INSURING BEHAVIORAL HEALTH

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ATP SUPPLEMENTAL APPLICATION

(To be used for all outpatient or residential addiction treatment or mental health facilities. For 100% Sober Living Homes or 100% Outpatient Methadone Clinics, please use our streamlined supplemental applications)

Required Submission Information

- Completed Acord Application
- Statement of Values
- Brochures, if no web site
- CARF Reports
- Currently valued insurance company loss runs for the current policy year plus three prior years

I. General Applicant Information

1. Applicant name: _____
2. Website address: _____
3. Contact name: _____
4. Contact email: _____
5. FEIN: _____
6. For Profit: ☐ Not-for-Profit: ☐
7. Year business was established: _____
8. Years under present management: _____
9. Annual revenues: _____
10. Funding Sources: Federal __% State __% County __% Insurance __%
    Private Pay __% Other: _____ __%
11. Accreditations of facility: CARF ☐ JCAHO ☐ COA ☐ Other: ☐ _____
    If CARF accredited, is accreditation: Three-Year ☐ One-Year ☐ Provisional ☐
    Preliminary ☐
12. List association memberships or affiliations: _____
13. Do you have a current valid license? Yes☐ No☐ N/A☐
14. Has Applicant's license been suspended or revoked in the last five years?
    If Yes, please explain: _____
15. Do you have any other business operations? Yes☐No☐
    If Yes, please explain: _____
16. Do you do any consulting work for other businesses? Yes ☐No ☐
    If Yes, explain: _____

II. Management Practices

1. Do you have sign in/sign out procedures for: Staff ☐ Clients ☐ Visitors/Public ☐
2. Type of security provided for the protection of the clients: Guards ☐ Video Cameras ☐
   Other ☐ _____
3. Do you have written elopement procedures? Yes ☐ No ☐
4. Do you have written incident reporting procedures? Yes ☐ No ☐
   If Yes, is written record kept? Yes ☐ No ☐
5. Do you have a written plan for medical emergencies? Yes ☐ No ☐
6. Do you have written job descriptions? Yes ☐ No ☐
7. Do you require ongoing staff training? Yes ☐ No ☐
8. Are any staff members under 21 years of age? Yes ☐ No ☐
9. Are any staff members or volunteers under 18 years of age? Yes ☐ No ☐
   If Yes, list their position(s) and how are they supervised? _____
   _____
10. What is the staff turnover rate for the last 12 months? _____%
11. Hiring Practices (employees and volunteers, before an offer is extended):
    a. Do you require staff to complete an employment application? Yes ☐ No ☐
    b. Do you verify employment-related references? Yes ☐ No ☐
    c. Do you verify licenses and other credentials of professional staff? Yes ☐ No ☐
    d. Do you obtain criminal background checks? Yes ☐ No ☐
    e. Do you perform drug testing? Yes ☐ No ☐
    f. Do you obtain Sexual Abuse Registry checks? Yes ☐ No ☐

III. Applicant Services and Programs

ASAM Criteria Levels of Care					
Level	**Service Provided**	**Yes or No**	**Level**	**Service Provided**	**Yes or No**
0.50	Early Intervention		III.3	Clinically managed Medium Intensity Residential	
I	Outpatient Services		III.5	Clinically managed High Intensity Residential	
II	Intensive Outpatient		III.7	Medically Monitored Intensive inpatient	
II.5	Partial Hospitalization		IV	Medically managed intensive inpatient	
III.1	Clinically managed Low Intensity Residential		OMP	Opioid Maintenance Therapy	

