NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America
New York Life Group Insurance Company of NY
Connecticut General Life Insurance Company

Mail Completed Form to:
New York Life Group Benefit Solutions
Pittsburgh Claim Service Center
P.O. Box 22328
Pittsburgh, PA15222-0328
Toll Free Number: 1.800.238.2125
Fax Number: 877.300.6770

CLEAR FORM

Accelerated Benefits Claim Form

NEW YORK FRAUD WARNING: 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 $5000 and the stated value of the claim for each such violation.

CAUTION: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***Arizona, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Vermont, Virginia or Washington.***

NOTICE TO NEW YORK RESIDENTS: No health care facility as defined in Section 20 of the New York Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

This Form Is for Accelerated Benefits Proceeds Only, A Feature of Your Life Insurance Policy.

This Claim Will Be Subject to Delay Or Return If These Instructions Are Not Followed.

To the Employer/Administrator: Complete the employer section of the form and deliver to the employee for submission to the assigned Claim Office.

To Be Completed by the Employer/Administrator for Employee and Dependent Benefits

Name of Employee (Last Name) (First Name) (Middle Initial)	Date of Birth	Social Security Number	Sex ☐ M ☐ F

Street Address City State Zip Code	Telephone Number

Insured's Marital Status
☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced ☐ Domestic Partner Relationship ☐ Civil Union

Policy Number	Occupation	Was Insurance Issued on The Basis Of Evidence? ☐ Yes ☐ No

Please Check the Appropriate Blocks Regarding the Insured's Employment Status.
☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local Number _____ ☐ Salaried ☐ Full-time
☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

Hours per week _____

Basic Annual Earnings	Date of Last Earnings Change	Date of Last Benefit Increase	**Full** Face Amount of Insurance Basic: _____ Voluntary: _____

Date Hired	Effective Date of Insurance	Last Date Worked	Premium Paid Through Date

% Of Insured's Contribution to Premium Basic: ____% Voluntary: ____%	Insured's Contribution Were Made On ☐ Pre-Tax or ☐ Post Tax	Has Employee Qualified for Premium Waiver? ☐ Yes ☐ No	If Yes, As of What Date?

To Be Completed if Claim is for Dependent Benefits

Name of Dependent (Last Name) (First Name) (Middle Initial)	Date of Birth	Social Security Number	Sex ☐ M ☐ F

Relationship to Employee	**Full** Face Amount of Dependent Insurance Policy Basic: _____ Voluntary: _____	Dependent's Occupation

Employer/Administrator's Certification

Name of Employer	Occupation	Email Address

Address (Street) (City) (State) (Zip Code)	Telephone Number

This is to certify that the facts as indicated above are true to the best of my knowledge and belief.

Signature of Authorized Representative _____ Title _____ Date Signed _____

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Instructions for Filing *(Complete All Information)*

Important
Instructions for Employer:

- Please complete the sections on page 1 of this form.
- Please provide a copy of the beneficiary designation.
- If the employee has voluntary or optional benefits, please provide proof of election or enrollment.
- Please provide this form and copies of the enrollment forms and beneficiary designation to the employee for his/her completion and submission to the claim office.

Instructions for Employee:

- Please complete the sections on pages 3, 4 and 5 of this form and review the NYL GBS Survivor Assurance Program Disclosure Notice and the Important Claim Notice.
- You must indicate which benefit you are applying for and the percentage applied for. If unsure about what benefits are available in your plan, please check your employee benefits booklet or plan or contact your human resources or benefits administrator.
- Please provide the requested information and dates regarding your condition.
- Be sure to provide the name, address, and telephone number of the Physician/s who has treated you or is familiar with your condition. The claim office will be writing to the Physician/s to confirm that you are eligible for benefits.
- Complete the requested information on your medical treatments within the past five years.
- Please sign the claim form.
- Please sign and date the Disclosure Authorization.
- If you are unable to sign the claim form, someone else must sign for you, indicate their relationship to you, and provide written proof of their ability to legally sign for you.
- Please forward the fully completed form with copies of your enrollment forms and beneficiary designation to New York Life Group Benefit Solutions, Pittsburgh Claim Service Center, P.O. Box 22328, Pittsburgh, PA 15222-0328.

