

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

APPROVED OVER-BOOK

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1 MEDICARE MEDICAID CHARLES CHARITABLE GROUP HEALTH PLAN OTHER 14 INSURED'S ID NUMBER (FROM PROGRAM IN ITEM 1)

2 PATIENT'S NAME (LAST FIRST MIDDLE INITIAL) 3 PATIENT'S BIRTH DATE 4 INSURED'S NAME (LAST FIRST MIDDLE INITIAL) 5 INSURED'S BIRTH DATE

6 PATIENT'S ADDRESS (last 9 digits) 7 INSURED'S ADDRESS (last 9 digits)

8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9 OTHER INSURED'S BIRTH DATE

10 EMPLOYER'S NAME OR SCHOOL NAME 11 EMPLOYER'S ADDRESS (last 9 digits)

12 EMPLOYER'S POLICY OR GROUP NUMBER 13 EMPLOYER'S DATE OF BIRTH

14 DATE OF SERVICE (MM/DD/YY) 15 DATE OF SERVICE (MM/DD/YY)

16 NAME OF PHYSICIAN OR SUPPLIER 17 NAME OF PHYSICIAN OR SUPPLIER

18 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED 19 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, CITY, STATE, ZIP CODE

20 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 21 OUTPATIENT CLINIC

22 PRIOR AUTHORIZATION NUMBER

23 FEDERAL TAX ID NUMBER 24 PATIENT'S ACCOUNT NO. 25 ACCOUNT ASSIGNMENT 26 TOTAL CHARGE 27 AMOUNT PAID 28 BALANCE DUE

29 SIGNATURE OF PHYSICIAN OR SUPPLIER 30 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED 31 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, CITY, STATE, ZIP CODE