IV. Premises Exposures

1. Is there always someone trained in CPR and first aid on the premises? Yes ☐No ☐
2. Are there fire extinguishers on the premises? Yes ☐No ☐
3. Are there smoke alarms on the premises? Yes ☐No ☐
   If Yes, are they hard-wired? Yes ☐No ☐
4. Do you have central station alarm monitoring? Yes ☐No ☐
5. Do you have a written emergency evacuation plan? Yes ☐No ☐
   If Yes, are the emergency evacuation procedures and floor plan posted? Yes ☐No ☐
   If Yes, is it tested annually by an external compliance/safety officer? Yes ☐ No ☐
6. Have you established a central meeting point outside the building? Yes ☐No ☐
7. Does the emergency plan include notification to the fire department? Yes ☐No ☐
8. Are all exits clearly marked? Yes ☐No ☐
9. Are there fire escapes? Yes ☐No ☐
10. Do you have a written and enforced No smoking policy? Yes ☐No ☐
    If No, do you have Designated Smoking Areas? Yes ☐No ☐
11. Do you have emergency lighting or backup generators? Yes ☐No ☐
12. Do you have a formal maintenance housekeeping program? Yes ☐No ☐
13. Do you require independent contractors to provide evidence of general liability and workers compensation insurance ? Yes ☐No ☐
14. If the building you occupy was built prior to 1971, has it been inspected for lead paint? Yes ☐No ☐
    If No, what is the plan for abatement? _____
15. Is cooking conducted on premises? Yes ☐No ☐
    If Yes, is equipment ☐Residential ☐Commercial
    If commercial, do installation, inspection & maintenance comply with NFPA 96? Yes ☐No ☐
    If commercial, are grease filters cleaned at least weekly? Yes ☐No ☐
16. Do you have a snow/ice removal plan? Yes ☐No ☐N/A ☐
17. Do you permit pets on premises? Yes ☐No ☐
    If Yes, do you restrict vicious breeds of dogs? Yes ☐No ☐
18. Do you have any of the following: Rope Course ☐ Gym ☐ Exercise Equipment ☐ Lakes/Ponds ☐Unfenced Swimming Pool ☐
    Do the above meet all state and local requirements? Yes ☐No ☐
19. Do you conduct organized sports activities or programs for your clients? Yes ☐No ☐
    If Yes, do you require clients to sign release forms prior to participating? Yes ☐No ☐
20. Do you have field trips or other off premises activities? Yes ☐No ☐
    If Yes, please answer the following:
    a. Number per year _____
    b. Are any overnight? Yes ☐No ☐
    c. What is the maximum distance traveled?_____
    d. Are signed release forms obtained? Yes ☐No ☐
    e. Explain the level of supervision. _____
21. Do you have experiential programs? Yes ☐No ☐
    If Yes, describe: _____

V. Abuse and Molestation

1. Does your current insurance program include Abuse and Molestation coverage? Yes ☐No ☐
   If Yes: Occurrence ☐Claims Made ☐Limits: _____ Retro Date: _____
   Carrier: _____
2. Are there written abuse and molestation procedures and are they clearly communicated to all employees? Yes ☐No ☐
3. Does your employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses? Yes ☐No ☐
4. Do you have a written crisis plan in place for dealing with employees, victims, parents, and the media if you have an incident of abuse? Yes ☐No ☐
5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off the premises? Yes ☐No ☐
6. Is there more than one person responsible for the welfare of any single patient? Yes ☐No ☐
7. Have any incidents resulted in an allegation of sexual or physical abuse? Yes ☐No ☐
   If Yes, explain: _____
8. Do you have a written de-escalation policy? Yes ☐No ☐
9. Do you use physical restraints or Isolation? Yes ☐No ☐
   If Yes, explain: _____
10. Are men and women housed in the same building? Yes ☐No ☐
    If Yes, are sleeping quarters separated? Yes ☐No ☐
11. Resident Age Groups: Under 18: __% 18-65: __% Over 65: __%
    Male: __% Female: __%
12. Do you offer residential programs for sex offenders (Greater than Level 1)? Yes ☐No ☐

VI. Automobile

1. Do you transport clients in company vehicles? Yes ☐No ☐
2. Do you rent 15-passenger or larger vehicles to transport clients? Yes ☐No ☐
3. Do you have vehicles equipped with a wheelchair lift? Yes ☐No ☐
4. Do you require all passengers to wear seat belts? Yes ☐No ☐
5. Do you have a vehicle maintenance program? Yes ☐No ☐
6. Do you obtain written authorization to release driver information from primary driving staff upon hiring? Yes ☐No ☐
7. Do you obtain and review MVR's on primary driving staff? Yes ☐No ☐
   Upon hire? Yes ☐No ☐ Annually? Yes ☐No ☐
8. Do you suspend driving duties due to at-fault accidents or moving violations? Yes ☐No ☐
9. Do you have a written driver safety program? Yes ☐No ☐
10. Are all drivers over 21 and under 70 years of age? Yes ☐No ☐
11. Is driver training provided for new employees prior to their transporting clients? Yes ☐No ☐
12. Do you allow personal use of your agency vehicles? Yes ☐No ☐
    If Yes, by whom and for what reason? _____
13. Do you allow clients to drive company vehicles? Yes ☐No ☐
14. How many employees drive personal vehicles for business use regularly?
    a. F/T: __ P/T: __ Volunteers: __
    b. Do you obtain proof of insurance for employees/volunteers who use their own vehicles? Yes ☐No ☐
    c. Do you update these records at least yearly? Yes ☐No ☐
    d. What minimum liability limits do you require for personal vehicles? _____
15. Do you provide paratransit services for non-resident clients? Yes ☐No ☐