Benefit Information - To Be Completed by the Employee

Benefit Applied For	Benefit Applied For **(If applicable)**	Date Diagnosed	Date of First Treatment
☐ Terminal Illness ☐ Specified Disease/ Critical Illness ☐ Nursing Care/ Custodial Care	Basic: ____% Voluntary: ____%		

Diagnosis or Nature of Condition

Please Provide the Name, Address and Telephone Number of Two (2) Physicians Familiar with The Insured's Condition.

Name of Physician _____
Address _____
City _____ State _____ Zip _____
Telephone Number _____ Fax Number _____

Name of Physician _____
Address _____
City _____ State _____ Zip _____
Telephone Number _____ Fax Number _____

Name Of Any Other Physicians, Hospitals, Or Clinics Treating Within the Past Five Years
(If applying for Terminal Illness, you must furnish one additional Physician Name)

Name	**Address**	**Treatment Period**

Portability/Conversion
Have You Applied for Portability? ☐ **Yes** ☐ **No** Application Date: _____
Have You Applied for Conversion? ☐ **Yes** ☐ **No** Application Date: _____

Please Provide the Name of Your Medical Insurance Carrier _____

Have You Ever Been Paid a Terminal Illness or Specified Disease Benefit? ☐ **Yes** ☐ **No**

Are You Subject to a Qualified Domestic Relations Order? ☐ **Yes** ☐ **No**

Assignment Made/Irrevocable Beneficiary Designated? ☐ **Yes** ☐ **No**
If, yes, assignee/irrevocable beneficiary's signature required below giving permission for release of benefits to insured with the concurrence that such signature will release interest/rights to policy proceeds to insured.

Signature of Assignee/Irrevocable Beneficiary _____ Date _____

I Certify that the Foregoing Statements are True, Correct and Complete

Signature of Claimant _____ Date _____

Note: The insurance carrier will report the amount of this distribution to the IRS on a Form 1099 LTC. The benefit may be TAXABLE INCOME. Your ability to receive certain government benefits/entitlements may be affected by receipt of this benefit. The insurance carrier recommends that you seek advice from a tax advisor and/or attorney if you have any questions about how the election of this benefit may affect your personal situation. Please remember that the face amount of the insurance policy will be reduced by any accelerated benefit amount paid. Premium payable will be calculated based on the full amount of the death benefit before any reductions were made due to the accelerated benefits paid.

New York Life Group Benefit Solutions (NYL GBS) Survivor Assurance

If your insurance benefit is $5,000 or more, NYL GBS will automatically open a free, interest-bearing account in your name. This account, called the NYL GBS Survivor Assurance, is a convenient and secure place to keep your proceeds while you decide how to best use them. Please review the attached NYL GBS Survivor Assurance Disclosure Notice for full details about the account.* Account balances are the liability of the insurance company and are not insured by the Federal Deposit Insurance Corporation or any federal agency. The insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than $5,000, NYL GBS will send you a check for the total benefit amount.

*Please read the NYL GBS Survivor Assurance Disclosure Notice before signing below.

I understand that if my benefit is $5,000 or more, I will receive a NYL GBS Survivor Assurance account.

I understand that I may write a draft for the total amount in my account at any time.

I understand that the account balance may be reduced for any benefit payment by the insurance company made in error.

I acknowledge that, if I do not separately sign the NYL GBS Survivor Assurance Section of this Claim Form, I am not participating in the NYL GBS Survivor Assurance and that I will receive a single lump sum check for the proceeds due if my claim is approved.

Signature* Date

*Please sign as you would sign on a check, as signature may be used for draft verification.

The issuance of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

GROUP BENEFIT SOLUTIONS

Disclosure Authorization

Claimant's Name: _____

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and relates to information necessary to administer benefits and services under Employer's employee health and welfare plan(s) ("the Plan") and statutory and/or private leave of absence or job accommodation programs. "Employer" is defined to mean your employer, or your family member's employer to the extent benefits, services, or leave are being sought under your family member's employer's Plan. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers may not be able to process your (or your family member's) request for benefits or services under the Plan or statutory and/or private leave of absence or job accommodation programs.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; social security disability advocate or representative; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits, to provide access to or copies of this information (whether by written, telephonic or electronic means) to Life Insurance Company of North America; New York Life Group Insurance Company of NY (Life Insurance Company of North America and New York Life Group Insurance Company of NY shall be collectively referred to as "Insurance Company"); and any other individual or entity (including nonaffiliated third parties) that provides services to or insurance benefits on behalf of the Plan and/or Employer's statutory and/or private leave of absence or job accommodation programs. If I am also covered by Cigna Health and Life Insurance Company or its affiliates ("Cigna"), I authorize Insurance Company to disclose the health and other information described above to Cigna to assist me with my health coverage and to provide its services and benefits. This information will be shared to coordinate benefits and provide other services to you.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes or genetic information.

