

PLEASE READ THIS INFORMATION CAREFULLY. It is important.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis and benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. The maximum benefit for physician's outpatient treatment in connection with physical therapy and/or spinal manipulation is \$1,250 per non-surgical injury for coverage purchased by the school. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following claim guidelines must be followed.

♦Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

♦If you have other insurance, submit your claim to your other insurer. Non-compliance with your primary health HMO/PPO plan will reduce this plans benefits by 50%. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

- 1) HCFA-1500 (standard form used by Providers; sample attached)
- 2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
- 3) ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

♦If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

♦Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident. File claim electronically by clicking [here](#).

♦If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

♦Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

[illegible]

										UNIT UNIT NO. UNIT NAME UNIT UNIT NO. UNIT NAME									
CURRENT NAME										CURRENT ADDRESS									
10 BIRTHDAY 11 SEX 12 AGE 13 MARITAL STATUS 14 RACE 15 RELIGION 16 OCCUPATION 17 EDUCATION 18 INCOME 19 SOCIAL SECURITY NO. 20 STATE										21 MARITAL STATUS 22 RACE 23 RELIGION 24 OCCUPATION 25 INCOME 26 SOCIAL SECURITY NO. 27 STATE									
28 DEPARTMENT 29 DIVISION 30 POSITION 31 GRADE 32 PAY RATE 33 PAY PERIOD 34 PAY DATE 35 PAY METHOD 36 PAY STATUS 37 PAY TYPE										38 DEPARTMENT 39 DIVISION 40 POSITION 41 GRADE 42 PAY RATE 43 PAY PERIOD 44 PAY DATE 45 PAY METHOD 46 PAY STATUS 47 PAY TYPE									
										48 PAYROLL STATUS 49 PAYROLL TYPE 50 PAYROLL DATE 51 PAYROLL METHOD 52 PAYROLL STATUS 53 PAYROLL TYPE 54 PAYROLL DATE 55 PAYROLL METHOD									
56 PAYROLL STATUS 57 PAYROLL TYPE 58 PAYROLL DATE 59 PAYROLL METHOD 60 PAYROLL STATUS 61 PAYROLL TYPE 62 PAYROLL DATE 63 PAYROLL METHOD										64 PAYROLL STATUS 65 PAYROLL TYPE 66 PAYROLL DATE 67 PAYROLL METHOD 68 PAYROLL STATUS 69 PAYROLL TYPE 70 PAYROLL DATE 71 PAYROLL METHOD									
72 PAYROLL STATUS 73 PAYROLL TYPE 74 PAYROLL DATE 75 PAYROLL METHOD 76 PAYROLL STATUS 77 PAYROLL TYPE 78 PAYROLL DATE 79 PAYROLL METHOD										80 PAYROLL STATUS 81 PAYROLL TYPE 82 PAYROLL DATE 83 PAYROLL METHOD 84 PAYROLL STATUS 85 PAYROLL TYPE 86 PAYROLL DATE 87 PAYROLL METHOD									
