Lincoln Financial Group®

Hospital Indemnity Claim Form

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (888) 735-7636
LincolnFinancial.com

Please call our Customer Service Center at 1-800-423-2765 if you have any questions about benefits or how to file your claim.

Follow these instructions to complete this form.

1. Complete **Section A, D and E** in full.
2. Complete **Section B** if treatment is due to an accident. If treatment is due to an illness, skip to and complete **Section C**.
3. Complete and sign **Section F**.
4. Have your physician complete **Section G** in full and sign.
5. Please provide an itemized bill from the hospital, lab reports, radiology reports, pathology reports, clinical diagnosis, and any other medical record documentation to support your claim. If the patient is deceased, please provide a copy of the death certificate. Retain copies for your records. Send the completed form and bills to:

   The Lincoln National Life Insurance Company
   PO Box 2609, Omaha, NE 68103-2609
   Fax: (888) 735-7636
   Email: fileclaim@lfg.com

Incomplete forms or missing documentation may delay processing of the claim.

Section A - Employee and Patient Information (to be completed by Employee)

Employee Information

Employer Name: Beaumont Independent School District	Policy Number: 0001025066
Employee's Name: (First, Middle, Last) _____ /_____ /_____	
Employee's Birthdate: (MM/DD/YYYY) _____ /_____ /_____	Employee's Work ID or Social Security Number: _____
Employee's Address: ☐ Check if address is new _____	
City/State/Zip: _____ /_____ /_____	Employee's Telephone Number: _____-_____-_____
Employee's e-mail: _____	Employee's Gender: ☐ Male ☐ Female

Patient Information

Patient Name: (First, Middle, Last, if not employee) _____ /_____ /_____	
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's Birthdate: (MM/DD/YYYY) _____ /_____ /_____
Patient's Gender: (if not employee) ☐ Male ☐ Female	Patient's Telephone Number: _____-_____-_____

Please check the box(es) that best describes your claim. Please be advised, some benefits may not be covered under your plan.

Admission & Confinement Benefits
- ☐ Hospital Admission
- ☐ Hospital Intensive Care Unit (ICU) Admission
- ☐ Hospital Confinement
- ☐ Hospital Intensive Care Unit (ICU) Confinement
- ☐ Rehabilitation Facility
- ☐ Substance Abuse Treatment
- ☐ Mental Disorder Treatment
- ☐ Newborn Care
- ☐ Birth Center

Outpatient Benefits
- ☐ Emergency Care
- ☐ Office Visit
- ☐ Urgent Care
- ☐ Walk-In Clinic
- ☐ Telemedicine
- ☐ Observation Unit

Surgery Benefits
- ☐ Inpatient Surgery
- ☐ Outpatient Surgery

Lab and Diagnostic Benefits
- ☐ Lab and X-Ray
- ☐ Diagnostic Imaging

Assistance & Recovery Benefits
- ☐ Air or Water Ambulance Transportation
- ☐ Ground Ambulance Transportation

Enhancement Benefits
- ☐ Hospital Neonatal Intensive Care Unit (NICU) Admission Increase
- ☐ Hospital Neonatal Intensive Care Unit (NICU) Confinement Increase

Section B - Accident Details

Date of Accident: (MM/DD/YYYY) _____/_____/_____	Where did the accident happen? _____
Is Accident related to employment? ☐ Yes ☐ No Is Accident an auto accident? ☐ Yes ☐ No	Were you driving? ☐ Yes ☐ No If Yes, please provide a police report.
Explain the injuries and how the accident happened: _____	

Section C - Illness Details

Date Symptoms Began: (MM/DD/YYYY) _____/_____/_____	Briefly explain the primary reason for seeking treatment: _____

Section D - Hospitalization Details

Were you hospitalized? ☐ Yes ☐ No	Admission Date: (MM/DD/YYYY) _____/_____/_____ _____AM/PM	Discharge Date: (MM/DD/YYYY) _____/_____/_____ _____AM/PM
Name of Hospital: _____		Hospital Telephone Number: _____-_____-_____
Hospital Address: _____	City/State/Zip: _____	

Section E - Payment Details

Please select a method of payment to receive your benefits. If no method of payment is selected, you will receive a check for your benefits.

