☐ **Deerfield Insurance Company**
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☐ **Essex Insurance Company**
☐ **Markel American Insurance Company**
☐ **Markel Insurance Company**
☐ **Associated International Insurance Company**

PLUS Professional Lines Underwriting Specialists, Inc.

APPLICATION FOR DENTISTS AND ORAL SURGEONS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: _____

(ii) Professional Degree: _____

(b) Principal practice address: _____
(Street) (County)

_____
(City) (State) (Zip)

(c) Additional practice locations: _____

_____

_____

(d) (i) Phone: _____ (ii) Fax: _____

(iii) E-Mail Address: _____ (iv) Website Address: _____

(e) (i) Date of Birth (MM/DD/YYYY): _____ (ii) Place of Birth: _____

2. Are you a U.S. citizen? ..... [ ] Yes [ ] No
If No, what is your status in the U.S. and current citizenship? _____

3. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)*
[ ] professional corporation* [ ] professional association*
[ ] limited liability company* [ ] partnership*
[ ] employee of _____ [ ] independent contractor of _____
[ ] other _____
* Specify full name of entity: _____

(b) Do you want coverage for the entity named Item 3(a) above? ..... [ ] Yes [ ] No

(c) Attach a copy of your letterhead.

(d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all others practicing under the entity name in Item 3(a)above.

_____

_____

4. Do you practice with any dentist not named in Item 3.(d) above? ..... [ ] Yes [ ] No
If Yes, provide the name of each dentist and the practice relationship. _____

_____

5. Are you currently in active military service? ..... [ ] Yes [ ] No

6. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

7. Federal DEA License No. and status: _____

8. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

Name	City	State	Percentage of Work	Type of Privileges

9. Are you currently a hospital chief of staff or head of any hospital department? ..... [ ] Yes [ ] No
If Yes, describe. _____

10. Do you or the entity firm named in Item 3(a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgicenter, urgent care center other facility where medical services are customarily provided? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation specifically including the name, location, size, and number of beds. _____

11. Does your practice utilize an Electronic Health Records (EHR) or Electronic Dental Records (EDR) system? ..... [ ] Yes [ ] No

12. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No
If Yes,
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No
(ii) Provide the name and title of the Applicant's Privacy Officer. _____
Our Business Associate Agreement is available at https://www.markelcorp.com/en/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

II. EDUCATION AND TRAINING

1. (a) Provide your dental specialty: _____
(b) Do you limit your practice to the specialty stated in item (a) above? ..... [ ] Yes [ ] No
If No, provide details. _____

2. Are you American dental board certified in any specialty? ..... [ ] Yes [ ] No
If Yes, provide the following: Board(s) in which you are certified: _____
Date of certification: _____ Any recertification date(s): _____
If No, do you plan on taking a Board examination? ..... [ ] Yes [ ] No

3. Provide the following information:

	Name of Institution	City	State	Date Completed
Dental School				
Internship – Specialty: _____				
Residency – Specialty: _____				
Fellowship – Specialty: _____				
Other: _____				

4. If you graduated from a foreign dental school, provide the date began your practice in the United States: _____

5. Attach a C.V. or provide a detailed summary of where you have practiced your profession since completing your training:

Street Address	City, State	Country	From (MM/YY)	To (MM/YY)

6. Indicate the professional organizations which you are a member of:

[ ] American Association of OMS (AAOMS)
[ ] American College of OMS ((ACOMS)
[ ] American Dental Association
[ ] Other (describe) _____
[ ] American Society of Dentist Anesthesiologists (ASDA)
[ ] State Society of OMS
[ ] OMS Society – Other _____

7. How many hours of continuing dental or medical education have you taken within each of the last two (2) years? ____

III. SCOPE OF PRACTICE

1. Provide the approximate percentage of your practice in the following:

Simple Extractions Only	____%	Periodontics	___%
Implant Restoration	____%		
Bonding	____%	Orthodontics	___%
Enamel Shaping	____%		
Full Month Restoration – Cosmetic Only	____%	Oral Surgery/Maxillofacial	___%
Veneers	____%	Extractions of Impacted Teeth	___%
Whitening (Laser or other)	____%	Microneurosurgical Procedures	___%
Removable Dental Devises		Bone Grafting	___%
(Dentures, Invisalign)	____%	TMJ Surgery	___%
Other Cosmetic Procedures (describe)		Sleep Apnea Surgery	___%
_____	____%	Orthognathic Procedures	___%
Pediatric Dentistry (No sedation)	____%	Facial – Elective Cosmetic	___%
TMJ (Non Surgical)	____%	Head and Neck Surgery	___%
Sleep Apnea (Non Surgical Therapy)	____%	Surgery Outside oral/maxillofacial region	
Non-Dental Cosmetic Procedures (including		(describe)_____	___%
injecting Botox, collagen and fillers)(describe)		Pediatric Procedures with anesthesia	___%
_____	____%		
		Osseointegration Implants	___%
Single Rooted Endodontics	____%	Mandibular Multi Quadrant/Ramus Frame	
Multi Rooted Endodontics	____%	Implants	___%
Sargenti Root Canal Method	____%	Endosteal Implants	___%
		Transosseous Implants	___%
Oral Pathology	____%	Other (describe)_____	___%
Oral Radiology	____%		