VII. Professional Liability

1. Does your current insurance program provide professional liability coverage? Yes ☐No ☐
   If Yes: Occurrence ☐Claims Made ☐Limits: _____ Retro Date: _____
   Carrier: _____
2. Name of Executive Director/Medical Director: _____
   Number of years' experience in this field: _____
   Number of years at this facility: _____
3. ASAM Certification Yes ☐No ☐
4. Do you have written continuous suicide risk assessment procedures? Yes ☐No ☐
5. Do you provide suicide assessment training for applicable staff? Yes ☐No ☐
6. Other specialized training or education: _____
7. Do you have written intake screening procedures? Yes ☐No ☐
8. Do you ever deny any client? Yes ☐No ☐
   If Yes, what percentage of intake candidates are denied? ___%
9. Client Intake Procedures:
   a. Do you require a nurse/physician to conduct or approve new clients? Yes ☐ No ☐
   b. Do you require blood tests? Yes ☐ No ☐
   c. Do you require a physical examination? Yes ☐ No ☐
   d. Do you obtain and document a list of medications? Yes ☐ No ☐
   e. Do you complete a bio-psycho-social assessment? Yes ☐ No ☐
   f. Do you conduct an assessment for suicide and danger to others? Yes ☐ No ☐
      If risk is identified, explain protocol: _____
10. Do you have formal medical discharge procedures that require signature of patient, family or primary care physician? Yes ☐ No ☐
11. Are clients referred to specialists when appropriate? Yes ☐No ☐
12. Do you provide professional services off premises in: Homes ☐ Schools ☐ Prisons ☐ Other: _____
13. Do you use electronic health records? Yes ☐No ☐
14. Are all files maintained to protect confidentiality of the clients? Yes ☐No ☐
15. Do you require a signed release form for the release of records to other individuals or institutions? Yes ☐No ☐
16. Have you experienced a sentinel event involving suicide or overdose? Yes ☐No ☐
    If Yes, explain: _____
17. Do you require annual certificates of insurance for physicians and psychiatrists not covered by the entity's professional liability policy? Yes ☐ No ☐
    What limits do you require? _____
18. Have any physicians/psychiatrists been subject to disciplinary proceeding, reprimand or convicted of crime or felony within last 12 months? Yes ☐ No ☐
19. Have any physicians/psychiatrists been treated for drug or alcoholism within last 12 months? Yes ☐ No ☐

Total Staff (Counts should include all administrative, executive and professional staff employed by Applicant at all locations):

Position	Employees F/T	Employees P/T	Volunteers F/T	Volunteers P/T	Contractors F/T	Contractors P/T
Administrators/Office/Management Staff						
Maintenance/Janitorial/Housekeeping						
Dentist/Dental Hygienist						
Nurse Assistant						
Nurse Practitioner						
Nurse – RN/LPN						
Nutritionist/Dietitian						
Optometrist						
Pharmacist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Resident Manager						
Counselor Social Worker – Licensed						
Counselor Social Worker – Unlicensed						
Therapist – Occupational						
Therapist – Physical						
Health Techs.						
Home Health Aid						
Medical Director						
Case Manager						
Teacher						
Acupuncturist						
Interventionist						
Sober Companion						
Sober Coach						
Other positions (Specify)						
Total						

Physicians and Psychiatrists (List all Full, Part Time, Volunteer and Contracted (attach a separate schedule if more than four):

Name of Doctor				
Specialty				
Board Certified (Y or N)				
Years in Practice				
Hours per Week for Insured				
Employed, Volunteer or Contracted?				
Individual carry own malpractice insurance?				
If yes, does policy include acts while working for the insured facility?				
Will the doctor be covered under this policy? If Yes, please attach a separate physician's application for each doctor.				

VIII. Substance Abuse, Mental Health or Foster Care Programs

1. Do you operate a detoxification unit? Yes ☐No ☐
   If Yes: Medically Supervised? ☐ Social? ☐ Outpatient ☐
2. Do you offer anesthesia-assisted detox? Yes ☐No ☐
3. Do you take Forced Placements? Yes ☐No ☐
   If Yes, what percentage of admissions? _____%
4. Do you operate a suicide hotline? Yes ☐No ☐
5. Do you offer eating disorder programs? Yes ☐ No ☐
6. Do you accept civil protective custody clients? Yes ☐ No ☐
7. Do you offer telemedicine? Yes ☐No ☐
8. Do you operate a needle-exchange program? Yes ☐No ☐
9. Do you provide crisis stabilization? Yes ☐No ☐
10. Do you use electro-convulsive therapy? Yes ☐No ☐
11. Do you provide services for Developmentally Disabled? Yes ☐No ☐
    If Yes, what percent of clients? _____ %
12. Do you provide a methadone maintenance program? Yes ☐No ☐
    If Yes, where is the methadone stored? _____
13. Number of methadone-only clients annually: _____
14. Number of clients with take home privileges: _____
15. Do you have procedures to deny methadone doses? Yes ☐No ☐
16. Do you provide take home Naloxone/Narcan kits? Yes ☐No ☐
17. Do you prescribe medications? Yes ☐No ☐
18. Do you dispense medications? Yes ☐No ☐
19. Do you prescribe off-label medicines? Yes ☐No ☐
20. Do you have policies and procedures in place for prescribing or administering medication? Yes ☐No ☐
21. Are all medications kept in a locked storage container? Yes ☐No ☐
22. Do you treat criminally insane clients? Yes ☐No ☐
23. Do you provide therapeutic foster care services? Yes ☐No ☐
    If Yes, what % of clients? _____%
    If Yes, what is the anticipated number of foster children over the next 12 months? _____
    If Yes, do you do placements? Yes ☐No ☐
    Do you conduct criminal and sexual abuse background checks of foster parents? Yes ☐No ☐
    If Yes, do you do parental training and certifications? Yes ☐No ☐