Select Payment Type:
- ☐ Direct deposit into my account
- ☐ Send me a check

9-Digit Routing Number: _____

Account Number: _____

Financial Institution Name: _____

Banking Type: ☐ Personal ☐ Business

Account Type: ☐ Checking ☐ Savings

Lincoln Financial Group®

Authorization For Release of Information

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (888) 735-7636
LincolnFinancial.com

1. In connection with a claim for benefits, I (the undersigned) **authorize** any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Name of Insured: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: XXX-XX-_____

2. **Information to be released (hereinafter referred to as "My Information"):**
   - data or records regarding my medical history, treatment, prescriptions, consultations [including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition I may now have or have had];
   - any information regarding insurance coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history).
3. **Information to be released to:** The Lincoln National Life Insurance Company ("Lincoln")
   PO Box 2609
   Omaha, NE 68103-2609
4. **I understand My Information will be used by Lincoln to evaluate and administer my claim for benefits. I also authorize Lincoln to release My Information as follows:**
   - to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
   - to a vendor, approved by Lincoln, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans, I understand the the information obtained with this Authorization may be used in discussions between Lincoln and my employer regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise may be required by law or as I may further authorize.
5. I understand My Information may be subject to re-disclosure by the recipient pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be re-disclosed or reused by the recipient under Colorado law.
6. I understand that I may revoke this Authorization in writing at any time, except to the extent Lincoln has taken action in reliance on this Authorization or the Company is using this Authorization in connection with a contestable claim regarding my policy. To initiate revocation of this Authorization, direct all correspondence to Lincoln at the above address. If written revocation is not received, this Authorization will be considered valid for a period of 24 months from the date of my signature below, or the duration of my claim for benefits, whichever is greater.
7. I agree that a copy of this Authorization shall be considered as valid as the original. I am entitled to receive a copy of this Authorization.
8. I understand that if I refuse to sign this Authorization, or subsequently revoke this Authorization, it may impair Lincoln's ability to process my application or evaluate claims and may be a basis for denying an application or claim for benefits.
9. If I do not sign this Authorization, it will not affect my ability to receive health care services.

SIGNATURE _____ **DATE** _____

Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient _____

ADDRESS: _____
(Street)

_____
(City) (State) (Zip Code)

PHONE NO: _____

Section G - Physician's Statement (to be completed by Physician)

Patient's Name: (First, Middle, Last)

_____/_____/_____

Patient's Birthdate: (MM/DD/YYYY)	Patient's relationship to employee:
_____/_____/_____	☐ Self ☐ Spouse ☐ Life Partner ☐ Child

Patient's Address:

_____

City/State/Zip:

_____/_____/_____

Primary Diagnosis with ICD10 code:	Secondary Diagnosis with ICD10 code:
_____	_____

Is this condition the result of an accidental injury? ☐ Yes ☐ No Date of Accident/Injury: _____/_____/_____

If Yes, please describe how the accident occurred:_____

Is this condition the result of an illness? ☐ Yes ☐ No Date first treated: _____/_____/_____

Is the patient's condition work related? ☐ Yes ☐ No If Yes, explain: _____

Was the patient treated in the ER? ☐ Yes ☐ No If Yes, date seen in ER: _____/_____/_____

If Yes, name of hospital: _____

Were x-rays performed? ☐ Yes ☐ No Date:_____/_____/_____ Results: _____

MRI/CT performed? ☐ Yes ☐ No Date:_____/_____/_____ Results: _____

Additional treatment date(s) for this condition: (MM/DD/YYYY) _____/_____/_____ _____/_____/_____

_____/_____/_____ _____/_____/_____

Name of Hospital:

_____

Hospital Address (Street/City/State/Zip):

_____

Hospital Telephone Number:	Dates Confined: (MM/DD/YYYY)
_____-_____-_____	_____/_____/_____ through _____/_____/_____
Hospital Fax Number:	Admission Time: _____AM/PM Discharge Time: _____AM/PM
_____-_____-_____	_____/_____/_____ through _____/_____/_____
	Admission Time: _____AM/PM Discharge Time: _____AM/PM

Hospital Stay Type: (if applicable)	Was the patient admitted to the ICU? ☐ Yes ☐ No
☐ Inpatient ☐ Outpatient ☐ Observation	

Nature of Surgical Procedure: (Describe fully, and provide CPTS and/or operative report)

_____

Section G - Physician's Statement (to be completed by Physician) (Continued)

Has the patient ever had same or similar condition? ☐ Yes ☐ No	If Yes, please provide dates: (MM/DD/YYYY) _____/_____/_____ _____/_____/_____
Predisposing risk factors or conditions related to the diagnoses, with dates: _____/_____/_____ _____/_____/_____ _____/_____/_____	
Was this patient referred to you by another physician? ☐ Yes ☐ No If Yes, please provide the following: Physician's Name: _____/_____ Address: _____ City/State/Zip: _____/_____/_____	

Physician Verification

Fraud Notice: The statements on the previous page are true and complete to the best of my knowledge and belief.