2. Have you performed any implant procedures during the last 12 months? ..... [ ] Yes [ ] No
If Yes, answer the following:
   (a) Provide the number of procedures performed. _____
   (b) Do your dental records include written notes that a process of patient evaluation occurred prior to treatment? ..... [ ] Yes [ ] No
   (c) Do you perform any surgical procedures, such as sinus lifts, in conjunction with the placement of implants? ..... [ ] Yes [ ] No
   (d) Attach a copy of the informed consent forms and patient education materials that are given to patients prior to treatment.
3. Do you render any services outside the scope of your state's Dental Practice Act? ..... [ ] Yes [ ] No
If Yes, describe._____
4. Do you use written informed consent documents for all procedures? ..... [ ] Yes [ ] No
If Yes, attached a copy of all form that are used. If No, attach an explanation.
5. Do you wire jaws closed for the purpose of weight loss? ..... [ ] Yes [ ] No
If Yes,

(a) Number performed in the last 12 months: _____
(b) Estimated number that will be performed in the coming year: _____

6. Has the nature of your practice, the type of procedures you perform or your use of anesthesia changed in the last 5 years? ..... [ ] Yes [ ] No
If Yes, provide details. _____

7. Do you have a surgical suite? ..... [ ] Yes [ ] No
If Yes, is your surgical suite certified? ..... [ ] Yes [ ] No
If Yes, provide the name of the certification body. _____

8. What percentage of your patients are under age 18? _____%

9. Do you perform any hospital emergency room care? ..... [ ] Yes [ ] No
If Yes, is this solely a requirement for active admitting privileges? ..... [ ] Yes [ ] No
If No, provide a detailed description including the approximate number of hours per month spent in emergency room care. _____

_____

10. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering dental/medical services, dental/medical opinions or dental/medical advice? ..... [ ] Yes [ ] No
If Yes, provide the following:
(a) Identify all states in which such patients reside: _____
(b) What percentage of your total practice is involved in such activities? _____

11. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? ..... [ ] Yes [ ] No
If Yes, identify all states in which such patients reside. _____

12. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? ..... [ ] Yes [ ] No
If Yes, do you follow FDA-approved protocols? ..... [ ] Yes [ ] No
If Yes, describe. _____

_____

(b) Are you a Principal Investigator for any clinical trial? ..... [ ] Yes [ ] No

13. (a) Indicate the number of professional employees in your practice for each of the following:
(If none, check here [ ])

___ Dentists other than yourself	___ Hygienists	___ Nurses
___ Dental Assistants	___ Physicians	___ Nurse Anesthetists*
___ Dental Technicians	___ Physicians Assistants*	___ Laboratory/Radiology Technicians
___ Estheticians	___ Surgeon's Assistants*	___ Other (describe) _____

*Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ..... [ ] Yes [ ] No
If No, provide a detailed explanation on a separate page.

14. (a) Average weekly patient load: _____ (b) Number of patients annually: _____

15. Average number of hours you practice each week: _____

16. What is your approximate gross annual income from your practice? (Check one.)

_____ Less than $50,000	___ $50,000 to $99,999
_____ $100,000 to $149,999	___ $150,000 to $199,999
_____ $200,000 to $499,999	___ $500,000 or more (estimate) $_____

17. (a) Do you supervise anyone other than your own employees? ..... [ ] Yes [ ] No
If Yes, indicate by profession the number of individuals you supervise:

___ Dentists other than yourself	___ Hygienists	___ Nurses
___ Dental Assistants	___ Physicians	___ Nurse Anesthetists*
___ Dental Technicians	___ Physicians Assistants*	___ Laboratory/Radiology Technicians
___ Estheticians	___ Surgeon's Assistants*	___ Other (describe) _____

* Attach protocols and description of the extent in which you supervise such persons.

Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. _____

_____

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ..... [ ] Yes [ ] No
If No, provide a detailed explanation on a separate page.

