3550 George Business Pkwy NW, Suite 305 Kennesaw, GA 30144

CRYOTHERAPY INSURANCE POLICY APPLICATION

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE AND REPORTED POLICY SUBJECT TO ITS TERMS. THE POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED IN WRITING TO THE UNDERWRITERS DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. THE UNDERWRITERS ARE NOT LIABLE FOR CLAIMS EXPENSES OR DAMAGES ONCE THE LIMIT OF LIABILITY IS EXHAUSTED. PLEASE READ THIS POLICY CAREFULLY.

Please fully answer all questions and submit all requested information. Terms appearing in bold face in this **Application** are defined in the Policy and have the same meaning in this **Application** as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker.

General Information

1. Legal Name of Entity: _____
   Address: _____
   City: _____ State: _____ ZIP: _____ Telephone: _____
   Website: _____ ◯ Facebook ◯ Instagram ◯ Snapchat ◯ Twitter ◯ Other
   FEIN: _____
   Hours of Operation: _____

   If additional locations, please add on page 6 of application.

2. Are clientele given remote access or allowed to use equipment/treatments without a trained employee supervising the treatments? ◯ Yes ◯ No
   If yes, please provide details. _____

3. The Entity has continuously been in existence since _____ and is a
   ◯ Corporation ◯ Partnership ◯ Individual ◯ Other: _____

4. Is the Applicant controlled or owned by, associated or affiliated with, or does it own, any other business enterprise? ◯ Yes ◯ No
   If yes, please explain: _____

5. Limits of Liability Desired ◯ $500K/$500K ◯ $500K/$1MM ◯ $1MM/$3MM ◯ $2MM/$4MM

6. Are any significant changes in the nature or size of the Applicant's business anticipated over the next twelve (12) months? Or have there been any such changes in the past twelve (12) months? ◯ Yes ◯ No

7. Total Gross Annual revenue for ALL services offered for last fiscal year (12 mos) _____ Anticipated current fiscal year _____ projected next fiscal year _____

8. Do you provide any services to animals? ◯ Yes ◯ No

   If yes, please provide the following:

   a. Equine (please complete equine supplemental) no of treatments _____ % of total revenues _____
   b. Canine - no of treatments _____ % of total revenues _____
   c. Other (please provide full details) _____

9. Please describe in detail the types of service the Applicant is engaged in and indicate the **Gross Revenues** derived from each:

Service	Past Fiscal Yr. Ending / /. (or Projected of applicant is a new entity)	No. of total Treatments
Cryotherapy – Whole Body/Sauna	$_____	_____
IV Therapy (complete supplemental)	$_____	_____
Infrared Sauna	$_____	_____
Massage Therapy	$_____	_____
Cryotherapy – Local	$_____	_____
Float Tanks	$_____	_____
Weight Loss Services	$_____	_____
MediSpa Treatments	$_____	_____
Other: _____	$_____	_____

Other: _____ $_____ _____

Please provide the percentage of local treatments by type (must total 100%):

Rehabilitative/Pain Management:_____ Weight Loss & Body Contouring _____

Aesthetic/Facials _____ Other (explain) _____ Details _____

If more space is needed, please list on page 6 of the application: _____

_____

10. Do you sell any products? ◯ Yes ◯ No

Gross receipts (excluding private label): $_____

a. Do you private label products for sale? ◯ Yes ◯ No
b. Do you sell or distribute herbal supplements, homeopathic remedies or nutraceuticals, drugs without FDA approval orproducts requiring a physician's prescription? ◯ Yes ◯ No

If Yes, please give details _____

_____

c. Do any of these products contain cannabis, THC or other marijuana derivatives/related products? ◯ Yes ◯ No

11. Do you want to include General Liability? ◯ Yes ◯ No

12. Do you want Business Personal Property and/or Business Income Insurance? ◯ Yes ◯ No

13. Do you provide any mobile services or services at locations other than your own? ◯ Yes ◯ No

a. Please break down the percentage of mobile services by location performed (must equal 100%):

1. Nursing Homes/Hospitals _____
2. Private Residences_____
3. Offices/Other businesses (not your own) _____
4. Trade Shows/Business Expo _____
5. Fairs _____ Please provide average daily attendance_____
6. Rodeos, Ranches, etc._____ Will you be treating Equine/Bovine or other livestock? ◯ Yes ◯ No
   If yes, how many treatments _____
7. Sporting Events_____
   a. Please provide full details including services you will be providing, type of sporting event, level (i.e. youth, select, collegiate, semi-pro, pro), date(s) and average attendance:

_____

_____

8. Music & Film Festivals_____
   a. If any Music/Film Festivals, are any above 1000 attendees daily? ◯ Yes ◯ No
   If yes, please provide full details including name of festival, website of festival, dates, and what services you will be performing there_____

_____

9. Other? _____ Please provide full details: _____

10. Please list the mobile services that you provide (i.e. IV Therapy, massage therapy, cryotherapy, etc.) and the annual number each: _____

_____

14. List the make and model of each Cryotherapy or other device and the number of each in use:

Device Make and Model:	Number	Inflatable:	Electric Cryo	Nitro Cryo
_____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
_____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
_____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
_____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

If additional room is needed, please attach a schedule of equipment.

15. Do you assess/treat scarring, stretchmarks, burns, etc.? ◯ Yes ◯ No
If Yes:

Which machine(s)/treatment(s) do you use? _____
Do you obtain a written referral from a doctor (MD) prior to performing treatments? ◯ Yes ◯ No
Do you retain the medical referral in the client's permanent file? ◯ Yes ◯ No
Do you have the client sign additional waivers acknowledging that there are no guarantees of results and/or that the fading may be only temporary? ◯ Yes ◯ No

16. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

Independent Certified and/or	Employee	Contractor	State Licensed	Own Insurance
Certified Cryo Technicians	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Massage Therapists	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Medical Assistants	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Other:	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No

17. Do you have a medical director? If yes, please provide name_____

18. Are you aware of, advertise for or otherwise promote Cryo services to professional /collegiate athletes, celebrity or other high profile clients? ◯ Yes ◯ No
If Yes, please give
a) Associated revenues: $_____Annual treatments: _____
b) Type of Athletes (i.e. pro/collegiate football, MMA, actor/actress, politician, etc.) _____
c) List these clients by name (if more space is needed please use page 5) :_____
_____

19. What is the minimum temperature you use in Cryo treatments?_____ºF

20. How long have they been working with Cryo devices? _____

21. What training do the operators receive? _____
_____

22. How many employees are trained to use the Cryo devices? _____

23. Do you have an operating protocol in place that requires supervision at all times whilst the device is in use? ◯ Yes ◯ No

24. Does the application provide **dry** hand and foot protection prior to use of cryotherapy equipment? ◯ Yes ◯ No

25. If the Applicant provides completely enclosed cryochambers, is **dry** head protection provided? ◯ Yes ◯ No ◯ N/A

26. Does the Applicant screen for medical conditions that may not be suitable for cryotherapy? ◯ Yes ◯ No

27. Does the Applicant use nitrogen monitors in cryotherapy rooms? (Electric Cryo Chamber. Nitrogen for Local Cryo only) ◯ Yes ◯ No

28. Does the Applicant limit cryotherapy sessions to the manufacturer recommended time limit? ◯ Yes ◯ No

29. Does the Applicant ensure that patients are able to exit cryotherapy machines without assistance? ◯ Yes ◯ No

30. Does the Applicant require all patients to sign an informed consent form? ◯ Yes ◯ No

31. Does the Applicant regularly inspect and calibrate cryotherapy machines as recommended by the manufacturer? ◯ Yes ◯ No

32. Are staff trained to provide first aid or CPR? ◯ Yes ◯ No

33. Does the Applicant allow staff or patients to provide cryotherapy to themselves? ◯ Yes ◯ No

34. Do you operate under a Franchise Agreement? ◯ Yes ◯ No
If Yes, Franchisor Name: _____
a. Do you own or rent/lease equipment from them? _____
b. Do you have a current service agreement for equipment maintenance with them? ◯ Yes ◯ No

35. Do you have a written procedure to document incidents and adverse reactions? ◯ Yes ◯ No

36. Has any applicant, employee or independent contractor of the applicant, or any owner or office ever been convicted of a criminal act other than a traffic offense? ◯ Yes ◯ No
37. Has any applicant, employee or independent contractor of the applicant, or any owner or office ever been treated for alcoholism or drug addiction (if yes, please attach details)? ◯ Yes ◯ No
38. Has any applicant, employee or independent contractor of the applicant, or any owner or office ever had any state professional license or license to prescribe narcotics suspended, revoked, renewal refused, or restricted or ever voluntarily surrendered a license? (if yes, please attach details) ◯ Yes ◯ No
39. Do you have all clients sign waivers of liability and/or informed consent forms prior to treatment in your facility and retain these forms in the clients' files? ◯ Yes ◯ No
40. Do you require a Physician signed prescription which will be kept on file for a minimum of 5 years for all Cryotherapy treatments? ◯ Yes ◯ No
41. Is there a medical director? ◯ Yes ◯ No

