REPRESENTATION STATEMENT

ASPEN AMERICAN INSURANCE COMPANY
(A stock insurance company)
Administrative Offices: 590 Madison Avenue, 7th Floor, New York, NY 10022

- **Please answer each question completely.**
- **Please type or print clearly in ink.**
- **This Representation Statement must be signed by a partner, principal, owner, director, or officer of the firm.**

A. GENERAL INFORMATION

Proposed Effective Date __/__/____ Quote Number: _____

Name of Applicant: _____

Form of Business: ☐ Individual ☐ LLC/LLP
☐ Partnership ☐ Other: _____
☐ Corporation

Principal Business Address – **Street Addresses Only** – **No P.O. Boxes**:

_____

Mailing Address:

_____

Telephone # (____) _____ Fax # (____) _____

Primary Contact and Title: Mr. / Ms. _____

E-mail address: _____

Please review the above information for accuracy and note any changes or corrections

The quote offer was provided on information from applications and other documents provided in lieu of the Aspen Application. The Applicant represents to the Company that the answers to the following questions are true and accurate.

B. Claims, Regulatory Inquires and Criminal Charges

1. The applicant has provided information on all claims, incidents or other circumstances which might be expected to be the basis of a claim or suit against the firm in the last five years. ☐ Yes ☐ No ☐ No claims

   If no – please provide a loss run and claims supplement

2. The applicant has disclosed all inquires by a governmental agency including state licensing board or regulatory agency. ☐ Yes ☐ No ☐ N/A

   If no – please provide copy of the Board Inquiry and resolution

3. The applicant has disclosed all criminal charges or convictions of firm members. ☐ Yes ☐ No ☐ N/A

   If No – please provide information on the charges and resolution

If No to any of the above, a review of the coverage offer will be required

C. Other Licenses

4. The applicant has provided a list of all personnel of the firm who have licenses other than Certified Public Accountant or enrolled Agent. ☐ Yes ☐ No ☐ N/A

   If no, please provide person's name, type of license and if professional liability is in place.

D. Professional Memberships and Risk Management

5. Please indicate firm membership in any of the following:
   ☐ AICPA
   ☐ AICPA Employee Benefit Plan Audit Quality Center
   ☐ AICPA Government Audit Quality Center
   ☐ AICPA Private Companies Practice Section
   ☐ AICPA Center for Public Company Audit Firms
   ☐ State CPA Society
   ☐ Other Professional Group or Associations *(please specify):*
   _____

6. Has any member of the firm attended a Loss Control Seminar or CLE in the last 3 years? ☐ Yes ☐ No

   If yes, please provide a copy of the completion certificate(s) for review for additional credit.

+Notice to Applicant – Please Read Carefully

THE APPLICANT REPRESENTS THAT THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED.

Applicant acknowledges a continuing obligation to report to the Insurer as soon as practicable any material changes in the facts and statements above, and in each supplemental application, of which applicant becomes aware after signing the application.

NOTE: In applying for coverage, applicant agrees that covered losses must be defended by an Insurer lawyer and that the deductible applies to damages and claims expenses, investigation costs and legal fees. If applicant elects to handle a claim without involving the Insurer, then the policy may not afford coverage for such claim.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF INSURER'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT IT WILL BE ATTACHED TO THE POLICY.

Applicant hereby authorizes the release of claim information from any prior issuer to the Insurer .

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Notice:

Failure to report:

1. Any claim made against you during your current policy term; or

2. Any facts, circumstances, or events that may give rise to a claim to your current insurance company BEFORE policy expiration may create a lack of coverage.

NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, FLORIDA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes 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 and denial of insurance benefits.

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: 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.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA 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 MAINE 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 who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK 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 is subject to a civil penalty not to exceed $5,000.00 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

NOTICE TO 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 claim containing any material false information or conceals for the purposes 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.

NOTICE TO PUERTO RICO APPLICANTS: The Entity understands that according to the Insurance Code of Puerto Rico (Article 27.320): “Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, it will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with a pain of no smaller fine of five thousand ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or, both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2).

NOTICE TO TENNESSEE AND VIRGINIA 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 include imprisonment, fines and denial of insurance benefits.

NOTICE TO VERMONT APPLICANTS: 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.

I UNDERSTAND THAT THE SIGNING AND DELIVERY OF THIS APPLICATION DOES NOT BIND ME TO COMPLETE THE INSURANCE, NOR THE INSURER TO ISSUE A POLICY: BUT EACH ANSWER GIVEN IN THIS APPLICATION IS A STATEMENT OF FACT THAT BECOMES A PART OF THE POLICY SHOULD A POLICY BE ISSUED. BY SIGNING THIS APPLICATION I ACKNOWLEDGE THAT I AM AWARE THAT IF AT ANY TIME IT IS DISCOVERED ANY OF THE STATEMENTS OF FACT CONTAINED IN THIS APPLICATION ARE CONCEALED OR FALSELY STATED, THE POLICY MAY BE MODIFIED, RESCINDED, OR DECLARED VOID FROM ITS INCEPTION AND IN ACCORDANCE WITH ANY APPLICABLE STATE LAWS.

_____

Applicant Signature (**Must be signed and dated in ink by a Partner, Principal, Owner, Director, or Officer of the Firm**).

_____ _____
Signature of Applicant Date (Month-Day-Year)

_____ _____
Print Name Title

_____
Firm

NOTICE TO MARYLAND APPLICANTS: IN THE EVENT OF ANY MATERIAL CHANGE, THE INSURER HAS THE ABILITY TO CANCEL A BINDER OR POLICY, OR RECALCULATE THE PREMIUM FROM THE EFFECTIVE DATE OF THE POLICY, DURING THE FOURTY-FIVE (45) DAY UNDERWRITING PERIOD, IN ACCORDANCE WITH MARYLAND INSURANCE ARTICLE §12-106.

This application is in compliance with Section 626.752, Florida Statutes. A copy has been furnished to the applicant or insured and coverage is: [ ] Bound Effective (time) (date); [ ] Not Bound.

BROKER'S SIGNATURE:
Florida requires that we have the Name and Address of your (Applicant's) Authorized Agent or Broker.

Signature of Authorized Agent or Broker: _____

Name of Authorized Agent Broker: _____

Address:_____

License Identification Number: _____