88 PAYROLL STATUS 89 PAYROLL TYPE 90 PAYROLL DATE 91 PAYROLL METHOD 92 PAYROLL STATUS 93 PAYROLL TYPE 94 PAYROLL DATE 95 PAYROLL METHOD										96 PAYROLL STATUS 97 PAYROLL TYPE 98 PAYROLL DATE 99 PAYROLL METHOD 100 PAYROLL STATUS 101 PAYROLL TYPE 102 PAYROLL DATE 103 PAYROLL METHOD									
104 PAYROLL STATUS 105 PAYROLL TYPE 106 PAYROLL DATE 107 PAYROLL METHOD 108 PAYROLL STATUS 109 PAYROLL TYPE 110 PAYROLL DATE 111 PAYROLL METHOD										112 PAYROLL STATUS 113 PAYROLL TYPE 114 PAYROLL DATE 115 PAYROLL METHOD 116 PAYROLL STATUS 117 PAYROLL TYPE 118 PAYROLL DATE 119 PAYROLL METHOD									
120 PAYROLL STATUS 121 PAYROLL TYPE 122 PAYROLL DATE 123 PAYROLL METHOD 124 PAYROLL STATUS 125 PAYROLL TYPE 126 PAYROLL DATE 127 PAYROLL METHOD										128 PAYROLL STATUS 129 PAYROLL TYPE 130 PAYROLL DATE 131 PAYROLL METHOD 132 PAYROLL STATUS 133 PAYROLL TYPE 134 PAYROLL DATE 135 PAYROLL METHOD									
136 PAYROLL STATUS 137 PAYROLL TYPE 138 PAYROLL DATE 139 PAYROLL METHOD 140 PAYROLL STATUS 141 PAYROLL TYPE 142 PAYROLL DATE 143 PAYROLL METHOD										144 PAYROLL STATUS 145 PAYROLL TYPE 146 PAYROLL DATE 147 PAYROLL METHOD 148 PAYROLL STATUS 149 PAYROLL TYPE 150 PAYROLL DATE 151 PAYROLL METHOD									
152 PAYROLL STATUS 153 PAYROLL TYPE 154 PAYROLL DATE 155 PAYROLL METHOD 156 PAYROLL STATUS 157 PAYROLL TYPE 158 PAYROLL DATE 159 PAYROLL METHOD										160 PAYROLL STATUS 161 PAYROLL TYPE 162 PAYROLL DATE 163 PAYROLL METHOD 164 PAYROLL STATUS 165 PAYROLL TYPE 166 PAYROLL DATE 167 PAYROLL METHOD									
168 PAYROLL STATUS 169 PAYROLL TYPE 170 PAYROLL DATE 171 PAYROLL METHOD 172 PAYROLL STATUS 173 PAYROLL TYPE 174 PAYROLL DATE 175 PAYROLL METHOD										176 PAYROLL STATUS 177 PAYROLL TYPE 178 PAYROLL DATE 179 PAYROLL METHOD 180 PAYROLL STATUS 181 PAYROLL TYPE 182 PAYROLL DATE 183 PAYROLL METHOD									
184 PAYROLL STATUS 185 PAYROLL TYPE 186 PAYROLL DATE 187 PAYROLL METHOD 188 PAYROLL STATUS 189 PAYROLL TYPE 190 PAYROLL DATE 191 PAYROLL METHOD										192 PAYROLL STATUS 193 PAYROLL TYPE 194 PAYROLL DATE 195 PAYROLL METHOD 196 PAYROLL STATUS 197 PAYROLL TYPE 198 PAYROLL DATE 199 PAYROLL METHOD									
200 PAYROLL STATUS 201 PAYROLL TYPE 202 PAYROLL DATE 203 PAYROLL METHOD 204 PAYROLL STATUS 205 PAYROLL TYPE 206 PAYROLL DATE 207 PAYROLL METHOD										208 PAYROLL STATUS 209 PAYROLL TYPE 210 PAYROLL DATE 211 PAYROLL METHOD 212 PAYROLL STATUS 213 PAYROLL TYPE 214 PAYROLL DATE 215 PAYROLL METHOD									
216 PAYROLL STATUS 217 PAYROLL TYPE 218 PAYROLL DATE 219 PAYROLL METHOD 220 PAYROLL STATUS 221 PAYROLL TYPE 222 PAYROLL DATE 223 PAYROLL METHOD										224 PAYROLL STATUS 225 PAYROLL TYPE 226 PAYROLL DATE 227 PAYROLL METHOD 228 PAYROLL STATUS 229 PAYROLL TYPE 230 PAYROLL DATE 231 PAYROLL METHOD									
