

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 in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following 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. 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. Organization/School name found on the claim form
3. 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.

SAMPLE HCFA 1500

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1 MEDICARE MEDICAID CHARLES CHARIPUR GROUP HEALTH PLAN OTHER INSURER'S ID NUMBER (FROM PROGRAM IN ITEM 1)

2 PATIENT'S NAME (LAST FIRST MIDDLE INITIAL) (SURNAME) 3 BIRTH DATE (MM/DD/YY) 4 INSURER'S NAME (LAST FIRST MIDDLE INITIAL)

5 PATIENT'S ADDRESS (last 9 digits) 6 PATIENT RELATIONSHIP TO INSURED 7 INSURER'S ADDRESS (last 9 digits)

8 OTHER INSURER'S POLICY OR GROUP NUMBER 9 EMPLOYMENT CURRENT OR PREVIOUS 10 INSURER'S DATE OF BIRTH 11 INSURER'S POLICY GROUP OR PLAN NUMBER

12 EMPLOYER'S NAME OR SCHOOL NAME 13 INSURANCE PLAN NAME OR PROGRAM NAME 14 OTHER INSURANCE DATE OF BIRTH 15 AUTO ACCIDENT? 16 EMPLOYEE'S NAME OR SCHOOL NAME 17 INSURANCE PLAN NAME OR PROGRAM NAME

18 EMPLOYER'S NAME OR SCHOOL NAME 19 INSURANCE PLAN NAME OR PROGRAM NAME 20 THERE ANOTHER HEALTH BENEFIT PLAN?

21 READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 22 EMPLOYER'S SIGNATURE 23 EMPLOYEE'S SIGNATURE 24 DATE OF SERVICE 25 DATE OF SERVICE 26 DATE OF SERVICE 27 DATE OF SERVICE 28 DATE OF SERVICE 29 DATE OF SERVICE 30 DATE OF SERVICE 31 DATE OF SERVICE 32 DATE OF SERVICE 33 DATE OF SERVICE 34 DATE OF SERVICE 35 DATE OF SERVICE 36 DATE OF SERVICE 37 DATE OF SERVICE 38 DATE OF SERVICE 39 DATE OF SERVICE 40 DATE OF SERVICE 41 DATE OF SERVICE 42 DATE OF SERVICE 43 DATE OF SERVICE 44 DATE OF SERVICE 45 DATE OF SERVICE 46 DATE OF SERVICE 47 DATE OF SERVICE 48 DATE OF SERVICE 49 DATE OF SERVICE 50 DATE OF SERVICE 51 DATE OF SERVICE 52 DATE OF SERVICE 53 DATE OF SERVICE 54 DATE OF SERVICE 55 DATE OF SERVICE 56 DATE OF SERVICE 57 DATE OF SERVICE 58 DATE OF SERVICE 59 DATE OF SERVICE 60 DATE OF SERVICE 61 DATE OF SERVICE 62 DATE OF SERVICE 63 DATE OF SERVICE 64 DATE OF SERVICE 65 DATE OF SERVICE 66 DATE OF SERVICE 67 DATE OF SERVICE 68 DATE OF SERVICE 69 DATE OF SERVICE 70 DATE OF SERVICE 71 DATE OF SERVICE 72 DATE OF SERVICE 73 DATE OF SERVICE 74 DATE OF SERVICE 75 DATE OF SERVICE 76 DATE OF SERVICE 77 DATE OF SERVICE 78 DATE OF SERVICE 79 DATE OF SERVICE 80 DATE OF SERVICE 81 DATE OF SERVICE 82 DATE OF SERVICE 83 DATE OF SERVICE 84 DATE OF SERVICE 85 DATE OF SERVICE 86 DATE OF SERVICE 87 DATE OF SERVICE 88 DATE OF SERVICE 89 DATE OF SERVICE 90 DATE OF SERVICE 91 DATE OF SERVICE 92 DATE OF SERVICE 93 DATE OF SERVICE 94 DATE OF SERVICE 95 DATE OF SERVICE 96 DATE OF SERVICE 97 DATE OF SERVICE 98 DATE OF SERVICE 99 DATE OF SERVICE 100 DATE OF SERVICE

29 FEDERAL TAX ID NUMBER 30 PATIENT ACCOUNT NO 31 ACCOUNT ASSIGNMENT 32 TOTAL CHARGE 33 AMOUNT PAID 34 BALANCE DUE

35 SIGNATURE OF PARTICIPANT OR SUPPLIER 36 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED 37 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ETC. 38 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ETC. 39 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ETC. 40 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ETC.

FORM 1500-1007 (12/04) 1500-1007 (12/04) 1500-1007 (12/04) 1500-1007 (12/04)

SAMPLE UB-04

UB-04

PAGE 1 OF 1

DATE: 04/29/18

SSN/ID #: 1-800-838-8010

EMPLOYEE: PFIIZER INC

BENEFIT PLAN: PFIIZER 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	COPY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9061512101	MEDICAL SERVICES	09/19/10	379.00	297.83	81.17		80%	64.94*	4C
	TOTAL		379.00	297.83	81.17			64.94	
								44.64	
								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 CO-PAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION

\$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY \$5	\$1000.00	\$1328.77
	\$500.00	\$1281.45
PLAN YEAR 2010	FAMILY \$5	\$1000.00
	INDV \$500.00	\$4000.00

SAMPLE ADA DENTAL CLAIM FORM

American Dental Association Dental Claim Form

1 Type of Transaction (Mark all applicable boxes) 2 Preauthorization/Prescription Number

3 Insurance Company/Dental Benefit Plan Information 4 Policyholder/Subscriber Information (For Insurance Company Named in #3)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) 6 Date of Birth (MM/DD/YYYY) 7 Gender 8 Relationship to Person Named in #2 (Other) 9 Plan/Group Number 10 Patient's Relationship to Person Named in #2 (Other) 11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code 12 Name, Last, First, Middle Initial, Suffix, Address, City, State, Zip Code 13 Date of Birth (MM/DD/YYYY) 14 Gender 15 Policyholder/Subscriber ID (SIN or ID#) 16 Plan/Group Number 17 Employee Name 18 Relationship to Policyholder/Subscriber in #12 Above 19 Student Status 20 Name, Last, First, Middle Initial, Suffix, Address, City, State, Zip Code 21 Patient Name 22 Address 1 23 Address 2 24 City 25 State 26 ZIP 27 Date of Birth (MM/DD/YYYY) 28 Gender 29 Patient ID/Account # (Assigned by Dentist)

30 Description 31 Fee

32 Remarks

33 Ancillary Claim/Treatment Information 34 Billing Dentist or Dental Entity 35 Treating Dentist and Treatment Location Information

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: 04/29/18
SSN/ID #: 1-800-838-8010
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIIZER 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	COPY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9061512101	MEDICAL SERVICES	09/19/10	379.00	297.83	81.17		80%	64.94*	4C
	TOTAL		379.00	297.83	81.17			64.94	
								44.64	
								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 CO-PAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION

\$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY \$5	\$1000.00	\$1328.77
	\$500.00	\$1281.45
PLAN YEAR 2010	FAMILY \$5	\$1000.00
	INDV \$500.00	\$4000.00



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:
This plan of insurance is secondary, in most instances, 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/College Name Policy Number
School/Team/League Name Phone No. ()
Address Email
Type of Activity/Sport

If Athletics, designate P.E. Class Intramural Interscholastic Intercollegiate 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

Claimant is a Student Player Coach Official/Umpire Volunteer Child Care Participant CE Student (# of credits)

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 #

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."