

HM LIFE INSURANCE COMPANY OF NEW YORK
420 Fifth Avenue, 3rd Floor, New York, NY 10018
1-800-235-6753

APPLICATION FOR PROVIDER EXCESS LOSS INSURANCE

Policyholder:

Principal Office Address:

Policy No.

Effective Dates: _____ **to** _____

This Policy is approved, and the terms contained within it is accepted by You and Us as issued.

This Application must be executed in duplicate. One copy will be attached to the Policy, and the other must be returned to HM Life Insurance Company of New York.

You acknowledge that:

- (a) a true and accurate copy of the Capitation Agreement(s) in force on the effective date of this Policy, and all other applicable information must be provided to Us for the Policy to be fully executed and losses reimbursable; and
- (b) changes to those documents must be reported as required by the Policy. Changes to the Capitation Agreement(s) may require changes to the rating basis indicated in the Schedule of Insurance.
- (c) **Arbitration of Disputes:** Do You agree to submit any disputes that arise to arbitration?
___ Yes ___ No

You and We agree that this Application replaces any prior application made for the same Policy.

FRAUD NOTICE: 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.

Executed By: _____ Witness: _____
(Signature)

(Title)

At: _____ On _____, 20____
(City, State)

HM Life Insurance Company of New York Signature _____