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. <u>You must submit the provider's medical bills</u>; <u>balance due statements will not be processed</u>. 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)
- ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

- 1. WebTPA contact information
- 2. Organization/School name found on the claim form
- 3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

◆If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

◆Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident.

◆If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

◆Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

- 1. Claim Forms Not Completed In Full or Not Submitted.
- 2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
- 3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

SAMPLE HCFA 1500

SAMPLE UB-04

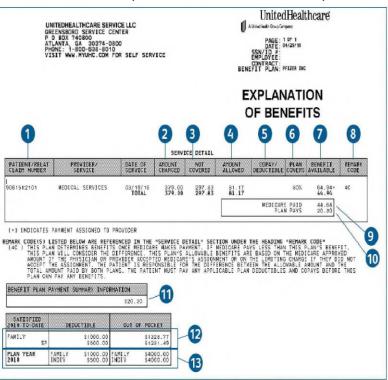
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SAMPLE ADA DENTAL CLAIM FORM

American Dental Association Dental Claim Fo	orm			
1. Type of Transaction (Mark all applicable boxes)				
Statement of Actual Services Request for Predetermination / Preautho	orization			
EPSIDT/THE XIX				
2. Predetermination/Preauthorization Number		POLICYHOLDER/SUBSCRIBER	INFORMATION (For Incurate)	Company Named In 421
2. Predetermination/ Presidentization Number				
		12. Policyholder/Subscriber Name (La	st, First, Middle Initial, Suffx), Addres	ss, City, State, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		Policyholder Name		
Company/Plan Name, Address, City, State, Zip Code		Address 1		
Insurance Company Name		Address 2		
			ST ZIP	
Address 1		City		
Address 2		13. Date of Birth (MM/DD/CCYY)	14. Gender 15. Policyholde	er/Subscriber ID (SSN or ID#)
City ST ZIP			M F	
OTHER COVERAGE		16. Plan/Group Number 1	7. Employer Name	
		16. Plandroup Number	/. Employer wane	
4. Other Dental or Medical Coverage? No ((ikip 5-11) Yes (Complete	§-11)			
. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		PATIENT INFORMATION		
		18. Relationship to Policyholder/Subsc	oriber in #12 Above	19. Student Status
5. Date of Birth (MM/DD/DC/Yr) 7. Gender 8. Policyholder/Subscriber ID	-0.04	Set Spouse		FTS PTS
	(SSN OF ID#)			
		20. Name (Last, First, Middle Initial, Su	iffa), Address, City, State, Zip Code	
Plan/Group Number 10. Patient's Relationship to Person Named in #5		Patient Name		
Self Spouse Dependent	Other	Address 1		
1. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zio Code				
		Address 2		
Other Insurance Company Name		City	ST ZIP	
Address		21 Date of Birth (MM/DD/DD/YY)	22. Gender 23. Patient ID/A	Account # (Assigned by Dentist)
City ST ZIP				
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RECORD OF SERVICES PROVIDED				
24. Procedure Date 25. Area 26. 27. Tooth Number(s) 28. To	oth 29. Proces			
24. Procedure Date 25. Arts 26. 27. Tooth Number(s) 28. To (MM/DD/CCYY) Cavty System or Letter(s) Suita	ce Code	-	30. Description	31. Fee
and allow		_		
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4 L L, L L				
MISSING TEETH INFORMATION Permanent 4. (Place an X on each missing tooth) 1 2 3 4 5 7 8				32. Other Fee(s)
22 31 30 29 28 27 26 25 24	23 22 21	20 19 18 17 T S R G	PONMLK	35. Total Fee
AUTHORIZATIONS		ANCILLARY CLAIM/TREATMEN		
6. I have been informed of the treatment plan and associated tees. I agree to be respons harpes for dental services and materials not paid by my dental benefit plan, unless prohil		38. Place of Treatment		per of Enclosures (00 to 99) preh(s) Cral Image(s) Medicis)
e treating dentist or dental practice has a contractual agreement with my plan prohibitin uch charges. To the extent permitted by law, I consent to your use and disclosure of my i	g all or a portion of	Provider's Office Hospital	ECF Other	
uch charges. To the extent permitted by law, I consent to your use and disclosure of my i formation to carry out payment activities in connection with this claim.	protected health	40 in Treatment for Orthogontics?	41. Date 40	plance Placed (MM/DD/CCYY)
normalion to carry our payment accesses in connection with this cash.				
		No (Skip 41-42) Ves (0		
Patient/Guardian signature Date		42. Months of Treatment 43. Replace	ement of Prosthesis? 44. Date Pri	for Placement (MM/DD/CCYY)
		Remaining	Yes (Complete 44)	
 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to lentist or dental entits. 	the below named	45. Treatment Resulting from		
CHOID OF CHORE CHORE				
		Occupational liness/injury	Auto accident	Other accident
ubscriber signature Date		46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State
ILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is		TREATING DENTIST AND TREAT		
ILLING DENTIST OH DENTAL ENTITY (Leave blank if dentist or dental entity is aim on behalf of the patient or insured/subscriber)	no suomeng	50. Thereby certify that the procedures a		
		 I hereby certify that the procedures a visits) or have been completed. 	is involved by case are in progress (for	a processing that require multiple
8. Name, Address, City, State, Zip Code				
Dentist Name		×		
		X Signed (Treating Dentist)		Date
Address 1				
Address 2		54. NPI	55. License Number	
City ST ZIP		56. Address, City, State, Zip Code	S6A. Provider Specialty Code	
49. NPI 50. License Number 51. SSN or TIN		Address		
			ST ZIP	
		City	ZIP	
C Phone 524 Additional				

