



A Member of the Tokio Marine Group

## Outpatient Counseling

### Occurrence Form

#### Group Entity/Corporate or Non-Profit Coverage Application

If existing customer, provide your policy number: AR195188

| Applicant Information   |  | For office use only: _____            | Effective Date: <u>11/02/2023</u>                                   |
|---|--|---------------------------------------|---|
| <b>1. Contact Information</b>   |  |                                       |   |
| Company Name: <b>Behavioral Teaching Solutions LLC</b>  |  | Residence Phone: _____                |   |
| Attn/Address 2: <b>Suite 705</b>  |  | Business Phone: <b>831-228-9398</b>   |   |
| Street: <b>1343 Main Street Suite 705</b>   |  | Fax: _____                            |   |
| City, State, Zip: <b>Sarasota, FL 34236</b>   |  | Email: <b>info@maribelcastillo.co</b> |   |
| Contact Name: <b>Maribel Stikeleather</b>   |  |                                       |   |
| 2. _____  |  |                                       |   |
| Have the professional services you provide changed since your last application?<br>Community-based, Telehealth, and home-based Behavioral health services, and consulting   |  |                                       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 3. Check Associations with which your membership is currently active: <u>APBA</u>   |  |                                       |   |
| <b>Professional Liability</b>   |  |                                       |   |
| <b>4. ONE set of limits of liability for the group:</b>   |  |                                       |   |
| <input checked="" type="checkbox"/> \$1 Million Each Occurrence/\$3 Million Aggregate   |  |                                       |   |
| <input type="checkbox"/> \$1 Million Each Occurrence/\$5 Million Aggregate  |  |                                       |   |
| <b>Renewal Acknowledge</b>  |  |                                       |   |
| We have loaded most of the selections from the previous policy. We do require to complete some questions to verify that nothing has changed. Please go through the application and confirm everything on your application before completing the renewals. |  |                                       |   |
| <input checked="" type="checkbox"/> I Understand  |  |                                       |   |

## 6. Staff

Please list the names and credentials of your staff:

- Besides yourself, do you have any additional owners/partners, w-2 employees, volunteers or students providing clinical services on behalf of your company (do not include administrative/clerical employees in your answer)? No
- Do you have independent contractors (1099s) providing clinical services for your company (do not include administrative/clerical employees in your answer)? No

Do you require each of these names to be listed on a Certificate of Insurance? ☐ Yes ☒ No

### B. Coverage for W-2 Employees and Volunteers \*\*All W-2 Employees must be listed\*\*

| List the Names of the W-2 employees/volunteers to be insured under this policy | Occupation*: List License or Certification (i.e. LPC, LMHC, Psychologist) | Employment Type:        |
|--|---|-------------------------|
| 1. Maribel Stikeleather  | Board Certified Behavior Analyst  | Owner/Partner/Principal |
| 2.   |   |                         |
| 3.   |   |                         |
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| 25.  |   |                         |

\* For any Paraprofessionals (unlicensed or uncertified), please indicate their job title.

You are required to include ALL W-2 employees, including Behavior Technicians or similar in the above schedule.

☒ I acknowledge the above statement

Enter all W-2s and Volunteers in the employee schedule above, or you may upload a spreadsheet or word document with a list of staff. Include first name, last name, occupation and employment status (W2, volunteer, owner):

7. Have you completed an approved Risk Management Course in the last 24 months? ☐ Yes ☒ No

## Optional Supplemental Coverages

- Items #7-#16 are OPTIONAL coverages, and are not required to be added.
- These coverages will be subject to additional underwriting approval and premium.
- By signing this application, you are acknowledging that you have considered your necessity of these optional coverages, and have agreed to add or not add them.

### 7. Additional Insureds

This coverage extends protection to the additional insured entity under your policy.

Please complete the below information to add an additional insured on your policy\*.

**Landlord (no additional charge) - All Others (added at 10% of your professional liability premium each):**

1.) Entity Name:  
Attn:  
Street:  
City, State, Zip: ,  
Professional Relationship:

**\*If you require more space, please use a separate sheet of paper using the same format as outlined above.**

### 8. State Licensing Board Increase

Your policy includes **\$35,000** for defense of a **State Licensing Board Investigation**. You have the option to **increase this coverage**.

