CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 84075 * Columbus,
GA. 31993 Phone (800) 433-3036 *
Fax (866) 849-2970

SHORT TERM DISABILITY CLAIM FORM INSTRUCTIONS

To avoid delays in processing of your claim form, complete each section attaching documentation below when it applies.

Note: This form is for initial filing of a disability claim. If your disability is being extended, you will need to complete the listed Supplemental Claim form.

Supporting Documentation Needed

- ✓ Chart Note to include admission and discharge paperwork if there was a hospital stay
- ✓ Surgical Report if surgery took place
- ✓ Receipts for follow up visits or physical therapy with dates and charges if applicable
- ✓ Email form to groupclaimfiling@aflac.com or fax to 1.866.849.2970.

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SHORT TERM DISABILITY CLAIM FORM

Please attach paperwork for any additional income you are receiving during this period of disability.

****Please sign and return the attached Authorization.**

PART A: POLICYHOLDER'S STATEMENT (FORMS ARE TO BE COMPLETED ON OR AFTER DISABILITY DATE TO AVOID PROCESSING DELAYS)

POLICY HOLDER'S NAME	POLICY/CERTIFICATE NUMBER	SOCIAL SECURITY/ ID	DATE OF BIRTH	GENDER

☐**PERMANENT ADDRESS** ☐**ADDRESS CHANGE**	POLICY HOLDER'S ADDRESS, CITY, STATE, ZIP	PHONE NUMBER (Please include area code)

E-MAIL ADDRESS	**** By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to delivery to you)***

EMPLOYER NAME	OCCUPATION
IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION? DATE REPORTED TO YOUR EMPLOYER	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO **STATUS** ☐APPROVED ☐PENDING ☐DENIED IF DENIED, HAS AN APPEAL BEEN FILED? ☐ YES ☐ NO

DATE SYMPTOM FIRST APPEARED	TREATING PHYSICIAN NAME ADDRESS
	IF HOSPITALIZED: (NAME/ADDRESS) DATES HOSPITALIZED

PLEASE PROVIDE DESCRIPTION OF SICKNESS OR INJURY

DATES YOU DID NOT WORK AT ALL	DATES YOU WORKED LESS THAN FULL TIME.	DATE YOU RETURNED OR EXPECT TO RETURN TO WORK.
FROM THROUGH	FROM THROUGH	FULL-TIME PART-TIME

PRIMARY DOCTOR NAME	TREATING DOCTOR NAME	REFERRING DOCTOR NAME
ADDRESS	ADDRESS	ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
PHONE NUMBER	PHONE NUMBER	PHONE NUMBER

AUTHORIZATION

Several states require that the following statement appear on the claim forms:
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.

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, and P.O. Box 84075, Columbus, Georgia 31993.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.
I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

POLICYHOLDER'S SIGNATURE: **DATE:**

Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970
groupclaimfiling@aflac.com

SHORT TERM DISABILITY CLAIM FORM

PART B: EMPLOYER'S STATEMENT: (To be completed by your Benefits Department unless self-employed)

EMPLOYEE'S NAME	EMPLOYEE ID NUMBER	DATE OF BIRTH	DATE OF HIRE

OCCUPATION AT TIME LAST WORKED: _____

EMPLOYEE'S JOB TITLE DUTIES: (Please mark selection in each category)

LIFTING ☐LESS THAN 15LBS ☐ 15 TO 44 ☐OVER 45	**STOOPING/BENDING** ☐NONE ☐SELDOM ☐ FREQUENT
REPETITIVE ☐NONE ☐SELDOM ☐FREQUENT	**CRAWLING/CLIMBING/KNEELING** ☐NONE ☐SELDOM ☐ FREQUENT
REACHING/PULLING/PUSHING ☐NONE ☐SELDOM ☐ FREQUENT	**MANAGEMENT DUTIES** ☐NONE ☐SELDOM ☐ FREQUENT
SITTING (NUMBER OF HOURS EACH DAY)	**STANDING/WALKING** (HOURS EACH DAY)
DATE EMPLOYEE WAS ACTUALLY LAST PRESENT AT WORK?	WORK SCHEDULE AT TIME LAST WORKED: DAYS/WEEK HOURS/DAY
DATES EMPLOYEE DID NOT WORK AT ALL FROM THROUGH	DATES EMPLOYEE WORKED LESS THAN FULL-TIME HOURS FROM THROUGH
DATE THE EMPLOYEE RETURNED TO FULL- TIME WORK OR LIGHT DUTY/PART-TIME	IF THE EMPLOYEE HAS NOT RETURNED, IS LIGHT DUTY AVAILABLE? **IF THE EMPLOYEE RETURNED TO WORK LIGHT DUTY/ PART TIME PLEASE PROVIDE HOURS WORKED AND EARNINGS**