I agree and understand that any information obtained with this authorization may be used and disclosed for the following purposes: 1) evaluating and administering coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan; 2) evaluating and administering services related to Employer's statutory and/or private leave of absence or job accommodation programs; 3) determining my eligibility for any governmental benefits similar to or that coordinate with benefits available to me under the Plan and assisting me in applying for such benefits; and 4) evaluating and administering benefits or services under any other plans sponsored by or offered through Employer such as health management, disease management, wellness, or employee/member assistance programs.

I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by HIPAA or other federal regulations governing the privacy of health information, although it may continue to be protected by other applicable privacy laws and regulations. I further understand that if any information is used for services relating to Employer's leave of absence or job accommodation programs, that information may be disclosed to Employer at any time. Additionally, I understand that information may be disclosed to the employee who elected my coverage or submitted a claim for benefits under my coverage, or requested leave.

This authorization shall be valid for 12 months or the duration of my claim for insurance benefits, whichever is longer. I also understand that Insurance Company will maintain a copy of this authorization, and that I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan or Employer's statutory and/or private leave of absence or job accommodation programs who rely on this authorization may not be able to evaluate or administer any request for benefits, coverage or services and that any request for benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling the claim.

(Claimant's Signature) _____ (Date Signed) _____

(Print Name) _____ (Date of Birth) _____

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

CLICK TO PRINT

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New York Life Group Benefit Solutions (NYL GBS)
Survivor Assurance Disclosure Notice

NYL GBS Survivor Assurance Disclosure

If your insurance benefit is $5,000 or more, NYL GBS will establish a free, interest-bearing draft account in your name. This account is a convenient and secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts (checks) will be mailed to you, once your claim has been approved. Personalized drafts are provided free of charge, and there are no per-draft fees, maintenance charges or penalties for withdrawal. There are charges for the following special services: drafts returned unpaid ($10), stop payment ($12) and copy of draft or statement ($2).

You will receive a quarterly statement for your NYL GBS Survivor Assurance account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. You may also check your account balance online at any time at www.nylgbssurvivorassurance.com.

Drafts are cleared through a draft account at BNY Mellon Bank (contact information on next page). NYL GBS's obligation to pay is satisfied by depositing the total proceeds in the retained asset account. Drafts draw upon funds held by NYL GBS (whereas a "check" draws upon funds held by a banking institution). You may write an unlimited number of drafts, in any amount, at any time up to your account balance. If you wish to withdraw the proceeds in full, you can write a draft for the total amount of the account at any time. You also have the right to receive an initial lump-sum payment in the form of a bank check. Please note that NYL GBS reserves the right to reduce account balances for any payment made in error. You also have the right to name a beneficiary to your account. If an account becomes inactive (as defined by your State's Department of Insurance), NYL GBS will return any remaining balance held in a RAA to your State of residence if no named beneficiary can be located.

This account is not insured by the Federal Deposit Insurance Corporation or any federal agency, but is guaranteed by the state guarantee association. Please contact the National Organization of Life and Health Insurance website (www.nolhga.com) to learn more about the coverage limitations to the account under a state guaranty association.

All funds are held by Life Insurance Company of North America or New York Life Group Insurance Company of NY. Like a bank, the insurance company may earn money on the invested amounts that exceeds the interest credited to the account and the cost of any other additional benefits and services.

Disclosure on Interest Earned

You earn an attractive interest rate on the funds in your NYL GBS Survivor Assurance Account from the day it is established until the date it is closed. The NYL GBS Survivor Assurance interest rate is reviewed weekly and will be based upon the previous week's Bank Rate Monitor Index (BRM) or any successor money market index. The BRM Index is the average annual effective yield earned on the money market accounts offered by 100 large US Bank and Thrifts across the country. Any amount that remains in the account will continue to earn interest at a rate equal to the national average bank money market rate.