232 PAYROLL STATUS 233 PAYROLL TYPE 234 PAYROLL DATE 235 PAYROLL METHOD 236 PAYROLL STATUS 237 PAYROLL TYPE 238 PAYROLL DATE 239 PAYROLL METHOD										240 PAYROLL STATUS 241 PAYROLL TYPE 242 PAYROLL DATE 243 PAYROLL METHOD 244 PAYROLL STATUS 245 PAYROLL TYPE 246 PAYROLL DATE 247 PAYROLL METHOD									
248 PAYROLL STATUS 249 PAYROLL TYPE 250 PAYROLL DATE 251 PAYROLL METHOD 252 PAYROLL STATUS 253 PAYROLL TYPE 254 PAYROLL DATE 255 PAYROLL METHOD										256 PAYROLL STATUS 257 PAYROLL TYPE 258 PAYROLL DATE 259 PAYROLL METHOD 260 PAYROLL STATUS 261 PAYROLL TYPE 262 PAYROLL DATE 263 PAYROLL METHOD									
264 PAYROLL STATUS 265 PAYROLL TYPE 266 PAYROLL DATE 267 PAYROLL METHOD 268 PAYROLL STATUS 269 PAYROLL TYPE 270 PAYROLL DATE 271 PAYROLL METHOD										272 PAYROLL STATUS 273 PAYROLL TYPE 274 PAYROLL DATE 275 PAYROLL METHOD 276 PAYROLL STATUS 277 PAYROLL TYPE 278 PAYROLL DATE 279 PAYROLL METHOD									
280 PAYROLL STATUS 281 PAYROLL TYPE 282 PAYROLL DATE 283 PAYROLL METHOD 284 PAYROLL STATUS 285 PAYROLL TYPE 286 PAYROLL DATE 287 PAYROLL METHOD										288 PAYROLL STATUS 289 PAYROLL TYPE 290 PAYROLL DATE 291 PAYROLL METHOD 292 PAYROLL STATUS 293 PAYROLL TYPE 294 PAYROLL DATE 295 PAYROLL METHOD									
296 PAYROLL STATUS 297 PAYROLL TYPE 298 PAYROLL DATE 299 PAYROLL METHOD 300 PAYROLL STATUS 301 PAYROLL TYPE 302 PAYROLL DATE 303 PAYROLL METHOD										304 PAYROLL STATUS 305 PAYROLL TYPE 306 PAYROLL DATE 307 PAYROLL METHOD 308 PAYROLL STATUS 309 PAYROLL TYPE 310 PAYROLL DATE 311 PAYROLL METHOD									
312 PAYROLL STATUS 313 PAYROLL TYPE 314 PAYROLL DATE 315 PAYROLL METHOD 316 PAYROLL STATUS 317 PAYROLL TYPE 318 PAYROLL DATE 319 PAYROLL METHOD										320 PAYROLL STATUS 321 PAYROLL TYPE 322 PAYROLL DATE 323 PAYROLL METHOD 324 PAYROLL STATUS 325 PAYROLL TYPE 326 PAYROLL DATE 327 PAYROLL METHOD									
328 PAYROLL STATUS 329 PAYROLL TYPE 330 PAYROLL DATE 331 PAYROLL METHOD 332 PAYROLL STATUS 333 PAYROLL TYPE 334 PAYROLL DATE 335 PAYROLL METHOD										336 PAYROLL STATUS 337 PAYROLL TYPE 338 PAYROLL DATE 339 PAYROLL METHOD 340 PAYROLL STATUS 341 PAYROLL TYPE 342 PAYROLL DATE 343 PAYROLL METHOD									
344 PAYROLL STATUS 345 PAYROLL TYPE 346 PAYROLL DATE 347 PAYROLL METHOD 348 PAYROLL STATUS 349 PAYROLL TYPE 350 PAYROLL DATE 351 PAYROLL METHOD										352 PAYROLL STATUS 353 PAYROLL TYPE 354 PAYROLL DATE 355 PAYROLL METHOD 356 PAYROLL STATUS 357 PAYROLL TYPE 358 PAYROLL DATE 359 PAYROLL METHOD									
360 PAYROLL STATUS 361 PAYROLL TYPE 362 PAYROLL DATE 363 PAYROLL METHOD 364 PAYROLL STATUS 365 PAYROLL TYPE 366 PAYROLL DATE 367 PAYROLL METHOD										368 PAYROLL STATUS 369 PAYROLL TYPE 370 PAYROLL DATE 371 PAYROLL METHOD 372 PAYROLL STATUS 373 PAYROLL TYPE 374 PAYROLL DATE 375 PAYROLL METHOD									