32 DATE 33 DATE

34 DATE

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41 DATE

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44 DATE

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89 DATE

90 DATE

91 DATE

92 DATE

93 DATE

94 DATE

95 DATE

96 DATE

97 DATE

98 DATE

99 DATE

100 DATE

SAMPLE UB-04

UB-04

1 PATIENT NAME 2 PATIENT ADDRESS 3 PATIENT BIRTH DATE 4 PATIENT SEX 5 PATIENT RACE 6 PATIENT ETHNICITY 7 PATIENT RELATIONSHIP TO INSURED 8 PATIENT OCCUPATION 9 PATIENT EMPLOYER 10 PATIENT POLICY OR GROUP NUMBER 11 PATIENT DATE OF BIRTH 12 PATIENT SEX 13 PATIENT SCHOOL NAME 14 PATIENT PLAN NAME OR PROGRAM NAME 15 PATIENT HEALTH PLAN NUMBER 16 PATIENT DATE OF BIRTH 17 PATIENT SEX 18 PATIENT SCHOOL NAME 19 PATIENT PLAN NAME OR PROGRAM NAME 20 PATIENT HEALTH PLAN NUMBER 21 PATIENT DATE OF BIRTH 22 PATIENT SEX 23 PATIENT SCHOOL NAME 24 PATIENT PLAN NAME OR PROGRAM NAME 25 PATIENT HEALTH PLAN NUMBER 26 PATIENT DATE OF BIRTH 27 PATIENT SEX 28 PATIENT SCHOOL NAME 29 PATIENT PLAN NAME OR PROGRAM NAME 30 PATIENT HEALTH PLAN NUMBER 31 PATIENT DATE OF BIRTH 32 PATIENT SEX 33 PATIENT SCHOOL NAME 34 PATIENT PLAN NAME OR PROGRAM NAME 35 PATIENT HEALTH PLAN NUMBER 36 PATIENT DATE OF BIRTH 37 PATIENT SEX 38 PATIENT SCHOOL NAME 39 PATIENT PLAN NAME OR PROGRAM NAME 40 PATIENT HEALTH PLAN NUMBER 41 PATIENT DATE OF BIRTH 42 PATIENT SEX 43 PATIENT SCHOOL NAME 44 PATIENT PLAN NAME OR PROGRAM NAME 45 PATIENT HEALTH PLAN NUMBER 46 PATIENT DATE OF BIRTH 47 PATIENT SEX 48 PATIENT SCHOOL NAME 49 PATIENT PLAN NAME OR PROGRAM NAME 50 PATIENT HEALTH PLAN NUMBER 51 PATIENT DATE OF BIRTH 52 PATIENT SEX 53 PATIENT SCHOOL NAME 54 PATIENT PLAN NAME OR PROGRAM NAME 55 PATIENT HEALTH PLAN NUMBER 56 PATIENT DATE OF BIRTH 57 PATIENT SEX 58 PATIENT SCHOOL NAME 59 PATIENT PLAN NAME OR PROGRAM NAME 60 PATIENT HEALTH PLAN NUMBER 61 PATIENT DATE OF BIRTH 62 PATIENT SEX 63 PATIENT SCHOOL NAME 64 PATIENT PLAN NAME OR PROGRAM NAME 65 PATIENT HEALTH PLAN NUMBER 66 PATIENT DATE OF BIRTH 67 PATIENT SEX 68 PATIENT SCHOOL NAME 69 PATIENT PLAN NAME OR PROGRAM NAME 70 PATIENT HEALTH PLAN NUMBER 71 PATIENT DATE OF BIRTH 72 PATIENT SEX 73 PATIENT SCHOOL NAME 74 PATIENT PLAN NAME OR PROGRAM NAME 75 PATIENT HEALTH PLAN NUMBER 76 PATIENT DATE OF BIRTH 77 PATIENT SEX 78 PATIENT SCHOOL NAME 79 PATIENT PLAN NAME OR PROGRAM NAME 80 PATIENT HEALTH PLAN NUMBER 81 PATIENT DATE OF BIRTH 82 PATIENT SEX 83 PATIENT SCHOOL NAME 84 PATIENT PLAN NAME OR PROGRAM NAME 85 PATIENT HEALTH PLAN NUMBER 86 PATIENT DATE OF BIRTH 87 PATIENT SEX 88 PATIENT SCHOOL NAME 89 PATIENT PLAN NAME OR PROGRAM NAME 90 PATIENT HEALTH PLAN NUMBER 91 PATIENT DATE OF BIRTH 92 PATIENT SEX 93 PATIENT SCHOOL NAME 94 PATIENT PLAN NAME OR PROGRAM NAME 95 PATIENT HEALTH PLAN NUMBER 96 PATIENT DATE OF BIRTH 97 PATIENT SEX 98 PATIENT SCHOOL NAME 99 PATIENT PLAN NAME OR PROGRAM NAME 100 PATIENT HEALTH PLAN NUMBER

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 Other Coverage 5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) 6 Date of Birth (MM/DD/YYYY) 7 Gender 8 Policyholder/Subscriber ID (SIN or ID#) 9 Plan/Group Number 10 Patient's Relationship to Person Named in #5 11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code 12 Name of Policyholder/Subscriber in #1 (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 23 City 24 Date of Birth (MM/DD/YYYY) 25 Gender 26 Patient ID/Account # (Assigned by Dentist) 27 Tooth Number 28 Tooth Surface 29 Procedure Code 30 Description 31 Fee 32 Missing Teeth Information 33 Remarks 34 Ancillary Claim/Treatment Information 35 Patient's Signature 36 Date 37 Health Insurance Signature 38 Date 39 Billing Dentist or Dental Entity 40 Name 41 Address 42 City 43 State 44 Zip 45 License Number 46 License Number 47 SSN or TIN 48 Name 49 Address 50 City 51 State 52 Zip 53 License Number 54 License Number 55 SSN or TIN 56 Name 57 Address 58 City 59 State 60 Zip 61 License Number 62 License Number 63 SSN or TIN 64 Name 65 Address 66 City 67 State 68 Zip 69 License Number 70 License Number 71 SSN or TIN 72 Name 73 Address 74 City 75 State 76 Zip 77 License Number 78 License Number 79 SSN or TIN 80 Name 81 Address 82 City 83 State 84 Zip 85 License Number 86 License Number 87 SSN or TIN 88 Name 89 Address 90 City 91 State 92 Zip 93 License Number 94 License Number 95 SSN or TIN 96 Name 97 Address 98 City 99 State 100 Zip

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 #:
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	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	
								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 CO-PAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

9 10

BENEFIT PLAN PAYMENT SUMMARY INFORMATION

11 \$20.30

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

12 13



CATASTROPHIC 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 DECEIVE 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."