DID THE CLAIM RESULT FROM JOB ACTIVITY?		HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? NO/ YES
HAS THE EMPLOYEE RECEIVED ANY OTHER INCOME AS A RESULT OF DISABILITY? ☐NO ☐YES	SALARY CONTINUANCE, SICK PAY OR VACATION WEEKLY BENEFIT: DATE CEASED	**STATUS** ☐APPROVED ☐PENDING ☐DENIED **IF DENIED**, HAS AN APPEAL BEEN FILED? Y/ N
IS ANY PORTION OF THE EMPLOYEE'S POLICY PAID FOR BY THE EMPLOYER? ☐NO ☐YES	IS THE EMPLOYEE'S POLICY PAID FOR WITH PRE-TAX DOLLARS (SECTION 125)? ☐NO ☐YES	WHAT ARE THE EMPLOYEE'S BASIC MONTHLY EARNINGS? **IF WORKING THE EMPLOYEE IS WORKING LIGHT DUTY OR PART- TIME, PLEASE PROVIDE EARNINGS AND HOURS WORKED**

AUTHORIZED EMPLOYER'S SIGNATURE

EMPLOYER'S COMPANY NAME	TELEPHONE NUMBER	FAX NUMBER

ADDRES	NAME AND TITLE OF PERSON COMPLETING THIS FORM
SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE	**DATE**

*** IF SELF-EMPLOYED, PLEASE SUBMIT 1099 FORM FOR VERIFICATION**

*** IF EMPLOYEE IS RECEIVING ANY OTHER INCOME, PLEASE SPECIFY TYPE AND AMOUNT OF INCOME**

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SHORT TERM DISABILITY CLAIM FORM

PART C: ATTENDING PHYSICIAN'S STATEMENT (To be completed by physician certifying disability on or after disability date to avoid processing delays)

PATIENT'S NAME		DATE OF BIRTH
DATE PATIENT BECAME DISABLED DUE TO PRESENT DIAGNOSIS	WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION/ DIAGNOSIS? ☐YES ☐NO
IS THIS A WORKER'S COMPENSATION INJURY? ☐YES ☐NO	DATE NAMES/ADDRESSES ANY ADDITIONAL PHYSICIANS TREATING PATIENT FOR CURRENT DIAGNOSIS	
DIAGNOSIS (INCLUDING COMPLICATIONS)	ICD CODE (S)	SUBJECTIVE SYMPTOMS **OBJECTIVE FINDINGS** (INCLUDING CURRENT X-RAYS, EKG'S, LA BORATORY DATA AND ANY CLINICAL FINDINGS.)

DIAGNOSIS

PREGNANCY EDC _____ LMP _____	**DATE OF DELIVERY**	METHOD OF DELIVERY ☐VAGINAL ☐ CESAREAN	PLEASE LIST ANY **PREGNANCY COMPLICATIONS**

TREATMENT

DATE FIRST TREATED FOR THIS CONDITION	LAST DATE TREATED FOR THIS CONDITION
NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)	DID PATIENT HAVE SURGERY? ☐YES ☐NO IF YES, **DATE OF SURGERY** **TYPE OF SURGERY**:
HAS THE PATIENT ☐RECOVERED ☐IMPROVED ☐ UNCHANGED ☐ RETROGRESSED	IS THE PATIENT ☐AMBULATORY ☐HOUSE CONFINED ☐ BED CONFINED ☐HOSPITAL CONFINED
IF CONFINED TO HOSPITAL, PLEASE PROVIDE DATES CONFINED FROM: TO:	NAME AND ADDRESS OF HOSPITAL: (IF CONFINED)
WHEN DO YOU EXPECT A FUNDAMENTAL CHANGE IN THE PATIENT'S CONDITION? (Please circle selection) ☐1 MO. ☐1-3 MO. ☐3-6 MO. ☐6-9 MO. ☐9-12MO. ☐NEVER	WHEN DO YOU ANTICIPATE A RETURN TO WORK FULL DUTY WITHOUT RESTRICTIONS?