SAMPLE EOB (EXPLANATION OF BENEFITS)





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

IMPORTANT NOTICE: This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: The accident policy benefits are limited and may not provide 100% coverage. coverage.

✓ IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED >

PART 1-A - TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School Dist	rict/College Name			Policy Nu	mber	
School/Team/League Na	me		Phone	e No. (<u>)</u>		
Address			Email	l		
			Туре	of Activity/Sp	ort	
If Athletics, designate	□P.E. Class □Intramural □Youth □Adult □Practio		□Intercollegiate		□Jr. Varsity	□Varsity
	student					
Date of Accident	A	cident Time				
Date of First Treatment _	На	s treatment been cor	mpleted? □Yes	□No		
Where and how did accid	lent occur? (Please be specific)					
Part of body Injured and supervised activity a	□Right_o nd were they a current student/r	- □Left At the tir nember of the Organi	ne of the accident, ization/School Distr	was the claii ict? □Yes	mant involved in □No	a sponsored
Under whose supervisior	ı?	Was	he/she a witness?	□Yes □	JNo	
Authorized Signature		Title			Date	
	ANIZATION/SCHOOL OFFICIAL UNLESS					
	COMPLETED IN FULL BY CL					
	gal Name					
Date of Birth	Age	Grade Level _		C	IMale □Fema	ale
	□Player □Coach □Official/Ur n or Parents/Guardian	•		•	•	,
Phone No. ()	E	mail Address				
If Injured party is over ag	e 18: Employer Name and Add	ress				
Phone No. ()	DSelf Emp	loyed DUnemploy	red			
Father/Guardian Name						
	Iress			Phone No	o. ()	
					nployed □Une	mployed

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 fror	n the dentist that the tooth/teeth are whole, sound	d and natural.	
is claimant covered under any other medical a	and or dental insurance policy? □Yes □No		
ls claimant covered under a government spon	nsored insurance such as Medicare/Medicaid?	⊐Yes □No	
Name of all companies providing claimant ins	urance coverage or prepaid health plans		
Name of Company	Address		Policy #
Are benefits due for this claim under these of	ther insurance coverages? □Yes □No (See IMF	PORTANT NOTICE at to	op of form on pag
Doos your con or daughter have medical insu	urance coverage as an eligible dependent from a	previous marriage as	mandated in a div

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.

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: _____

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 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 DECIEVE 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 APPLICTION 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."