
		%			☐ Yes ☐ No

*If **Subsidiary** is less than 100 percent owned, provide details of all other owners, by attachment.

3. Please list any names of other entities that you own or manage or that you do business under (such entities are not requesting coverage under this policy): ______________________________

____

____

4. Years in operation under current ownership/management: ______________________________

5. Mailing Address: ______________________________
City: ______________________________ State: __________ Zip: __________

6. Primary/Premise Address: ______________________________
City: ______________________________ State: __________ Zip: __________
(If you have multiple premise locations, please attach a complete address list.)

7. Name and title for best contact: ______________________________
   a. Phone Number: ______________________________
   b. Email Address: ______________________________

8. Website: ______________________________

9. Do you currently have the requested Liability Insurance for your operations? ☐ Yes ☐ No
   a. If yes and your policy is with Richmond National, what is the policy number? __________
      (if your policy is with Richmond National, skip b. through f. below)
   b. What is the policy expiry date? ______________________________
   c. If your current policy is on a Claims Made form, what is the Retroactive Date? __________
      Please attach a copy of your current policy Declarations Page for Date and Limits confirmation if you want to retain this Retroactive Date.
   d. Who is the current insurance carrier? ______________________________
   e. Are they offering renewal? ☐ Yes ☐ No
   f. Expiring premium: ______________________________

10. Has the Applicant been involved with, negotiated, attempted or transacted any merger, acquisition, asset sale or divestment in the past eighteen (24) months where such merger, acquisition, asset sale or divestment involved more than twenty five percent (25%) of the total assets or securities of the Applicant?
☐ Yes ☐ No

11. Does the Applicant contemplate transacting any merger, acquisition, asset sale or divestment in the next twelve (12) months where such merger, acquisition, asset sale or divestment would involve more than fifty percent (50%) of the total assets or securities of the Applicant? ☐ Yes ☐ No

12. Does any entity own your business or does your business own or control any other entity? ☐ Yes ☐ No

13. Has the name or ownership of the entity changed or has any other business been purchased, merged, or consolidated with the entity within the last 5 years? ☐ Yes ☐ No

14. During the past five years, has your name been changed or has any other business purchased, merged, or consolidated with you? ☐ Yes ☐ No

15. Does the Applicant have foreign operations? ☐ Yes ☐ No

If you answered Yes to questions 10-15, please provide full details including the timing, the essential terms of the event, arrangement, impact on employee base and the surrounding circumstances. Please use a separate page, if needed.

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IV. DIRECTORS AND OFFICERS

- **Please provide a copy of the most recent interim financial statements (audited, if available).**
- **Please provide a list of the Board of Directors and Senior Executive Officers.**
- **Please provide a full Capitalization Table with 100% of ownership and shareholders.**

1. Please describe the applicant's nature of operations or business (type of products or services provided):

____

____

2. Is the Insured Entity engaged in any of the following activities? If "None", so state. ☐ None

☐ Activities that fall under The Investment Company Act of 1940

☐ General Partnership Operations

☐ Captive Insurance Company Operations

☐ Insurance Company Operations

☐ Franchising

☐ Joint Venture(s)

3. What is the total number of Applicant's voting shareholders: ________________

4. What is the total l number of shares or units outstanding: _______________

5. What is the total number of shares owned by the Directors and Officers: ________________

Please list respective percentages of voting shares owned by D's and O's on a separate attachment.

6. List all shareholders, unit holders or members with 10% or more interest in the Named Insured:

Name	Percent Ownership	Director/Officer	Family
	%	☐Yes ☐No	☐Yes ☐No

		%	☐ Yes ☐ No	☐ Yes ☐ No
		%	☐ Yes ☐ No	☐ Yes ☐ No
		%	☐ Yes ☐ No	☐ Yes ☐ No

7. Have there been any changes to the applicants Board of Directors or key executives in the past 12 months? (If Yes, please attach full details.) ☐ Yes ☐ No

   Or contemplating any changes in the next 12 months? (If Yes, please provide full details.) ☐ Yes ☐ No

8. Does the Applicant's charter or by-laws contain indemnification provisions? ☐ Yes ☐ No

9. Does the Applicant or any Subsidiary perform the rendering of any professional services or engage in any standard setting, accrediting, credentialing or licensing activities? (If Yes, please provide full details.)

