

## Student Accident Insurance Coverage 2020–2021 School Year

Our School District provides to all enrolled students (Pre-K through 12<sup>th</sup> Grade) an Excess Student Accident insurance policy through Gerber Life Insurance Company. The Student Accident insurance provides coverage during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premise. Coverage includes participation in Interscholastic Sports; including Football, Religious Education Classes, One Day Field Trips and Overnight Field Trips\* (no more than 7 consecutive nights). This includes travel directly (uninterruptedly) to and from a regularly scheduled activity with other members as a group. Travel must be supervised by a person authorized by the school.

### Schedule of Benefits:

**Maximum Benefit \$25,000**

**Deductible \$250**

**Coinsurance None**

#### Inpatient

Room & Board:	100% Usual and Customary Charges
Intensive Care:	100% Usual and Customary Charges
Hospital Miscellaneous:	100% Usual and Customary Charges
Surgery:	100% Usual and Customary Charges based on data provided by Ingenix, at the 80 <sup>th</sup> percentile.
Assistant Surgeon:	100% Usual and Customary Charges
Anesthetist:	100% Usual and Customary Charges
Registered Nurse:	100% Usual and Customary Charges
Physician's Visits:	100% Usual and Customary Charges
Pre-admission Testing:	100% Usual and Customary Charges

#### Outpatient

Surgery:	100% Usual and Customary Charges based on data provided by Ingenix at the 80 <sup>th</sup> percentile.
Day Surgery Miscellaneous:	100% Usual and Customary Charges (Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)
Assistant Surgeon:	100% Usual and Customary Charges
Anesthetist:	100% Usual and Customary Charges
Outpatient Misc. Benefit:	100% Usual and Customary Charges
Physician's Visits:	100% Usual and Customary Charges
Physiotherapy:	100% Usual and Customary Charges
Medical Emergency:	100% Usual and Customary Charges
Diagnostic X-Rays:	100% Usual and Customary Charges
Laboratory:	100% Usual and Customary Charges
Tests & Procedures:	100% Usual and Customary Charges
Prescription Drugs:	100% Usual and Customary Charges

**Other**

Ambulance: 100% Usual and Customary Charges  
Durable Medical Equipment: 100% Usual and Customary Charges  
Dental (Benefits paid on Injury to Sound, Natural Teeth only.) 100% Usual and Customary Charges

Replacement of eyeglasses, hearing aids or contact lenses damaged during a covered Injury, if medical treatment is also received for the covered Injury. 100% Usual and Customary Charges

*This is a highlight of benefits and all claims payments are subject to the term of the policy.*

**HOW BENEFITS ARE PAID  
(Excess Coverage)**

**Excess Coverage:** If an Injury to the Insured Person results in incurring Covered Medical Expenses for any of the services specified in the Schedule of Benefits, the Company will pay the Covered Medical Expenses incurred subject to the Deductible Amount and Coinsurance Percentage (if any), that are in excess of Covered Medical Expenses payable by any other valid and collectible insurance.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

**NOTICE OF CLAIM**

Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company. Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Treatment must begin 180 days after the date of Injury and is received within 12 months after date of injury.

**In the event of an Accident, students should:**

1. Secure treatment at the nearest medical facility of their choice.
2. Obtain a receipt (if payment of any bills were made) and itemized copy of charges from the provider of medical services and send copies of their itemized bills, primary insurance Explanation of Benefits and the fully completed and signed accident claim form to the claims office – mail all correspondence to WEB-TPA, P.O. Box 2415, Grapevine, TX 76099-2415.
3. Call 1-866-975-9468, Policy #28-3767-20 with any Claims questions.

**Cobertura del seguro de accidentes para estudiantes  
2020-2021 Año escolar**

Nuestro distrito escolar proporcionará a todos los estudiantes matriculados (Pre-K a 12 ° Grado) una póliza de seguro de accidentes estudiantiles en exceso a través de Gerber Life Insurance Company. El seguro de accidentes para estudiantes proporciona cobertura durante las horas y días en que la escuela está en sesión, mientras participa en actividades patrocinadas y supervisadas por la escuela. La cobertura incluye la participación en deportes interescolares; incluyendo fútbol, clases de educación religiosa, excursiones de un día y excursiones de una noche \* (no más de 7 noches consecutivas). Esto incluye viajar directamente (ininterrumpidamente) hacia y desde una actividad programada regularmente con otros miembros como grupo. El viaje debe ser supervisado por una persona autorizada por la escuela.

**Horario de beneficios:**

**Beneficio máximo \$ 25,000**

**Deducible \$ 250**

**Coseguro Ninguno**

**paciente interno**

Habitación y comida:	100% de los cargos usuales y habituales
cuidados intensivos:	100% de los cargos usuales y habituales
hospital misceláneo:	100% de los cargos usuales y habituales
Cirugía:	100% de los cargos usuales y habituales en base a los datos proporcionados por ingenix, en el percentil 80
Cirujano asistente:	100% de los cargos usuales y habituales
Anestesista:	100% de los cargos usuales y habituales
enfermera registrada:	100% de los cargos usuales y habituales
visitas del medico:	100% de los cargos usuales y habituales

