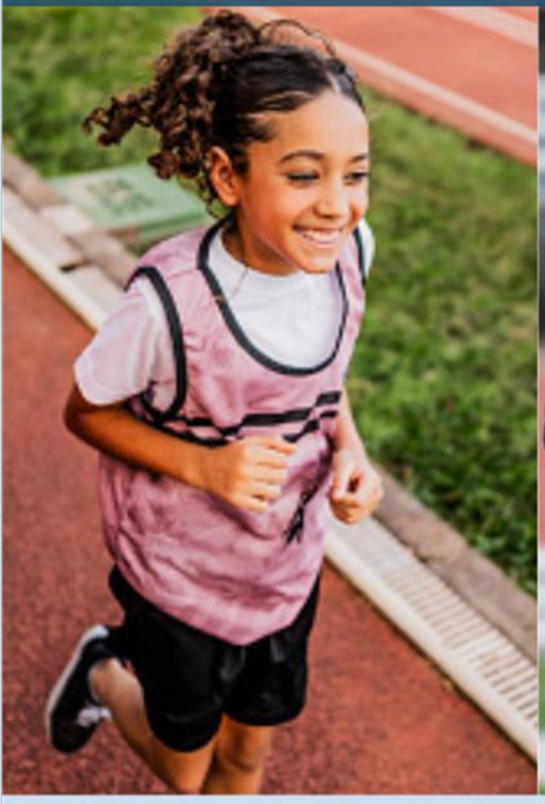
BENEFIT OVERVIEW – VOLUNTARY PARTICIPANT ACCIDENT INSURANCE.



THE HARTFORD

24 HOUR ACCIDENT COVERAGE

Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12…… $88.00

SCHOOL TIME ACCIDENT COVERAGE

Provides coverage while in attendance at school during the hours and on the days that school is in session. Includes traveling directly and without interruption to or from the Insured's residence and the school for regular school session, for such travel time as is required, but not to exceed one hour after school is dismissed, or if additional travel time on the school bus is required, coverage here under shall extend for such additional travel time as might be necessary. Participation in or attending an activity exclusively organized, sponsored and solely supervised by the school and while under the supervision of school employees Travel is limited to school supervised transportation. SEE EXCLUSIONS.

Full Time, Registered Student K-12..... PAID

CONDITIONS

The accident must be reported immediately to a school authority under the School Time Coverage. Under the 24 Hour Coverage report the accident to the school or Lefebvre Insurance (the address is below). The claim form must be filed with the Company within 90 days after the accident. Covered Excess Expenses must be incurred within 90 days from the date of accident. Related expenses are eligible for up to two years from the date of accident. A claim for those Covered Expenses must be submitted to the Company for payment as soon as reasonably possible, but no later than one year from the date of service. It is the parent's responsibility to file the claim form within 90 days.

Direct All Questions and Correspondence To:

Lefebvre Insurance, LLC
901 Pleasant Street, #1413
Attleboro, MA 02703
1-800-451-9668
1-508-384-0101

This brochure is not a contract. It is simply an illustration of benefits. You may read the master policy at the school district office. You will not receive an Individual Accident Policy. Keep your cancelled check, as it is proof of purchase. **DO NOT SEND CASH.**

OPTIONAL $100,000.00 Extended Dental Benefit

When this option is purchased, the basic dental benefit will be extended to provide for the Usual & Customary Charges for Dental Treatment of a Dental Injury expenses incurred within 2 years from the date of the Covered Injury. Also included in this benefit are the following:

1. for Treatment of an Injury to sound, natural teeth, including examinations, x-rays, endodontics and oral surgery, Bridge or Orthodontics, dental or similar repair (new or replacement) that must be postponed to a date more than 104 weeks after the date of that Injury due to the physiological changes occurring to an Insured Person who is a growing child.
2. Expenses are not covered unless a Physician submits a written certification that the Treatment must be postponed for the reasons stated in the paragraphs above. Such certification must be submitted to Us within 104 weeks after the Injury.