   ☐ Yes ☐ No

10. Does the Applicant anticipate transacting in the next eighteen (18) months or has the Applicant transacted in the last eighteen (18) months any:

    a. private debt or equity offering or sale of securities through the use of an offering prospectus, memorandum, circular or similar document? ☐ Yes ☐ No

    b. direct sale of securities to a person or entity through any means other than the use of an offering prospectus, memorandum circular or similar document? ☐ Yes ☐ No

    c. sale of securities, services, goods or products for the purpose of funding Applicant operations or capital through social networking, crowdfunding, crowdsourcing or any similar mechanism? ☐ Yes ☐ No

    If Yes to 10 a.-c., please provide details below or use on a separate page, if needed.

    ____

    ____

    ____

    ____

V. FINANCIAL INFORMATION (Send financial statements – both a Balance Sheet and P&L statements)

1. Provide the following financial information for the Named Insured and related Subsidiaries:

Indicate the following as it relates to the Applicant's fiscal year-end (FYE) *(Please indicate negative figures with "( )" or "-" as appropriate)*	**Most Recent FYE (Month/Year)** **(_____/_____)**	**Prior FYE (Month/Year)** **(_____/_____)**
Total Assets		
Total Liabilities		
Gross/Total Revenues		
Net Income (Net Loss)		

Cash Flow from Operations		

2. Is the Applicant currently (or has it been in the past 24 months) in violation of, or has it received an amendment to any debt covenant? ☐ Yes ☐ No
3. Does the Applicant or any Subsidiary have any plans to raise capital in the next twelve months?

   ☐ Yes ☐ No
4. If Yes to questions 2-3, please provide full details below.

   ____

   ____

   ____

   ____

VI. EMPLOYMENT PRACTICES LIABILITY (Complete only If applying for this coverage)

1. Number of Employees, Independent Contractors, and Volunteers:

   Full Time ___________

   Part Time ___________

   Leased ___________

   Temporary/Seasonal ___________

   Independent Contractors ___________

   Volunteers ___________

   Total number of employees **located outside the U.S** (please include the country/territory): ___________
2. If you have multiple locations, please list employees by state:

	State:	State:	State:	State:	State:
Full Time					
Part Time					
Leased					
Temporary/Seasonal					
Independent Contractors					
Volunteers					

3. Salary Ranges: Number of employees by total head count above (including bonuses, dividends, and commissions for all mentioned above)

   $50,000 or less: ____________

   $50,001 to $100,000: ___________

   $100,001 to $250,000: ___________

   $250,000 and over: ___________

4. What's the average annual percentage of employee turnover?
   - ☐ <5%
   - ☐ 5%-15%
   - ☐ 16%-30%
   - ☐ >30%

5. How many employees are covered by collective bargaining or other union agreements? _____________

6. In the past 12 months, how many **officers** have left your employment? ______________________________

   Of the above, how many were involuntarily terminated? ____

7. In the past 12 months, how many **other employees** have left your employment? ______________________

   Of the above, how many were involuntarily terminated? ____

8. In the past twelve (12) months, has your total number of employees decreased by more than ten percent (10) or five (5) employees, whichever is greater, through any reduction in force, systematic lay-off, closure of any division, office or facility that you own or operate or for any other reason? (If Yes, please complete the Reduction In Force supplement.) ☐ Yes ☐ No

9. In the next twelve (12) months, do you anticipate the total number of your employees to decrease by more than ten percent (10%) or five (5) employees, whichever is greater, through any reduction in force, systematic lay-off, closure of any division, office or facility that you own or operate or for any other reason? (If Yes, please complete the Reduction In Force supplement.) ☐ Yes ☐ No