**paciente externo**

Cirugía:	100% de los cargos usuales y habituales en base a los datos proporcionados por ingenix, en el percentil 80
----------	---------------------------------------------------------------------------------------------------------------

cirugía diurna varios	100% de los cargos usuales y habituales (los cargos usuales y habituales para la cirugía diaria se basan en el índice de cargo de la instalación quirúrgica para pacientes ambulatorios)
-----------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Cirujano asistente:	100% de los cargos usuales y habituales
Anestesista:	100% de los cargos usuales y habituales
beneficio misceláneo para pacientes ambulatorios:	100% de los cargos usuales y habituales
visitas del medico:	100% de los cargos usuales y habituales
fisioterapia:	100% de los cargos usuales y habituales
Emergencia médica:	100% de los cargos usuales y habituales

radiografías de diagnóstico: 100% de los cargos usuales y habituales  
laboratorio: 100% de los cargos usuales y habituales  
pruebas y procedimientos: 100% de los cargos usuales y habituales

**Otro**

Ambulancia: 100% de los cargos usuales y habituales  
Equipo médico duradero: 100% de los cargos usuales y habituales  
Dental: (beneficios pagados por lesiones a dientes sanos y naturales solamente) 100% de los cargos usuales y habituales

Reemplazo de anteojos, audífonos o lentes de contacto dañados durante una lesión cubierta, si también se recibe tratamiento médico por la lesión cubierta.

100% de los cargos usuales y habituales

*Esto es lo más destacado de los beneficios y los pagos de reclamaciones están sujetos al plazo de la póliza.*

**Cómo se pagan los beneficios  
(Exceso de cobertura)**

**Exceso de cobertura.** Si una lesión a la persona asegurada resulta en incurrir en gastos médicos cubiertos por cualquiera de los servicios especificados en el cronograma de beneficios, la compañía pagará los gastos médicos cubiertos incurridos sujeto al monto del deducible y porcentaje de coseguro (si corresponde), que están en exceso de gastos médicos cubiertos pagaderos por otro seguro válido y cobrable.

Los gastos médicos cubiertos excluyen los montos no cubiertos por el portador principal debido a las penalizaciones impuestas al asegurado por no cumplir con las disposiciones o requisitos de la póliza.

**Aviso de reclamo**

Se debe entregar un aviso por escrito de la reclamación a la compañía dentro de los 90 días posteriores a la ocurrencia o al comienzo de cualquier pérdida cubierta por esta política, o tan pronto como sea razonablemente posible. El aviso dado por o en nombre del asegurado nombrado a la compañía, con información suficiente para identificar al asegurado nombrado se considerará aviso a la compañía. Se debe presentar un comprobante de pérdida por escrito a la compañía en dicha oficina dentro de los 90 días posteriores a la fecha de dicha pérdida. El tratamiento debe comenzar 180 días después de la fecha de la lesión y se recibió dentro de los 12 meses posteriores a la fecha de la lesión.

**En caso de accidente, los estudiantes deben:**

1. Asegure el tratamiento en la instalación médica más cercana de su elección.
2. Obtenga un recibo (si se hicieron pagos) y una copia detallada de los cargos del proveedor de servicios médicos y envíe copias de sus facturas detalladas, explicación de beneficios del seguro primario y el formulario de reclamo de accidente completamente completado y firmado a los reclamos office-mail toda la correspondencia a WEB\_TPA, PO Box 2415, Grapevine, TX 76099-2415.
3. Llame al 1-866-975-9468, Política # 28-3767-18 con cualquier pregunta sobre reclamos.

**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.

◆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**

**SAMPLE UB-04**

HEALTH INSURANCE CLAIM FORM

Member Name: [REDACTED]

Member ID: [REDACTED]

Service Center: [REDACTED]

Address: [REDACTED]

City: [REDACTED] State: [REDACTED] Zip: [REDACTED]

Phone: [REDACTED]

Signature: [REDACTED]

Date: [REDACTED]

UNIVERSAL HEALTHCARE SERVICE, LLC

MEMBER INFORMATION

Member Name: [REDACTED]

Member ID: [REDACTED]

Service Center: [REDACTED]

Address: [REDACTED]

City: [REDACTED] State: [REDACTED] Zip: [REDACTED]

Phone: [REDACTED]

Signature: [REDACTED]

Date: [REDACTED]

**SAMPLE ADA DENTAL CLAIM FORM**

**SAMPLE EOB (EXPLANATION OF BENEFITS)**

ADA DENTAL CLAIM FORM

Member Name: [REDACTED]

Member ID: [REDACTED]

Service Center: [REDACTED]

Address: [REDACTED]

City: [REDACTED] State: [REDACTED] Zip: [REDACTED]

Phone: [REDACTED]

Signature: [REDACTED]

Date: [REDACTED]

UNIVERSAL HEALTHCARE SERVICE, LLC

MEMBER INFORMATION

Member Name: [REDACTED]

Member ID: [REDACTED]

Service Center: [REDACTED]

Address: [REDACTED]

City: [REDACTED] State: [REDACTED] Zip: [REDACTED]

Phone: [REDACTED]

Signature: [REDACTED]

Date: [REDACTED]

**EXPLANATION OF BENEFITS**

1	2	3	4	5	6	7	8
IDENTIFICATION NUMBER	PRIMARY SERVICE	DATE OF SERVICE	AMOUNT BILLED	AMOUNT PAID	AMOUNT DENIED	REASON FOR DENIAL	APPROVAL CODE
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

9

10

11

12

13



CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE
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

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. 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 Nevada Public Agency Insurance Pool Policy Number 28-3767-20
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 #

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 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 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 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 RESIDENTS 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 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 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."

**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, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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 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."

**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/SHE 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:** "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 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:** IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "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."