SAMPLE EOB (EXPLANATION OF BENEFITS)

UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-838-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

1	2	3	4	5	6	7	8		
PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
I 9061512101	MEDICAL SERVICES	03/19/10 TOTAL	379.00 379.00	297.83 297.83	81.17 81.17		80%	64.94* 64.94	4C
						MEDICARE PAID		44.64	
						PLAN PAYS		20.30	

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
\$20.30

SATISFIED 2010 TO DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY	\$1000.00	\$1328.77
SR	\$500.00	\$1281.48
PLAN YEAR 2010	FAMILY \$1000.00	FAMILY \$4000.00
	INDIV \$500.00	INDIV \$4000.00



STUDENT ACCIDENT INSURANCE CLAIM FORM

SIGNED CLAIM FORM IS REQUIRED

1. PLEASE FULLY COMPLETE THIS FORM **PAGE 1 & PAGE 2**
2. ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE
3. SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com
File Electronically: Click [Here](#)

IMPORTANT NOTICE:

Your insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: **The accident policy benefits are limited and may not provide 100% coverage.**

◀ IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED ▶

PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District Name _____ Policy Number _____

School Name _____ Phone No. () _____

Address _____ Email _____

_____ Type of Activity/Sport _____

If Athletics, designate ☐ P.E. Class ☐ Intramural ☐ Interscholastic ☐ Game ☐ Jr. Varsity ☐ Varsity
☐ Youth ☐ Adult ☐ Practice ☐ Other _____

Name of injured person/student _____

Date of Accident _____ Accident Time _____

Date of First Treatment _____ Has treatment been completed? ☐ Yes ☐ No

Where and how did accident occur? (Please be specific) _____

Part of body Injured _____ ☐ Right or ☐ Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? ☐ Yes ☐ No

Under whose supervision? _____ Was he/she a witness? ☐ Yes ☐ No

Authorized Signature _____ Title _____ Date _____

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name _____ Preferred/Nickname: _____

Date of Birth _____ Age _____ Grade Level _____ ☐ Male ☐ Female

Address of Injured Person or Parents/Guardian _____

Phone No. () _____ Email Address _____

If Injured party is over age 18: Employer Name and Address _____

Phone No. () _____ ☐ Self Employed ☐ Unemployed

Father/Guardian Name _____

Employer Name and Address _____ Phone No. () _____

☐ Self Employed ☐ Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name _____
Employer Name and Address _____ Phone No. () _____
_____ ☐Self Employed ☐Unemployed

If Dental Injury. Please submit verification from the dentist that the tooth/teeth are whole, sound and natural.

Is claimant covered under any other medical and or dental insurance policy? ☐Yes ☐No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐Yes ☐No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	Address	Policy #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are benefits due for this claim under these other insurance coverages? ☐Yes ☐No (See IMPORTANT NOTICE at top of form on page 1)

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? ☐Yes ☐No If yes, please give name, address and phone number of responsible party _____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Injured Person, Parent or Guardian _____ Date: _____
SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Injured Person, Parent or Guardian _____ Date: _____

FRAUD NOTICE STATEMENTS

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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF ALABAMA: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION OF FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

RESIDENTS OF ALASKA APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

RESIDENTS OF ARKANSAS 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."

RESIDENTS OF ARIZONA APPLICANTS: "FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF CALIFORNIA: "FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF 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."

RESIDENTS OF DELAWARE: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

RESIDENTS OF 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."

RESIDENTS OF 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."

RESIDENTS OF IDAHO: "ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECIEVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

RESIDENTS OF INDIANA: "ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD AN INSURER FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON 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 STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY 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, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILED A 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."

RESIDENTS OF 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."

RESIDENTS OF MAINE 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."

RESIDENTS OF MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF MINNESOTA APPLICANTS: "ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

RESIDENTS OF NEW HAMPSHIRE: "ANY PERSON WHO, WITH THE PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN RSA 638.20."

RESIDENTS OF NEW JERSEY APPLICANTS: "ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF 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."

RESIDENTS OF 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 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."

RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF OKLAHOMA APPLICANTS: "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."

RESIDENTS OF 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."

RESIDENTS OF 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 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."

RESIDENTS OF RHODE ISLAND: "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 OR MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF TENNESSEE 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."

RESIDENTS OF TEXAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF 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."

RESIDENTS OF 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 MAY INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WASHINGTON APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WEST VIRGINIA 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."