10. If during the next 12 months, circumstances of which are you currently unaware make it necessary for you to decrease the number of your employees by ten percent (10%) or five (5) employees, whichever is great, through the implementation of any reduction in force, systematic layoff, closure of any division, office or facility that you own or operate or for any other reason (with any such reduction, lay-off or closure not known, anticipated or planned by you as of the date of this Application), do you agree that you will consult with, and adopt the advice of, a lawyer who specializes in labor and employment law (may include in-house counsel, but only if that counsel if qualified and experienced in the practice of labor and employment law) as respects the implementation of such reduction, lay-off or closure? (If No, please explain on a separate sheet.) ☐ Yes ☐ No

11. Does the Applicant anticipate any merger, acquisition, or addition of any operations that would comprise a twenty-five percent (25%) or ten (10) employees, whichever is greater, increase over the current number of employees? (If Yes, please provide full details on a separate sheet.) ☐ Yes ☐ No

12. Has any insurer ever cancelled or non-renewed the Applicant or its predecessor for this type of coverage? (If Yes, please provide details on a separate sheet.) ☐ Yes ☐ No

VII. HUMAN RESOURCES

1. Have all management staff and officers attended training and education programs on sexual harassment within the last eighteen (18) months? ☐ Yes ☐ No

   If Yes, who has attended? ____

   If Yes, who conducts the sessions? ____

2. Do you have written employment agreements with all the officers? ☐ Yes ☐ No
3. Do you have your labor relations or employment counsel review the employment policies/procedures at least annually? ☐ Yes ☐ No

   If Yes, identify the firm and date of last review: ______________________________
4. Do you have a separate Human Resources Department? ☐ Yes ☐ No

   If Yes, how many employee are in this department? _________ Is it centralized? ☐ Yes ☐ No

   If No, who handles this function? ______________________________
5. Does the Applicant publish and distribute an employee handbook? ☐ Yes ☐ No
   a. If Yes, does the Applicant distribute it to all employees? ☐ Yes ☐ No
   b. If Yes, do all employees sign up for its receipt? ☐ Yes ☐ No
   c. If Yes, does it expressly state that it is not a contract and that employment is "at will"? ☐ Yes ☐ No
6. Does an employment attorney review the Employee handbook? ☐ Yes ☐ No

   If Yes, when was the Employee handbook last reviewed by an employment attorney and what was the name of the firm or attorney? ______________________________

   ____
7. Are there written procedures for handling employee complaints of discrimination or sexual harassment? ☐ Yes ☐ No
8. Do you have written procedures for handling employee grievances or complaints? ☐ Yes ☐ No
9. Do you have a parental leave policy in place? ☐ Yes ☐ No
10. Do you provide Mother/Lactation room and/or allocated time for Mothers? ☐ Yes ☐ No
11. Who does the Applicant require all terminations to be reviewed by:

    The person in charge of human resources? ☐ Yes ☐ No

    Outside counsel? ☐ Yes ☐ No

    Other: ______________________________ ☐ Yes ☐ No
12. Does the Applicant maintain a personnel file for each employee? ☐ Yes ☐ No
13. Have you had in place for the past three years or since formation, whichever is the shorter time period, written procedures and guidelines to classify the status of each employee as Non-Exempt or Exempt under the rules and regulations of the Fair Labor Standards Act of 1938, as amended?

    ☐ Yes ☐ No
14. What percentage of the applicant's employee base is: Exempt ___________% Non-Exempt ___________

VIII. THIRD PARTY INFORMATION (Complete only If applying for this coverage)

1. Please describe the frequency and nature of third-party contact. ______________________________

   ____

   ____
2. Estimated number of employees with customer/client contact. ______________________________

3. Have you or you predecessors ever received a formal or informal complaint from a non-employee, such as a customer, client, or prospective customer or client complaining about discrimination or harassment by the Applicant or any employee of the Applicant? ☐ Yes ☐ No

   If Yes, please provide details here or on a separate page. ______________________________

____

____

4. Do you conduct staff training on client and customer relations issues such as avoiding discriminatory behavior? ☐ Yes ☐ No
5. Does the applicant have policies and procedures for reporting and dealing with complaints by customers/clients? ☐ Yes ☐ No
6. Is the Applicant in compliance with Title III of the Americans with Disabilities Act (building and premises requirements)? ☐ Yes ☐ No