WHEN COULD A TRIAL EMPLOYMENT COMMENCE? (IF PATIENT RELEASED TO RETURN TO WORK WITH RESTRICTIONS) DATE (PATIENT'S JOB):

CAPACITY: ☐FULL-TIME ☐PART-TIME ☐LIGHT DUTY

PHYSICAL IMPAIRMENTS (AS DEFINED IN THE FEDERAL DICTIONARY OF OCCUPATIONAL TITLES)

CLASS 1 – NO LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF HEAVY WORK. NO RESTRICTIONS (0-10%)
CLASS 2 – MEDIUM MANUAL ACTIVITY. (15-30%)
CLASS 3 – SLIGHT LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF LIGHT WORK. (35-55%)
CLASS 4 – MODERATE LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF CLERICAL/ADMINISTRATIVE (SEDENTARY) ACTIVITY. (60-70% (75-100%)
CLASS 5 – SEVERE LIMITATION OF FUNCTIONAL CAPACITY; INCAPABLE OF MINIMUM (SEDENTARY) ACTIVITY

RESTRICTIONS AND LIMITATIONS: (What specific activities/ work duties is the patient incapable of performing)

REMARKS: (Additional comments regarding the patient's condition)

NAME: (ATTENDING PHYSICIAN)	FAX NUMBER	TELEPHONE NUMBER	MEDICAL ID NUMBER

PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE

AUTHORIZED SIGNATURE OF PHYSICIAN

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

SIGNATURE	**DATE**

AUTHORIZATION TO OBTAIN INFORMATION

Send to:
Continental American Insurance Company
Post Office Box 84075
Columbus, GA 31993

Phone: (800) 433-3036
Fax: (866) 849-2970
Email: groupclaimfiling@aflac.com

Primary Certificate Holder Name:	**SSN**(optional):	**Date of Birth:**	
Certificate Number(s):			
Address:	**City:**	**State:**	**Zip:**
Name of Individual Subject to Disclosure (If not the primary Certificate Holder):		**Date of Birth:**	
Relationship to Primary Certificate Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild			

I. Authorization:

For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:

I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:

I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Signature of Individual Subject to Disclosure _____ Date Signed _____

Legal Representative's Printed Name _____ Legal Representative's Signature _____ Legal Relationship _____ Date _____

******If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney***

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 84075
Columbus, Georgia 31993

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

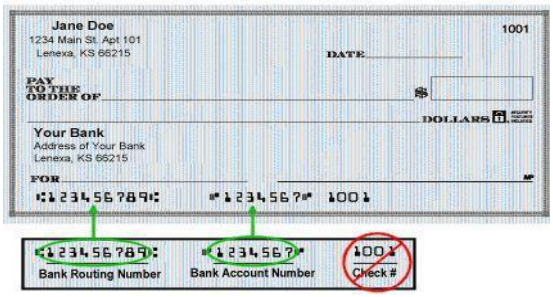
Authorization Agreement for Direct Deposit

I would like to: ☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**



9-Digit Routing Number:		Account Number:
Name of Financial Institution:		
Address:		City:
State:	Zip:	Phone:

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*):	
Address:	City/State/Zip:
Phone #:	E-mail Address:
Employer Name or Group #:	Certificate #:

****By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)*

Note: Forms received without signature will not be processed. Electronic signatures not accepted.

Policy/Certificate Holder Signature *(Required)* **Date Signed:**

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.	**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
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.	**INDIANA:** A 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.
ARKANSAS: 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.	**KENTUCKY:** 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.
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.	**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.
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 agencies.	**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 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.
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.	**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.
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.	**NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, ormisleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
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.	**NEW JERSEY:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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 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.

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: 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: 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 may be guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and withintent 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: 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 with the penalty of 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 are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuatingcircumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: 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 acrime and may be subject to fines and confinement instate prison.

VIRGINIA: 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.

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.

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.

ALL OTHER STATES: 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.