    If yes, do they have their own medical malpractice? _____

42. Have you in the past, or do you plan to begin in the future, provide or offer services to anyone under the age of 18? ◯ Yes ◯ No

    If Yes, please provide a breakdown of the age of minors treated by percent (must total 100% of minor services):

    - Under 5 years old _____%
    - 5 years – 9 years old _____%
    - 10 years -13 years old _____%
    - 14 years – 18 years old _____%

    a. Please state the average number of monthly visits for clients under 18_____

    b. Are employees in the same room as clients under 18 when they are undressing? ◯ Yes ◯ No

    c. Are there cameras in the treatment rooms? ◯ Yes ◯ No

    d. Do parents always remain present with minors under 14 during treatment? ◯ Yes ◯ No

    e. Does the insured follow all manufacturer's guidelines for all machines, modalities, treatments and services, including but not limited to any age restrictions? ◯ Yes ◯ No

    f. Does the insured require an expanded waiver, signed by the parent/guardian that lists any additional risks of treatments based on age? ◯ Yes ◯ No

    g. What specific services, modalities, and treatments are minors under the age of 14 allowed to receive?

    Please list all services for minors under 14 _____

Insurance History

43. Please provide history of professional liability insurance for past five years (if none, state none)

Carrier:_____Limit:_____Premium:_____Term_____
Carrier:_____Limit:_____Premium:_____Term_____
Carrier:_____Limit:_____Premium:_____Term_____
Carrier:_____Limit:_____Premium:_____Term_____
Carrier:_____Limit:_____Premium:_____Term_____

44. Do you offer any childcare or are any other business operations taking place on your premises? If yes, please attach details ◯ Yes ◯ No

45. Who is your nitrogen provider? _____

46. Has any professional liability or general liability insurance ever been declined or cancelled? ◯ Yes ◯ No

47. Have any of the Applicant's current professional liability or general liability Underwriters formally indicated intent not to offer renewal terms? ◯ Yes ◯ No
If Yes, please explain: _____

48. Has the Applicant or any director, officer, partner or principal been a party to any lawsuit or other legal proceeding or been the subject of a disciplinary action as a result of their professional activities? ◯ Yes ◯ No

49. Is the Applicant aware of any errors, omissions or claims (including any circumstances reported to previous Underwriters which have not developed into claims) during the last five (5) years? ◯ Yes ◯ No

50. Has the Applicant or any director, officer, employee or other proposed Insured given written notice under the provisions of any prior or current errors or omissions or professional liability policy of specific facts or circumstances which might give rise to a Claim being made against any proposed Insured? ◯ Yes ◯ No

51. List additional insured needed: _____

Name/Address of AI_____Relationship of AI _____

_____

_____

The undersigned declares that the statements set forth herein are true and include all material information. For New Hampshire applicants, the foregoing statement is limited to the best of the undersigned's knowledge, after reasonable inquiry. The undersigned agrees that if the information supplied in this Application changes between the date of this Application and the effective date of the insurance, he/she will, in order for the information to be accurate on the effective date of the insurance, immediately notify the Underwriters of such changes, and the Underwriters may withdraw or modify any outstanding quotations or authorizations or agreements to bind the insurance.

Signing of this Application does not bind the Applicant or the Underwriters to complete the insurance, but it is represented that the statements contained in this Application and the materials submitted herewith are the basis of the contract should a Policy be issued and have been relied upon by the Underwriters in issuing any Policy. The Underwriters is authorized to make any investigation and inquiry in connection with this Application as it deems necessary.

All written statements and materials furnished to the Underwriters in conjunction with this Application are hereby incorporated by reference into this Application and made a part hereof. This Application and materials submitted with it shall be retained on file with the Underwriters and shall be deemed attached to and become part of the Policy if issued. For North Carolina, Utah, and Wisconsin Applicants, such Application and materials are part of the policy, if issued, only if attached at issuance.