Print Full Name: (First, Middle, Last) _____/_____/_____	
Medical Specialty: _____	
Phone Number: _____/_____/_____	Fax Number: _____-_____-_____
Address: _____	
City/State/Zip: _____	
Signature of Physician: _____	Date: (MM/DD/YYYY) _____/_____/_____
Tax ID Number: _____	NPI Number: _____
Are you, the physician, related to the patient? ☐ Yes ☐ No If Yes, what is the relationship? _____	

FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.

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 FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

ALASKA: 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.

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

ARKANSAS, RHODE ISLAND AND WEST VIRGINIA: 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.

CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATIONTO 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.

COLORADO: 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 SERVICES.

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.

DISTRICT OF COLUMBIA: 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.

FLORIDA: 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.

KANSAS: A PERSON MAY BE GUILTY OF FRAUD AS DETERMINED BY A COURT OF LAW, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD AN INSURANCE COMPANY OR OTHER PERSON FILES 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.

LOUISIANA: 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.

MAINE: 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.

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

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

NEW MEXICO: 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.

NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR 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, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

NORTH CAROLINA: PROHIBITED ACT. - IT IS UNLAWFUL FOR A PERSON TO, WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE AN INSURER OR INSURANCE CLAIMANT, DO EITHER OF THE FOLLOWING: (1) PRESENT OR CAUSE TO BE PRESENTED A WRITTEN OR ORAL STATEMENT, INCLUDING COMPUTER-GENERATED DOCUMENTS AS PART OF, IN SUPPORT OF, OR IN OPPOSITION TO, A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR MATTER MATERIAL TO THE CLAIM. (2) ASSIST, ABET, SOLICIT, OR CONSPIRE WITH ANOTHER PERSON TO PREPARE OR MAKE ANY WRITTEN OR ORAL STATEMENT THAT IS INTENDED TO BE PRESENTED TO AN INSURER OR INSURANCE CLAIMANT IN CONNECTION WITH, IN SUPPORT OF, OR IN OPPOSITION TO, A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS FALSE OR MISLEADING INFORMATION CONCERNING A FACT OR MATTER MATERIAL TO THE CLAIM.

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

OKLAHOMA: 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.

OREGON: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A MISSTATEMENT, MISREPRESENTATION, OMISSION OR CONCEALMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

PENNSYLVANIA: 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 CIVIL PENALTIES.

PUERTO RICO: ANY PERSON WHO KNOWINGLY AND WITH THE INTENTION OF DEFRAUDING PRESENTS FALSE INFORMATION IN AN INSURANCE APPLICATION, OR PRESENTS, HELPS, OR CAUSES THE PRESENTATION OF A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR ANY OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME DAMAGE OR LOSS, SHALL INCUR A FELONY AND, UPON CONVICTION, SHALL BE SANCTIONED FOR EACH VIOLATION BY A FINE OF NOT LESS THAN FIVE THOUSAND DOLLARS ($5,000) AND NOT MORE THAN TEN THOUSAND DOLLARS ($10,000), OR A FIXED TERM OF IMPRISONMENT FOR THREE (3) YEARS, OR BOTH PENALTIES. SHOULD AGGRAVATING CIRCUMSTANCES BE PRESENT, THE PENALTY THUS ESTABLISHED MAY BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS, IF EXTENUATING CIRCUMSTANCES ARE PRESENT, IT MAY BE REDUCED TO A MINIMUM OF TWO (2) YEARS.

TENNESSEE, VIRGINIA, AND WASHINGTON: 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.

TEXAS: 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.

VERMONT: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE OR CLAIM FOR PAYMENT OF A LOSS OR BENEFIT MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

FOR ALL OTHER STATES. A PERSON MAY BE COMMITTING INSURANCE FRAUD IF HE OR SHE SUBMITS AN APPLCIATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.