Full Time, Registered Student K-12 ..... $9.00
This coverage cannot be purchased without School Time or 24 Hour coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT

When Injury shall result in any one of the following losses within 180 days from the date of accident, the company will pay for loss of:

Life	$5,000
($15,000 for a death under the Sports Condition of Coverage)	
Both Hands or Both Feet or Sight of Both Eyes	$20,000
One Hand and One Foot	$20,000
One Hand and Sight of One Eye	$20,000
One Foot and Sight of One Eye	$20,000
Speech and Hearing in Both Ears	$20,000
Speech and Hearing in One Ear	$15,000
One Arm or One Leg	$15,000
One Hand or One Foot	$10,000
Sight of One Eye	$10,000
Speech or Hearing in Both Ears	$10,000
Thumb and Index Finger on the Same Hand	$5,000
Hearing in One Ear	$5,000
One Thumb	$2,000

Loss of Arm means Severance of an arm above the elbow joint, including the Severance of the entire arm. Loss of Both Feet, Loss of One Foot means Severance of a foot or both feet above the ankle joint, including the Severance of an entire leg or any part of a leg that includes an entire foot. Loss of Both Hands, Loss of One Hand means Severance of at least four whole fingers at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand) from one or both hands, including the Severance of an entire arm or any part of an arm that includes an entire hand. Loss of Fingers or Thumb means Severance of more than one finger or the thumb at least at or proximal to the first interphalangeal joint of each finger. Loss of Hearing means total and permanent loss of hearing in one or both ears which cannot be corrected by any means. Loss of Leg means Severance of a leg above the knee joint, including the Severance of the entire leg. Loss of Sight of Both Eyes, Loss of Sight of One Eye means total and permanent loss of sight or blindness which cannot be corrected by any means, or Severance of one or both eyes. Loss of Speech means total and permanent loss of audible voice communication which cannot be corrected by any means. Severance means the complete separation and dismemberment of the part from the body. If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

Effective & Termination Date

Coverage begins at 12:01 AM on the date the School receives a completed application and payment of premium. Otherwise, coverage begins on the day of receipt of the application and the first official day of school or the first official practice of interscholastic athletics/activities.

The coverage terminates on the date the Insured ceases to be a registered student or the termination date of the policy, whichever occurs first. If the student, teacher, or administrative employee moves or transfers to another Public or Parochial Day School, the student, teacher, or administrative employee will be covered at the new school until this policy expires. If the premium check is returned from the bank for any reason, the coverage is null and void.

All other coverages end when School begins regularly scheduled classes for the following School term.

THIS INSURANCE DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES.

ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $1,000,000 MEDICAL EXPENSE

The company will pay Usual and Customary Expenses incurred for a Covered Injury if treatment is received within 90 days after the Injury. The Schedule of Benefits are stated below. Benefits are payable for 52 weeks from the date of the Injury.

MAXIMUM BENEFITS

Hospital:
Daily Room & Board (Semi-private) …... up to $800 per day
Intensive Care Room & Board…. Usual & Customary (not to exceed $1,000/day for 7 days)

Hospital Miscellaneous Expenses:
During Hospital Confinement or when surgery is performed…….. up to $800/day
Emergency Room out-patient: when Hospital Confinement is not required ..... $500 Max

Physician Services:
expenses for Treatment provided by a Physician……
Surgery…….. $5,000 Max

Anesthesia: (including administration) and assistant surgeon: (25% of surgical allowance)
Includes office visits other than for Physiotherapy or similar treatment when no surgery benefit is paid ..... Usual & Customary

Consultants (when required by attending physician for confirmation or determining a diagnosis, but not for treatment) and second opinion…….Up to $250 Max

Laboratory & Radiological Procedures:
Other than Dental and including fee for interpretation and/or reading of X-ray when not Hospital Confined ..... Up to $750 Max
Lab ..... Up to $500 Max
MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for interpretation and/or reading . . . . Up to $500 Max

Additional Services:
Physiotherapy or similar treatment:
In-Hospital or out of Hospital……Usual & Customary (Maximum of 10 visits)
Chiropractic Care (in or out of hospital) ……. Up to $200.00
Registered Nurse (in or out of hospital) ... Usual & Customary
Ambulance to initial treatment facility …... Usual & Customary