NOTICE TO NEW YORK APPLICANTS: THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE POLICY SUBJECT TO ITS TERMS. UPON TERMINATION OF COVERAGE FOR ANY REASON, A 60-DAY AUTOMATIC EXTENSION PERIOD WILL APPLY. FOR AN ADDITIONAL PREMIUM, AN OPTIONAL EXTENSION PERIOD CAN BE PURCHASED AS INDICATED IN ITEM 8. OF THE DECLARATIONS.EXCEPT AS OTHERWISE PROVIDED HEREIN, THIS POLICY ONLY APPLIES TO CLAIMS FIRST MADE DURING THE POLICY PERIOD, THE AUTOMATIC EXTENSION PERIOD OR, IF APPLICABLE, THE OPTIONAL EXTENSION PERIOD. NO COVERAGE EXISTS FOR OCURRENCES WHICH TAKE PLACE PRIOR TO THE RETROACTIVE DATE STATED IN THE POLICY. NO COVERAGE EXISTS FOR CLAIMS MADE AFTER THE END OF THE POLICY PERIOD AND THE AUTOMATIC EXTENSION PERIOD UNLESS, AND TO THE EXTENT, THE OPTIONAL EXTENSION PERIOD APPLIES. NO COVERAGE WILL EXIST AFTER THE EXPIRATION OF THE AUTOMATIC EXTENSION PERIOD OR, IF PURCHASED, THE OPTIONAL EXTENSION PERIOD, WHICH MAY RESULT IN A POTENTIAL COVERAGE GAP IF PRIOR ACTS COVERAGE IS NOT SUBSEQUENTLY PROVIDED BY ANOTHER UNDERWRITER. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY CLAIMS EXPENSES AND CLAIMS EXPENSES SHALL BE APPLIED TO THE DEDUCTIBLE. THE UNDERWRITERS ARE NOT OBLIGATED TO PAY CLAIMS EXPENSES OR ANY SETTLEMENTS OR JUDGMENTS AFTER THE LIMIT OF LIABILITY HAS BEEN EXHAUSTED. DURING THE FIRST SEVERAL YEARS OF A CLAIMS-MADE RELATIONSHIP, CLAIMS-MADE RATES ARE COMPARATIVELY LOWER THAN OCCURRENCE RATES, AND THE INSURED CAN EXPECT SUBSTANTIAL ANNUAL PREMIUM INCREASES, INDEPENDENT OF OVERALL RATE INCREASES, UNTIL THE CLAIMS-MADE RELATIONSHIP REACHES MATURITY.

NOTICE TO MINNESOTA APPLICANTS: THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE AND REPORTED POLICY SUBJECT TO ITS TERMS. THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED TO THE UNDERWRITERS DURING THE POLICY PERIOD OR OPTIONAL EXTENSION PERIOD, IF APPLICABLE. THIS MEANS THAT ONLY CLAIMS ACTUALLY MADE DURING THE POLICY PERIOD ARE COVERED UNLESS COVERAGE FOR AN OPTIONAL EXTENSION PERIOD IS PURCHASED. IF AN OPTIONAL EXTENSION PERIOD IS NOT MADE AVAILABLE TO YOU, YOU RISK HAVING GAPS IN COVERAGE WHEN SWITCHING FROM ONE COMPANY TO ANOTHER. MOREOVER, EVEN IF SUCH A REPORTING PERIOD IS MADE AVAILABLE TO YOU, YOU MAY STILL BE PERSONALLY LIABLE FOR CLAIMS REPORTED AFTER THE PERIOD EXPIRES. CLAIMS MADE POLICIES MAY NOT PROVIDE COVERAGE FOR NEGLIGENT ACTS, ERRORS OR OMISSIONS OF THE INSURED IN RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES COMMITTED BEFORE A FIXED RETROACTIVE DATE. RATES FOR CLAIMS MADE POLICIES ARE DISCOUNTED IN THE EARLY YEARS OF A POLICY, BUT INCREASE STEADILY OVER TIME. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE.

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE INCLUDING ATTACHMENT “A” AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO 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 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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

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 KANSAS APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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 MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR 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.

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 KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND 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 CLAIMS CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

Please list additional locations, additional services, etc. here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signed: Date: _____

Print Name:_____Title: _____

(Owner, Partner, Authorized Officer)

Authorized Representative_____

If this Application is completed in Florida, please provide the Insurance Agent's name and license number as designated. If this Application is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Name of Insurance Agent & License Identification No._____

Authorized Representative_____