**Select An Option:**

- ☒ Increase this limit to \$75,000 (\$75.00 additional premium)  
☐ Increase this limit to \$100,000 (\$100.00 additional premium)  
☐ No Increase

### 9. Cyber Liability Coverage

We are excited to announce that you can now add **Cyber Liability coverage** to your policy.

**Select An Option:**

- ☒ Add Cyber Liability limit of \$15,000 (\$87.00 additional premium)  
☐ Add Cyber Liability limit of \$25,000 (\$141.00 additional premium)  
☐ Do not add

**NOTICE:** *Cyber liability is not available in the following states: Alaska, New Mexico and North Dakota. If you relocate to one of these states mid-policy or reside in one of these states at the time of your next renewal, this coverage will no longer be available.*

### 10. CPH TOP Coverage

**The CPH TOP® Provides General Liability “Slip and Fall Coverage” and Personal Property Coverage Protection.**

**General Liability Coverage** includes **\$1 Million/\$3 Million limits** for Bodily Injury and Property Damage Liability.

**Personal Property Coverage** provides **up to \$15,000** for property that is in your care, custody, or control.

\*Property coverage is NOT available in Florida

**Select An Option:**

- ☐ CPH TOP (General Liability AND Property Coverage): **\$332** \*Not available in Florida  
☐ General Liability ONLY: **\$182**  
☒ Do Not Add This Coverage

**To add CPH TOP® or General Liability coverage, provide full street addresses for each location to be covered.**

Please use a separate sheet of paper for more than 2.

## Optional Supplemental Coverages (Continued)

### 11. Vicarious Sexual Abuse/Molestation\* (Rating basis for limits of \$1,000,000 each occurrence/ \$1,000,000 aggregate)

☐ I would like to add this coverage

Do you provide background checks for all employees? ..... ☐ Yes ☐ No

**Additional Premium: \$300 (First Person) + \$50 (Each Additional Employee)**

**\*Provides protection in the event you or your business are held legally responsible for another person's abusive conduct.**

### 12. Separate Limits

When you take out a corporate/group policy, the corporate/group name is automatically covered under a single set of limits that is also shared by the insured individuals listed on the policy. We offer the option to purchase "Separate Limits", which adds an identical set of limits for the corporate/group name in addition to the limits shared by the insured individuals. This can be added at an additional charge of **10% of your professional liability premium**.

☐ I would like to add this coverage

### 14. Additional Occupation

Do you or any of your employees provide services as a Coach, Hypnotherapist, Biofeedback, Mediator, etc? Coverage can be extended to services provided under this licensure/certification for an additional charge of **10% of your professional liability premium**.

☐ I would like to add this coverage

**Services/License to be covered:** \_\_\_\_\_

**Qualification Questions**

Answer the below questions for any incidents, complaints, or claims **NOT PREVIOUSLY REPORTED** to CPH Insurance. If the situation is already on file with CPH, answer "No".

- |  |   |
|--|---|
| 17. Is your company an inpatient facility (patients reside at your facility or spend the night)?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 18. Do you provide home studies, or facilitate/make recommendations for foster care/adoption placements? (Answer "No" if you simply provide counseling to foster care or adopted clients).   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 19. Do you provide respite care, companion services or housing?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 20. Is your company a school or daycare facility (adult or minor)?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 21. Have you or any of your employees ever been refused coverage for professional liability or malpractice insurance or has your malpractice or professional liability insurance ever been canceled or declined for renewal (non-renewed)?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 22. Has any claim or suit ever been brought against you or any of your employees for alleged malpractice or professional liability, or are you aware of any incident or existing circumstances that might reasonably lead to a claim or suit?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 23. Have you or any of your employees ever been convicted of a misdemeanor or felony that has not been previously reported to CPH?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 24. Have you or any of your employees ever had your license, certification or registration suspended, revoked, or placed on probation by a licensing board, board of examiners, or any other governmental entity that regulates your profession?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Have you or any of your employees received a citation or paid a fine as a result of a board proceeding?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 26. Have you or any of your employees surrendered, either voluntarily or otherwise, your license, certification, or registration?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 27. Have you or any of your employees ever been vicariously or directly accused of sexual misconduct or any professional impropriety?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28. Have any complaints ever been filed against you or any of your employees or have there ever been any formal or informal investigations or inquiries opened with a peer review committee or an ethics committee of a professional association, hospital, health care facility, or any other governmental or private entity? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 29. Do you know of any reason why you or any of your employees cannot comply with the legal, ethical, or professional standards set by law, by regulation, by a peer review committee or by an applicable code of ethics in any jurisdiction where you provide services?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 30. Does your company staff any Medical Doctors in any capacity?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 33. Does your company staff any Nurse Practitioners or individuals with prescriptive authority in any capacity?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