    If Yes, do you conduct evaluation visits to foster care homes Yes ☐No ☐
    Frequency of visits: ☐weekly ☐monthly ☐Other: _____
    If Yes, do you obtain evidence of foster care liability insurance? Yes ☐No ☐

IX. Health and Wellness Programs

1. Do you own or operate a medical clinic that provides primary care services? Yes ☐No ☐
   If Yes, are the facilities for: Clients ☐General Public ☐Staff ☐
2. Is the Medical Clinic open 24/**7**? Yes ☐No ☐
3. Select the following treatments that are offered at the Medical Clinic:
   Flu Shots ☐ Immunizations ☐ X-Rays ☐ Cough/Colds ☐
   Physical Exams ☐ Gynecology ☐ Sinus Infections ☐
   Minor Wound Care ☐ Other: _____
4. Do you operate a Pharmacy open to the public? Yes ☐No ☐
5. Are the medications and equipment kept in a locked facility? Yes ☐No ☐
   If No, where are they kept? _____
6. Do you maintain medical history and care records for each individual? Yes ☐No ☐

X. Residential Facilities

Residents	# Beds	Residents	# Beds	Residents	# Beds
Inpatient Addiction Treatment		Sober Living		Homeless Shelter	
Inpatient Mental Health Treatment		Supported Housing		Women & Children Programs	
Inpatient Crisis Stabilization		Group Care (MR/DD)		Other	
Inpatient Detox		Nursing Home & Assisted Living		Other	
Eating Disorder		Primary Care		Other	

1. Average length of stay? _____
2. What was the date of the last inspection by a licensing agency? _____
3. Were there any violations or deficiencies noted? Yes ☐No ☐
   If Yes, explain: _____
4. What is the ratio of residents to staff? _____
5. Are there any non-ambulatory clients? Yes ☐No ☐
6. For inpatient crisis stabilization or detox residents, do you provide nursing care 24 hours a day, 7 days per week? Yes ☐ No ☐
7. Do you allow clients to leave the premises without supervision? Yes ☐No ☐
8. Do you have bunk beds? Yes ☐No ☐
9. How often are bed checks done? Random ☐Scheduled ☐
   If Scheduled, explain frequency_____
10. Are residents' doors ever locked from the outside? Yes ☐No ☐

XI. Outpatient Facilities

Type of Service	# of Clients	Type of Service	# of Clients
Mental Health		MR/DD	
Addiction		Foster Care	
Primary Care		Eating Disorder	
Dual Diagnosis		Other	

1. What are your hours of operation? _____
2. Do you offer group therapy? Yes ☐ No ☐
3. Do you offer one-on-one/individual therapy? Yes ☐ No ☐
4. Do you operate a crisis hotline? Yes ☐ No ☐
   If Yes, what is the annual number of calls? _____
   If Yes, is training provided? Yes ☐ No ☐
5. Do you provide child care services for the children of your counseling patients? Yes ☐ No ☐

Fraud Notice Statements

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 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 THAT PERSON TO 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).
(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).

APPLICABLE IN AL, AR, AZ, DC, 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 OR CONFINEMENT IN 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 ORAWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECIEVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IF GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: 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, PERPORTED INSURER, BROKER OR ANY 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 OFMISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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 MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE, 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. PENBALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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 MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Applicant Representations

This Application must be signed by an authorized partner, officer or other principal of Applicant of this Application. By signing this Application, Applicant represents the following:

- The statements in the Application or Renewal Application furnished to the Company (and any attachments submitted with the application) are, to the best of Applicant's knowledge and belief and after reasonable inquiry, accurate and complete on behalf of all proposed Insured and may be relied upon by the Company in quoting and issuing the policy;
- Those representations are a material inducement to the Company to provide a premium proposal;
- The Applicant understands that the signing of the this Application does not bind the Company to offer a proposal or the Applicant to purchase the policy;
- If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report to the Company in writing; and
- The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.
- If a policy is issued, the Company will have issued this Policy in reliance upon those representations; and

_____	_____
NAME (PLEASE PRINT/TYPE)	TITLE
_____	_____
APPLICANT SIGNATURE	DATE