IX. FIDUCIARY LIABILITY (Complete only if applying for this coverage)

Plan Name	Plan Type	Year Established	Total Plan Assets	Total # of Participants	Multi or Multiple Employer Plan (Yes/No)	Plan Funding Percent
			$			%
			$			%
			$			%
			$			%

Types of Plans: Defined Contribution = DC; Defined Benefit = DB; Excess Benefit Plan = EB; Welfare Benefit Plan = WB; Employee Stock Ownership Plan = ESOP

1. 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
2. Is any listed Plan a multiemployer or multiple employer plan? ☐ Yes ☐ No

   If Yes please provide detail and if merger activity is anticipated. ______________________________

____

____

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. Does the Applicant or any Subsidiary utilize a Plan investment manager? ☐Yes ☐No

If Yes, what % of Plan assets are managed by the manager as defined by ERISA? __________%

6. Has any fiduciary been:

(a) Accused of, found guilty of, or held liable for a breach of trust?

(b) Convicted of criminal conduct?

If Yes to any of the above, please attach a full description of the details. ____________________

____

7. How often are plan guidelines and goals reviewed and/or amended by the fiduciaries? __________

8. Does the Applicant or any Subsidiary expect any reduction in benefits, cessation of benefits, or increase in costs to the Plan participants as a result of any plan amendment anticipated in the next twelve months? ☐Yes ☐No

Was any such amendment adopted within the last two years? ☐Yes ☐No

9. 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

X. PRIOR KNOWLEDGE & OTHER MATERIAL INFORMATION

1. Does the Applicant or any individual or entity proposed for coverage have any knowledge of or information about any fact, circumstance, situation, transaction, event, act, error, omission, misstatement, misleading statement, neglect, breach of duty or other matter which could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance?

☐ Yes ☐No

2. After inquiry with each person as appropriate, in the last five (5) years, does anyone have any other Material Facts to disclose? (If Yes, please provide such Material Facts on a separate sheet.)

☐ Yes ☐No

A Material Fact is something that is likely to influence assessment of this risk, the premium we charge, or the terms and conditions we offer. If there is any doubt as to whether a fact would be considered material, you should disclose it. All the information requested in this application is material.

XI. INSURANCE AND LOSS HISTORY

1. Please provide your **organization's** recent Directors & Officers Insurance history below:

	Insurance Carrier	Limits Per Claim/Aggregate	Deductible	Policy Period (Month/Day/Year)	Annual Premium

Current Year					
Prior Year 1					
Prior Year 2					
Prior Year 3					
Prior Year 4					

2. Does your expiring D&O policy also include:

   Employment Practices Liability (EPL) insurance? ☐ Yes ☐ No

   Fiduciary Liability insurance? ☐ Yes ☐ No

   If "No", do you have a separate Employment Practices Liability (EPL) or Fiduciary policy in place?

   ☐ Yes ☐ No

3. Please provide your **organization's** recent Employment Practices Liability Insurance history below:

	Insurance Carrier	**Limits Per Claim/Aggregate**	**Deductible**	**Policy Period (Month/Day/Year)**	**Annual Premium**
Current Year					
Prior Year 1					
Prior Year 2					
Prior Year 3					
Prior Year 4					

4. Please provide your **organization's** recent Fiduciary Liability Insurance history below:

	Insurance Carrier	**Limits Per Claim/Aggregate**	**Deductible**	**Policy Period (Month/Day/Year)**	**Annual Premium**
Current Year					
Prior Year 1					
Prior Year 2					
Prior Year 3					

Prior Year 4					

5. Are you being canceled or non-renewed by your current Directors & Officers Liability, Employment Practices Liability or Fiduciary Liability carrier? ☐ Yes ☐ No

   If Yes, please explain in detail why: ____

____

6. During the last 5 years, has any **Insured**, including any **Subsidiary**, received any written demands for monetary or non-monetary relief, been involved in, or had any knowledge of any civil or criminal action, administrative proceeding or arbitration, regulatory proceeding or investigation, including both domestic or foreign equivalents, involving:

   (a) any current or former employee or third-party alleging discrimination, harassment, wrongful discharge and/or any wrongful employment act? ☐ Yes ☐ No

   (b) the Equal Employment Opportunity Commission or any similar state or local agency? ☐ Yes ☐ No

   (c) the National Labor Relations Board? ☐ Yes ☐ No

   (d) actual or alleged violations of any wage and hour law, including but not limited to, the Fair Labor Standards Act? ☐ Yes ☐ No

   (e) the U.S. Immigration and Customs Enforcement Agency? ☐ Yes ☐ No

   (f) the Department of Justice, U.S. Department of Labor, Pension Benefit Guarantee Corporation, Securities and Exchange Commission, Internal Revenue Service or any similar state or local agency? ☐ Yes ☐ No

   (g) any intellectual property disputes, including Copyright, Patent, or Trademark Laws? ☐ Yes ☐ No

   (h) any security law or regulation, anti-trust or fair trade law, the Foreign Corrupt Practices Act or Office of Federal Contract Compliance Programs? ☐ Yes ☐ No

   If "Yes" to any of the above how many? __________Please complete a separate Supplemental Claim Application for each claim or suit and include a currently valued loss run for each claim.

7. After inquiry with each person as appropriate, do you, or any of your partners, officers, directors, or employees know of any circumstances, acts, errors, omissions, or any allegations or contentions of any incident that could result in a Directors and Officers claim, or any employment related claim, including third party claims? ☐ Yes ☐ No

   If "Yes," how many? ___________Please complete a separate Supplemental Claim Application for each claim or suit and include a currently valued loss run for each claim.

8. Is any Insured aware of any fact, circumstance or situation involving any Insureds that might reasonably be expected to result in a Claim as defined in the Directors & Officers & Private Organization Liability Coverage Section? ☐ Yes ☐ No

   If "Yes," how many? ___________Please complete a separate Supplemental Claim Application for each claim or suit and include a currently valued loss run for each claim.

9. During the last 5 years has any **Insured**, including any **Subsidiary**, been involved in any lawsuit not disclosed above? ☐ Yes ☐ No

   If "Yes," how many? ___________Please complete a separate Supplemental Claim Application for each claim or suit and include a currently valued loss run for each claim.

XII. ACKNOWLEDGEMENTS AND SIGNATURE

FRAUD WARNING

General Fraud Warning: 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 applicants in the following states, districts, and territories, the below notice supersedes the previous paragraph:

Alabama	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 is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona	For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas	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.
California	***For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.***
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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
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.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	Application: 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. Claim: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
Louisiana	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.
Maine	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.
Maryland	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.
Minnesota	A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.
New Hampshire	Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
New Jersey	Claim: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Application: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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 civil fines and criminal penalties.
New York	General: 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. Auto: Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.

Ohio	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
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.
Pennsylvania	General: 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. Auto: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.
Rhode Island	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.
Tennessee	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.
Virginia	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.
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.
West Virginia	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.

Applicant:

By signing below, I declare that to the best of my knowledge all answers provided herein and any attached or appended documents are true, that no material facts have been withheld or misstated, and that my answers are based on a reasonable inquiry or investigation.

I understand that I have a continuing obligation to notify Richmond National of any material changes in the answers to the questions on this application which may arise prior to the effective date of any policy issued pursuant to this application, and I understand that any outstanding quotations may be modified or withdrawn based upon such changes at Richmond National's sole discretion. I understand that all written statements and materials furnished to Richmond National in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

I understand that completion of this form does not bind coverage, and that I will need to accept Richmond National's quotation prior to binding coverage and policy issuance.

Applicant Signature: ______________________________

Applicant Written Name and Title: ______________________________

Date: ______________________________

Agent/Broker:

1. If coverage is currently in place, does your office currently control this risk? □ Yes □ No
2. If this application is completed on behalf of an insured, are you personally familiar with the applicant's operations? *(Application will need to be verified and signed by the applicant prior to binding if a quote is offered.)* □ Yes □ No

Agent or Broker Signature: ______________________________

Agent or Broker Written Name and Agency/Brokerage: ______________________________

Date: ______________________________