18. If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: **H** = Hospital **O** = Office **S** = Surgi-center or Certified Surgical Suite

	Location		Location
___ Acupuncture	_____	___ Laser Surgery (describe)_____	_____
___ Adenoidectomy/Tonsillectomy	_____	Liposuction – above the neck	
Anesthesia:		(specify volume) _____	_____
___ General	_____	Liposuction – below the neck:	
___ Twilight	_____	___ under 3500 cc's volume	_____
___ Other – (describe) _____	_____	___ 3500 cc's or more volume	_____
Assisting in Surgery:		___ Nerve Grafts	_____
___ Oral Surgery	_____	___ Oral/Maxillofacial Surgery	_____
___ Other Surgery (describe)		___ Open Reduction of Fractures	_____
_____	_____	___ Pain Management (describe)	
___ Biopsies (describe)_____	_____	_____	_____
___ Blepharoplasty	_____	Plastic Surgery:	
___ Cheek Implant	_____	___ Reconstructive Facial	_____
___ Chin Surgery	_____	___ Reconstructive - Other (describe)	
___ Cleft Lip and Palate Surgery	_____	_____	_____
___ Cosmetic Surgery	_____	___ Rhinoplasty	_____
___ Cryosurgery	_____	___ Radiation Therapy	_____
___ Dental Alveolar Surgery	_____	___ Radiopaque dye injections into blood	
Extractions:		vessels, lymphatics, sinus tracts or	
___ Non-Impacted Teeth	_____	fistulae	_____
___ Impacted Teeth	_____	___ Sargenti Root Canal Method	_____
___ Face Lift	_____	___ Sinus Lift	_____
___ Hair Transplants or Suturing of		___ TMJ Surgery	_____
Hairpieces	_____	___ Uvulopalatoplasty	_____
___ Laser Skin Resurfacing	_____		

19. If you perform any of the following procedures, check all that apply. For each procedure performed indicate the qualifications of the individual performing the procedure: **D** = Dentist **H** = Hygienist/Dental Assistant **N** = Nurse **E** = Esthetician **T** = Technician

	Qualification		Qualification
___ Chemical Peel:		___ Botox Injections	_____
Solution Strength(specify) _____	_____	___Dermabrasion/Microdermabrasion	_____
___ Cosmetic implantation of		___ Dermal Fillers (juvederm, restylane, etc.)	_____
silicone or other material	_____	___ Laser Skin Treatment	_____

20. List your prior Professional Liability Insurance for each of the last (5) years, including the current year:

(a)

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date
(1)					
(2)					
(3)					
(4)					
(5)					

(b) Does the policy for the current year allow the reporting of any incidents or circumstances that are likely to result in a claim? ..... [ ] Yes [ ] No

(c) Do any of the above policies provide coverage for any:
(i) procedures not describes in this application and in which you no longer perform? ..... [ ] Yes [ ] No
(ii) practice(s) not described in this application? ..... [ ] Yes [ ] No

IV. ANESTHESIA INFORMATION

1. Is analgesia, sedation or anesthesia used on patients? [ ] Yes [ ] No
   If Yes, answer the following:
   (a) Local only [ ] Yes [ ] No
   (b) Inhalation conscious sedation [ ] Yes [ ] No
      If Yes, answer the following:
      (i) Percentage of patients under age 18: _____%
      (ii) Drugs used: [ ] Nitrous Oxide [ ] Other _____
      (iii) Is sedation done in an office, surgi-center or hospital? _____
      (iv) Administered by: [ ] You [ ] Oral Surgeon [ ] Physician Anesthesiologist
      [ ] Dentist Anesthesiologist [ ] CRNA [ ] RN/LPN [ ] Other: _____
   (c) Oral conscious sedation using drugs that are swallowed [ ] Yes [ ] No
      If Yes, answer the following:
      (i) Percentage of patients under age 18: _____%
      (ii) List all drugs used: _____
      (iii) Is sedation done in an office, surgi-center or hospital? _____
      (iv) How long have you used conscious sedation in your office or surgical suite? _____
      (v) Administered by: [ ] You [ ] Oral Surgeon [ ] Physician Anesthesiologist
      [ ] Dentist Anesthesiologist [ ] CRNA [ ] RN/LPN [ ] Other: _____
   (d) Parenteral conscious sedation (minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof) [ ] Yes [ ] No
      If Yes, answer the following:
      (i) Percentage of patients under age 18: _____%
      (ii) List all drugs used: _____
      (iii) Is sedation done in an office, surgi-center or hospital? _____
      (iv) How long have you used conscious sedation in your office or surgical suite? _____
      (v) Administered by: [ ] You [ ] Oral Surgeon [ ] Physician Anesthesiologist
      [ ] Dentist Anesthesiologist [ ] CRNA [ ] Other: _____
   (e) Parenteral deep sedation (a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including inability to respond purposely to verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof) [ ] Yes [ ] No
      If Yes, answer the following:
      (i) Percentage of patients under age 18: _____%
      (ii) List all drugs used: _____
      (iii) Is sedation done in an office, surgi-center or hospital? _____
      (iv) Administered by: [ ] You [ ] Oral Surgeon [ ] Physician Anesthesiologists
      [ ] Dentist Anesthesiologist [ ] CRNA [ ] Other: _____
   (f) General anesthesia (a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof) [ ] Yes [ ] No
      If Yes, answer the following:
      (i) Percentage of patients under age 18: _____%
      (ii) List all drugs used: _____
      (iii) Is sedation done in an office, surgi-center or hospital? _____
      (iv) How long have you used general anesthesia in your office or surgical suite? _____
      (v) Administered by: [ ] You [ ] Oral Surgeon [ ] Physician Anesthesiologist
      [ ] Dentist Anesthesiologist [ ] CRNA [ ] Other: _____
   (g) Are Harvard Standards for the administration of all anesthesia adhered to? [ ] Yes [ ] No
      If No, explain. _____