Please call our toll-free number 855.836.0697 for the current rate. Both your principal and any interest you earn are guaranteed by the insurance company. Any interest earned on the account may be taxable and you should consult a tax, investment, or other financial advisor regarding tax liability and investment options. Interest earned on your account is compounded daily and is credited to your account at the end of each month. All funds, including earned interest, are fully guaranteed by the insurance company.

If you have additional questions or would like additional information about the NYL GBS Survivor Assurance, you can **call us at 800.570.3778**

Or write us at: NYL GBS Survivor Assurance
PO Box 534029
Pittsburgh, PA 15253-4029

For further information, please contact your State Department of Insurance using the information provided on the next page.

Draft Accounts are setup by BNY Mellon Bank, located at 500 Ross Street, Pittsburgh, PA 15262.

The issuance of this notice is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights with respect to the insurance.

NYL GBS Survivor Assurance Disclosure Notice

State Insurance Department Contact Information

Alabama
PO Box 303351
Montgomery, AL 36130
(334) 269-3550
www.aldoi.gov

Alaska
PO Box 110805
Juneau, AK 99811
(907) 465-2515
https://www.commerce.alaska.gov/web/ins/

Arizona
100 N. 15th Ave, Suite 261
Phoenix, AZ 85007-2630
(602) 364-3100
https://insurance.az.gov

Arkansas
1 Commerce Way, Bldg 4, Suite 502
Little Rock, AR 72202
(800) 282-9134
www.insurance.arkansas.gov

California
300 South Spring Street, 14th Floor
South Tower
Los Angeles, CA 90013
(800) 927-4357
www.insurance.ca.gov

Colorado
1560 Broadway, Suite 850
Denver, CO 80202
(800) 930-3745
https://doi.colorado.gov/

Connecticut
153 Market Street, 7th Floor
Hartford, CT 06103
(800) 203-3447
www.ct.gov/cid/site/default.asp

Delaware
Delaware Dept of Insurance
1351 W. North Street, Suite 101
Dover, DE 19004
(800) 282-8611
http://insurance.delaware.gov

District of Columbia
1050 First Street, NE, Suite 801
Washington, DC 20002
(202) 727-8000
http://disb.dc.gov

Florida
The Edwin A. Larson Building
200 East Gaines Street, RM 1001A
Tallahassee, FL 32399
(877) 693-5236
www.floir.com

Georgia
Office of Insurance and
Safety Fire Commissioner
Two Martin Luther King, Jr. Drive
West Tower, Suite 704, Floyd Bldg.
Atlanta, Georgia 30334
(800) 656-2298
https://oci.georgia.gov

Hawaii
PO Box 3614
Honolulu, HI 96811
(808) 586-2790
https://cca.hawaii.gov/ins/

Idaho
700 West State Street
PO Box 83720
Boise, ID 83720
(208) 334-4250
www.doi.idaho.gov

Illinois
122 S. Michigan Avenue, 19th Floor
Chicago, Illinois 60603
(312) 814-2420
https://insurance.illinois.gov/

Indiana
311 W Washington Street
Suite 103
Indianapolis, IN 46204
(317) 232-2385
https://www.in.gov/idoi

Iowa
1963 Bell Avenue, Suite 100
Des Moines, Iowa 50315
(515) 654-6600
www.iid.state.ia.us

Kansas
1300 SW Arrowhead Road
Topeka, Kansas 66604
(800) 432-2484
https://insurance.kansas.gov

Kentucky
500 Mero Street, 2 SE11
Frankfort, KY 40601
(800) 595-6053
https://insurance.ky.gov/

Louisiana
PO Box 94214
Baton Rouge, Louisiana 70802
(800) 259-5300
https://ldi.la.gov

Maine
34 State House Station
Augusta, ME 04333
(800) 300-5000
https://www.maine.gov/pfr/insurance/home

Maryland
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
(800) 492-6116
http://insurance.maryland.gov

Massachusetts
1000 Washington Street, Suite 810
Boston, MA 02118
(877) 563-4467
https://www.mass.gov

Michigan
PO Box 30220
Lansing, MI 48909
(877) 999-6442
www.michigan.gov/ofir

Minnesota
85 7th Place East, Suite 280
Saint Paul, MN 55101
(651) 539-1500
https://mn.gov/commerce