Durable Medical Equipment Rental "Orthopedic Appliances":
In-hospital $950
Out of Hospital $500
Outpatient Drugs & Medication:
Administered by a Doctor ..... Usual & Customary
Eyeglasses, contact lenses, and hearing aids when damage occurs in a Covered Accident that requires medical Treatment ……..$600.00

Dental Services:
For Treatment, repair or replacement of injured natural teeth, includes braces when required for Treatment of covered Injury as well as examination, x-rays, restorative Treatment, endodontics, oral surgery, and Treatment for gingivitis resulting from trauma for which pulpal tissues are healthy and intact; and replacement of caps, crowns, dentures, and orthodontic appliances (including braces), fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services as a result of an Injury . . . Up to $500 per tooth, Max $10,000

Primary Benefits
This Rider pays the Usual and Customary Charges without regard to coverage under any other Benefit Plan only after the Insured Person satisfies any Deductible. Expenses must be incurred within the Maximum Benefit Period shown in the Rider Schedule. The Maximum Amount per Insured Person payable under this Rider is shown in the Rider Schedule. We pay benefits without regard to any coordination of benefits provisions in any other Benefit Plan.

EXCLUSIONS AND LIMITATIONS

Exclusions: The policy does not cover any loss incurred as a result of:

Limitation for Motor Vehicle Accidents
Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Accident that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed $5,000.

Excluded Expenses

For the purposes of this Accident Medical Benefit, the following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. expenses payable by any automobile insurance policy without regard to fault;
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses; and
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.

Exclusions

In addition to the exclusions in the Policy, We will not pay benefits for any loss, Treatment, or services resulting from, or contributed to, by:

1) intentionally self-inflicted Injury, suicide, or attempted suicide, whether sane or insane;
2) war or act of war, whether declared or undeclared;
3) Injury sustained while in the armed forces (land, water or air) of any country or international authority;
4) Injury sustained while in or on, boarding or alighting from, being struck or run down by, any aircraft except as an airline passenger on an aircraft:
    a) operated by a passenger airline on a regularly scheduled trip over its established route or that is chartered by that airline; or
    b) any transport type aircraft operated by the Military Airlift Command (MAC) of the United States or any national government recognized by the United States;
5) repair or replacement of artificial limbs or orthopedic braces;
6) Injury for which the Insured Person is eligible to receive Workers' Compensation benefits or similar benefits, regardless of whether he or she has applied for the benefits;
7) Injury sustained or contracted as a consequence of the Insured Person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a licensed Physician;
8) Injury sustained by an Insured Person while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;
9) Injury sustained as a result of the Insured Person's being legally intoxicated from the use of alcohol while operating a motor vehicle;
10) Expenses incurred for services, Treatment, supplies or facilities rendered by:
    a) the Policyholder's health service or infirmary; or
    b) any Physician or nurse employed or retained by the Policyholder;
11) pregnancy, childbirth, elective abortion, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
12) Complications of Pregnancy or miscarriage, except as a result of a Covered Accident;
13) elective or cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
14) orthopedic appliances used mainly to protect an Injury, so the Insured Person can participate in a Covered Activity interscholastic, intercollegiate or club sports;
15) expenses paid or payable under any mandatory no fault automobile insurance policy without regard to fault; (This exclusion does not apply in any state where prohibited.);
16) Treatment or service provided by a private duty nurse;
17) routine physical exams and medical services or wellness visits;
18) overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, frostbite, malfunctions of the heart, embolism, reinjuries or the aggravation thereof, sprains, hernia, strains, muscle tears, or repetitive motion Injury, and/or Treatment of Injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal result of participation in a Covered Activity, except as specifically provided in the Rider;
19) expenses due to an aggravation or re-Injury of a Pre-existing Condition;
20) expenses incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
21) Mental and Nervous Disorders;
22) Medical Emergency Evacuation;
23) Experimental or Investigative Treatment or procedures;
24) Treatment of any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

IMPORTANT NOTICE: This information is a brief description of the important benefits and features of the Accident Medical Insurance Plan underwritten by Hartford Fire Insurance Company. It is not intended to serve as the prevailing insurance contract. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth within the policy form, and said policy form will prevail in the event of any discrepancies. Any policy issued is subject to the laws of the jurisdiction in which it is issued.

THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES

DO NOT SEND CASH

ENROLLMENT FORM

Please Print

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOME ADDRESS APT#

CITY STATE ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

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 act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE OF PARENT OR GUARDIAN DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

School Year Rate – ✓ CHECK YOUR SELECTION

COVERAGE PLANS	PREMIUMS
BEST BUY! 24-Hour	☐ $88.00
School Time	PAID
Dental Accident Insurance (with either of the above plans)	☐ $9.00

Make checks payable to The Hartford Insurance Company.

HOW TO ENROLL

1. Decide whether you want the 24-Hour Accident Protection plan, with or without the Extended Dental Plan.
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to The Hartford Insurance Company for the correct amount.
3. Mail envelope to Lefebvre Insurance LLC, 901 Pleasant Street, #1413 Attleboro, MA 02703.
   Your cancelled check or money order stub will be your receipt and confirmation of payment.
   (Please write the student's name and school name on your check.)

HOW TO FILE A CLAIM

Claims Administrator:	**NAHGA** **P.O. Box 189** **Bridgton, ME 04009** **Phone number: 1-888-998-2240** **Fax number: 1-207-647-4569** **Email address:** claims@nahga.com

Claim Procedures:
Always keep a copy of all claim related documents. Written proof of loss should be submitted within 90 days from the date of service.

Step 1: Submit a completed Notice of Claim to the claim's facility by fax or mail

- ***Part I – Policyholder's Statement***

Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan. Provide any necessary attachments.

- ***Part II – Claimant's Statement***

Form is to be completed in its entirety and signed by the Claimant or their parent/guardian. Read and sign the Important Notice on page 4.

Step 2: Submit itemized medical bill(s) and supporting documentation to NAHGA.

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting company Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.TheHartford.com. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. © 2024 The Hartford

Blanket Accident Form Series includes BSR-1000, BSR-1200 or state equivalent.

NOT AVAILABLE IN ALL STATES.

Participant Accident
Statement of Claim for
Medical Expense Benefits

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Medical Expense benefits under a Participant Accident policy.

Step 1: Submit a completed Notice of Claim to our office by fax or mail

Part I – Policyholder's Statement

☐ Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.

☐ Provide any necessary attachments (see Section D).

Part II – Claimant's Statement

☐ Form is to be completed in its entirety and signed by the Claimant or their parent/guardian.

☐ Read and sign the Important Notice on page 4.

Step 2: Submit itemized medical bill(s) and supporting documentation (see below)

Helpful Information for submitting claims and expediting payment

- If the Participant Accident Policy provides coverage on an Excess basis, you must file your bills through your primary insurance carrier prior to filing for benefits under this Policy. The Explanation of Benefits (EOB) that corresponds with the medical bill(s) that have been processed by the other carrier must be submitted with your claim. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.
- A fully-completed Notice of Claim is required for each accident/injury a Claimant incurs. Submitting incomplete information will delay the processing of your claim.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date(s) of service, diagnosis, procedure code(s), amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough detail to process the charges. Accordingly, we recommend providers submit standardized billing statements, specifically, UB-04 forms for hospital charges and/or CMS-1500 forms for physician charges.
- Claim payment is sent directly to the medical providers unless proof that a Claimant has paid the bill in whole or in part (e.g., a copy of check or balance statement) is received.

Please detach this page and forward the completed Statement of Claim and supporting documentation to the address listed below. We recommend you retain copies of the items you have submitted for future reference.

Submit claim by mail to: P.O. Box 189
Bridgton, ME 04009

Phone number: 1-888-998-2240
Fax number: 1-207-647-4569
Email address: claims@nahga.com

Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization.