**If your answer to any of the above questions is "yes", please provide a detailed explanation on a separate sheet. Please also attach any pertaining documentation (i.e. Dismissal Letters, Consent Agreements, etc....)**

PLEASE SIGN AND DATE THE CONFIRMATION ON PAGE 6

Thank you for choosing CPH Insurance!

If your application is approved, you will receive a quote within 48 hours with payment instructions.

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*Office Hours: Monday - Friday 8:30 AM-5 PM CST*

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*711 S. Dearborn, Suite 205, Chicago, IL 60605 Fax: 312-987-0902 Phone: 800-875-1911  
E-mail: [applications@cphins.com](mailto:applications@cphins.com) Website: [www.cphins.com](http://www.cphins.com)*

## **CONSUMER DISCLOSURE AND CONSENT TO ELECTRONIC FORM AND DELIVERY OF INSURANCE DOCUMENTS AND COMMUNICATIONS**

The CPH Insurance Insurance Agency Inc would like to provide all insurance policies, endorsements and other related documents to you electronically. Electronic delivery will not apply to any non-renewal notice or cancellation notice we may send to you, in the event such notice is ever necessary

By accepting the terms of this Disclosure and Consent Form, you will not receive a paper copy of any communication or document except for the ones stated above. Please read the information below and if you agree to the following terms and conditions, including the receipt of written communications electronically, please confirm your agreement by clicking the "I Accept" button once you have read the Disclosure and Consent Form.

### **Requesting Paper Copies**

You may at any time request a paper copy, without charge, of any communication or document provided to you or made available to you electronically through email by following the instructions in the How to Contact Us section below. *Please include your policy or account number in your communication to us.*

### **Electronic Notifications of Policy Expiration**

CPH & Associates may use autodialed and/or pre-recorded calls and text messages to cell phones (and for pre-recorded and artificial voice calls to residential land lines) for insurance policy expiration notices. Submitting this form constitutes your express consent to receive these calls and/or text messages.

### **Withdrawing Consent**

You may at any time withdraw your consent to receive communications in electronic form, without charge, by contacting us and requesting paper documents and communications going forward by following the instructions in the How to Contact Us section below. Withdrawal of your consent will be effective within 15 days of the date your withdrawal request is received. *Please include your policy or account number in your communication to us.*

### **Updating Your Email Address**

If you have a new e-mail address, please let us know immediately to ensure that you receive policies and other related documents in a timely manner by following the instructions in the How to Contact Us section below. In your communication to us, please provide your previous email address as well as your new email address. Any change in your email address for the delivery of documents will be effective within 15 days of the date your email address change request is received. *Please include your policy or account number in your communication to us.*

### **How to Contact Us**

You may contact us by email or by United States Postal Service mail to update your information, request paper copies, or withdraw consent to receive policies and other related documents electronically. *Please include your policy or account number in your communication to us.*

**Email:** info@cphins.com

**USPS Mailing Address:** CPH Insurance | 711 S. Dearborn St, Ste. 205 | Chicago, IL 60605

## Minimum Hardware and Software Requirements

By signing this consent, you acknowledge and agree to maintain the following minimum hardware and software requirements:

- | Operating Systems: Windows® XP; Windows Vista™; Windows® 7; Windows® 8; Mac OS X®
- | Browsers: Final release versions of Internet Explorer® 7.0 or above (Windows only); Mozilla® Firefox® 15.0 or above (Windows and Mac); Safari™ 6.0 or above (Mac OS only); Google Chrome® 20.0 or above (Windows and Mac).
- | Mobile Applications: Apple iOS® 6.0 and above. Android™ 2.3 or above
- | Needed Software/Electronic Document Formats: Use of Adobe Acrobat Reader or equivalent for PDF files; Word program for Word files; The Adobe Reader software is available free of charge from Adobe's website [www.adobe.com](http://www.adobe.com)
- | Mobile Sending: Apple iOS® 6.0 and above. Android™ 2.3 or above.
- | Screen Resolution: 1024 x 768 minimum
- | Enabled Security Settings: Allow per session cookies. Users accessing the Internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection.
- | Pre-release (i.e. beta) versions of operating systems and browsers are not supported

For you to be able to view and retain insurance policies and other insurance documents delivered to you electronically by us or your agent, you must have (a) a computer, iPad, or other electronic device that has access to the internet; (b) a valid e-mail address; (c) an operational program installed on your computer, iPad, or other electronic device capable of receiving e-mail; (d) an operational program installed on your computer, iPad, or other electronic device that will permit you to view a document in Adobe Acrobat Reader; and (e) a hard drive, thumb drive, or other device included within or attached to your computer, iPad, or other electronic device to which a document in the above format may be permanently downloaded.

\* These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (i.e. beta) versions of operating systems and browsers are not supported.

## Acknowledging Your Access and Consent to Receive Communications Electronically

If you consent to receive insurance policies, endorsements and other related documents exclusively in electronic format during the course of our relationship with you and in accordance with the terms and conditions described above, please let us know by clicking the "I Accept" button below. If you do not agree to the Terms and Conditions of this Disclosure and Consent Form, you understand that you should not select "Accept" and you should close this document window by clicking the X in the upper right corner.

By clicking the "I Accept" button, you acknowledge that you:

- | Reviewed the Disclosure and Consent Form and understand its contents;
- | Can access and retain electronic documents in the format described in the Disclosure and Consent Form;
- | Consent to having the insurance documents described in the Disclosure and Consent Form delivered to you electronically at the e-mail address you furnish;
- | Acknowledge that your insurance policy and the other documents described in the Disclosure and Consent Form will be deemed to have been delivered to you when sent to the e-mail address you furnish.

I, Maribel Stikeleather, have read and understand the terms and conditions set forth in this Disclosure and Consent Form on 09/13/2023.

## Billing Information:

Card Type: MASTERCARD

Last 4 digits of Credit Card: XXXX5279

**Confirm: Please Read, Sign & Date Below**

**FRAUD STATEMENT AND SIGNATURE SECTIONS**

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

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

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

**VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.**

**FRAUD NOTICE STATEMENTS**

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

**APPLICABLE IN AL, AR, LA, MD, NM, RI AND WV:**ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON (IN ALABAMA, MAYBE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF).

**APPLICABLE IN 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 PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

**APPLICABLE IN COLORADO:**IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

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

**APPLICABLE IN KENTUCKY:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS 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.

**APPLICABLE IN 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.

**APPLICABLE IN NEW JERSEY:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**APPLICABLE IN 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.

**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 PENNSYLVANIA:** 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.

**APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**APPLICABLE IN VERMONT:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

**APPLICABLE IN NEW YORK:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. THIS APPLIES TO AUTO INSURANCE. THIS APPLIES TO AUTO INSURANCE.

**Maribel Stikeleather**

INSURED NAME (PLEASE PRINT/TYPE)

**OWNER/PARTNER/PRINCIPAL**

TITLE (MUST BE SIGNED BY THE GROUP OWNER, PARTNER, OR PRINCIPAL)

**Maribel Stikeleather**

INSURED SIGNATURE

**09/13/2023**

DATE

**11/02/2023**

DESIRED POLICY EFFECTIVE DATE

**SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT**

PRODUCER: **CPH Insurance**

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

PRODUCER LICENSE NUMBER: **19193**

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

ADDRESS: **711 S. Dearborn St., Suite 205, Chicago, IL 60605**

AGENCY: **CPH Insurance**