Mississippi
PO Box 79
Jackson, MS 39205
(800) 562-2957
www.mid.state.ms.us

Missouri
PO Box 690
Jefferson City, MO 65102
(800) 726-7390
www.insurance.mo.gov

Montana
840 Helena Ave.
Helena, MT 59601
(800) 332-6148
https://csimt.gov

Nebraska
PO Box 95087
Lincoln, NE 68509
(877) 564-7323
www.doi.nebraska.gov

Nevada
1818 E. College Pkwy., Suite 103
Carson City, NV 89706
(888) 872-3234
https://doi.nv.gov

New Hampshire
21 South Fruit Street, Suite 14
Concord, NH 03301
(800) 852-3416
www.nh.gov/insurance

New Jersey
20 West State Street
PO Box 325
Trenton, NJ 08625
(800) 446-7467
www.state.nj.us/dobi/index.html

New Mexico
1120 Paseo De Peralta
Santa Fe, New Mexico 87501
(855) 427-5674
www.osi.state.nm.us

New York
One State Street
New York, NY 10004
(800) 342-3736
www.dfs.ny.gov

North Carolina
1201 Mail Service Center
Raleigh, NC 27699
(855) 408-1212
www.ncdoi.gov

North Dakota
600 E. Boulevard Ave., 5th Floor
Bismarck, ND 58505
(701) 328-2440
https://www.insurance.nd.gov

Ohio
50 W. Town Street, Suite 300
Columbus, OH 43215
(800) 686-1526
www.insurance.ohio.gov

Oklahoma
400 NE 50th Street
Oklahoma City, Oklahoma 73105-1816
(800) 522-0071
https://www.oid.ok.gov

Oregon
PO Box 14480
Salem, OR 97309
(888) 877-4894
http://dfr.oregon.gov

Pennsylvania
1326 Strawberry Square
Harrisburg, PA 17120
(877) 881-6388
www.insurance.pa.gov

Puerto Rico
361 Calle Calaf
PO Box 195415
San Juan, Puerto Rico 00919
(787) 304-8686
English: https://ocs.pr.gov/English
Spanish: https://ocs.pr.gov

Rhode Island
1511 Pontiac Avenue, Building 69-2
Cranston, RI 02920
(401) 462-9500
https://www.dbr.ri.gov/divisions/insurance

South Carolina
PO Box 100105
Columbia, SC 29202
(803) 737-6180
www.doi.sc.gov

South Dakota
124 South Euclid Avenue,
2nd Floor
Pierre, SD 57501
(605) 773-3563
https://dlr.sd.gov/insurance

Tennessee
500 James Robertson Pkwy.
Nashville, TN 37243
(800) 342-4029
www.tn.gov/commerce/insurance

Texas
PO Box 12030
Austin, TX 78711-2030
(800) 578-4677
www.tdi.texas.gov

Utah
4315 S. 2700 W., Suite 2300
Taylorsville, Utah 84129
(800) 439-3805
www.insurance.utah.gov

Vermont
89 Main Street
Montpelier, VT 05620-3101
(833) 337-4685
https://dfr.vermont.gov

Virginia
Bureau of Insurance - SCC
PO Box 1157
Richmond, VA 23218
(800) 552-7945
www.scc.virginia.gov/boi

Virgin Islands
For St. Croix
1131 King Street, 3rd Floor, Suite 101
Christiansted, St. Croix, VI 00820
(340) 773-6449
https://ltg.gov.vi

For St. Thomas/St. John
5049 Kongens Gade
St. Thomas, Virgin Islands 00802
(340) 774-2991
https://ltg.gov.vi

Washington
PO Box 40255
Olympia, WA 98504
(800) 562-6900
www.insurance.wa.gov

West Virginia
PO Box 50540
Charleston, WV 25305
(888) 879-9842
www.wvinsurance.gov

Wisconsin
PO Box 7873
Madison, WI 53707
(800) 236-8517
www.oci.wi.gov

Wyoming
106 East 6th Avenue
Cheyenne, WY 82002
(800) 438-5768
https://doi.wyo.gov

The issuance of this notice is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights with respect to the insurance.

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Important Claim Notice

Arizona Residents: 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.

California Residents: 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.

Colorado Residents: 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.

District of Columbia Residents: **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 Residents: 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 Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any 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 Residents: 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.

Maryland Residents: 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.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma Residents: **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.

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Pennsylvania Residents: 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.

Puerto Rico Residents: **Caution:** 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.

Rhode Island Residents: 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.

Tennessee Residents: 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 Residents: 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 Residents: 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.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents: 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.