Please verify if the insured qualifies for any other group benefits through The Hartford and submit the claim accordingly.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

P.O. Box 189
Mail forms to: Bridgton, ME 04009

Phone number: 1-888-998-2240
Fax number: 1-207-647-4569
Email address: claims@nahga.com

THE HARTFORD

Participant Accident
Statement of Claim for Medical Expense Benefits

PART I - POLICYHOLDER'S STATEMENT – To be completed by the Official Representative of the Policyholder/Plan

A. Information About the Policyholder

Policy Number:	Policyholder Name:	
Policyholder Email Address:	Policyholder Telephone Number: ( )	Policyholder Fax Number: ( )
Policyholder Address (Street, City, State, & Zip Code):		
Participating Organization (or "n/a" if this does not apply):	Class (or "n/a" if this does not apply):	

B. Information About the Claimant

Claimant Name:	Claimant DOB:	Claimant Social Security Number:
Claimant Address (Street, City, State, & Zip Code):		Claimant Telephone Number: ( )

C. Information About the Claim

Medical Expense benefits claimed due to:

☐ Contagious and Infectious Disease ☐ Accidental Injury ☐ Heart or Circulatory Malfunction ☐ Sickness

For claims due to injury, complete the following:

Date of Accident:	Time of Accident (hh:mm): ☐AM ☐PM	Place of Accident:
Nature of injury(ies):		
Fully describe the circumstances of the Accident (Use a separate sheet of paper, if necessary):		

For claims due to illness, complete the following:

Nature of illness:	Date illness first commenced:
Fully describe the circumstances of the sickness (Use a separate sheet of paper, if necessary):	

D. Required Attachments and Signature

Please attach copies of the following documents as applicable:

- Medical information from the Claimant's file relating to this injury/illness, if available.
- Incident/police reports relating to the Incident.

I hereby certify the Insured is a member of the group insured under the above Policy and the loss was sustained under adequate supervision while participating in an official Covered Activity.

I certify that the information provided on the Policyholder's Statement is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by The Hartford and/or its representative.

Title of Policyholder Official	Signature of Policyholder Official	Date

Mail forms to: P.O. Box 189
Bridgton, ME 04009

Phone number: 1-888-998-2240
Fax number: 1-207-647-4569
Email address: claims@nahga.com

THE HARTFORD

Participant Accident
Statement of Claim for Medical Expense Benefits

PART II – CLAIMANT'S STATEMENT – To be completed by the Adult Claimant or parent/guardian if Claimant is a minor

A. Information about the Claimant

Name: (Last, First, Middle Initial)	Date of Birth:	Social Security Number:
Address: (Street, City, State, & Zip Code)		Gender: ☐ Male ☐ Female

Name of Parent/Guardian and relationship to Claimant (if applicable):

Phone Numbers:
Daytime: (____) _____ Evening: (____) _____ Personal Cell Phone: (____) _____
E-mail Address: _____
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐Yes ☐No and/or request this by E-mail? ☐Yes ☐No

_____ _____
Signature Date

Please indicate any other sources of medical insurance under which the Claimant is covered:

Medicare	☐	Mother's Employer's policy*	☐
Medicaid	☐	Father's Employer's policy*	☐
Employer's policy*	☐	Guardian's Employer's policy*	☐
Spouse's Employer's policy*	☐	Any other medical policy*	☐

*If Yes and the Participant Accident Policy provides coverage on an Excess basis, please include the other carrier(s) Explanation of Benefits (EOB) for each medical bill submitted. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.

B. Information about the Claimant's condition

1. For injury, answer the following questions:

When, where, and how did the injury occur?

Name and address of law enforcement agency involved and Case Number (if applicable):

2. For illness, answer the following questions:

What were the first symptoms?	
When did the symptoms begin?	Has the claimant had this illness before? ☐ Yes ☐ No If Yes, when?

3. For injury or illness, answer the following questions:

Date of initial treatment:	Nature of treatment received to date:

Is further treatment anticipated? ☐ Yes ☐ No If Yes, nature and duration of expected treatment:

C. Certification

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have read and signed the Important Notice on page 4 of this form. I also authorize any physician/hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.

_____ _____
Signature of Adult Claimant or Parent/Guardian Date

Important Notice - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of Arizona: 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.

For 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 fines or confinement in prison, or any combination thereof.

For Residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

For residents of Maine, Tennessee, 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 may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing 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.

For residents of Oklahoma: 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of 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.

For residents of Virginia: Any person who, with the 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 may have violated the state law.

For residents of New York: 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____