2. (a) Have you completed an ACLS course? [ ] Yes [ ] No
   (b) Do you hold an ACLS certificate? [ ] Yes [ ] No
      If Yes, what it's the expiration date? _____
      If No, are you currently CPR Certified? [ ] Yes [ ] No
   (c) Is any member of your operating staff currently CPR certified? [ ] Yes [ ] No

3. Check all that apply:
   (a) Have you completed an ADA-accredited general anesthesia program of one year or longer? [ ] Yes [ ] No
   (b) Did your oral surgery training include 6 or more months of training in general anesthesia? [ ] Yes [ ] No

(c) Have you taken at least two years of anesthesia training following dental school for certification as an anesthesiologists? ..... [ ] Yes [ ] No

4. Are vital signs of your patients under sedation or general anesthesia continuously monitored? ..... [ ] Yes [ ] No
If Yes, by whom? [ ] You [ ] CRNA [ ] Dentist Anesthesiologist [ ] Other: _____

5. If you use any of the following methods to monitor patients, indicate by using **S** for sedation, G for general anesthesia or B for both.

___ Manual monitoring of blood pressure and heart rate
___ Precordial stethoscope
___ Electronic/automatic monitoring of blood pressure and heart rate
___ EKG monitor
___ Pulse oximeter
___ Other (describe) _____

6. Which of the following items do you have available for emergency treatment? Check all that apply.

___ Oral airway ___ Ambu bag ___ Endotracheal tubes/scopes
___ Oxygen ___ Emergency drugs

7. Does the state you practice in require you to hold a current certificate/permit to administer general anesthesia or intravenous sedation? ..... [ ] Yes [ ] No
If Yes, provide the following:
Certificate number: _____ Date of renewal: _____

V. AFFILIATIONS

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section I. 3(a) above? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section I. 3(a) above? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

If Yes, does any contract contain a hold harmless agreement? ..... [ ] Yes [ ] No
If Yes, attach a copy of the contract.

3. Are you in the employ of or under contract to any governmental entity? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

4. Do you advertise your professional services in any manner other than a simple listing in a telephone directory or web based banner advertisements? ..... [ ] Yes [ ] No
If Yes, attach a copy of all advertisements.

5. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? ..... [ ] Yes [ ] No
If Yes, attach a copy of the advertisement or applicable website address.

6. Are you the Dental/Medical Director of a nursing home, clinic, commercial enterprise or any other organization? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position. _____

7. Do you have any administrative or teaching responsibilities? ..... [ ] Yes [ ] No
If Yes, provide the following and attach a copy of any contract or agreement:
(a) Name of entity and location: _____
Your title _____
(b) Does the entity provide you coverage for:
(i) Your administrative responsibilities? ..... [ ] Yes [ ] No
(ii) Your direct patient care? ..... [ ] Yes [ ] No

8. Do you work for any locum tenens companies? ..... [ ] Yes [ ] No
   If Yes, attach a copy of your Certificates of Insurance.

9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location? ..... [ ] Yes [ ] No
   If Yes, provide details. _____

10. Are you engaged in or planning to engage in any "moonlighting" activities? ..... [ ] Yes [ ] No
    If Yes, do you want coverage for your "moonlighting" activities? ..... [ ] Yes [ ] No
    If Yes, describe the activities. _____

VI. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? ..... [ ] Yes [ ] No
   If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? ..... [ ] Yes [ ] No
   If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.

3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? ... [ ] Yes [ ] No
   If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.

4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? ..... [ ] Yes [ ] No

5. Has your license to practice dentistry or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ..... [ ] Yes [ ] No

6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? ..... [ ] Yes [ ] No

7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? ..... [ ] Yes [ ] No

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? ..... [ ] Yes [ ] No

9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? ..... [ ] Yes [ ] No

10. Has any insurance company, risk retention group or Lloyd's canceled, declined, or refused to renew or accepted only on special terms malpractice insurance? ..... [ ] Yes [ ] No

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant	Title
Signature of Applicant	Date

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS