



Mail to: Colonial Life & Accident Insurance Company  
PO Box 100195  
Columbia SC 29202-3195

Fax to: 1.800.880.9325

If you fax your claim, there is no need to mail the original. Reminder: Please copy the back pages and fax all the pages of the claim together.

#### WELLNESS/HEALTH SCREENING

If you wish to file a **Wellness/Cancer Screening claim for a test performed within the past 12 months**, you'll need to submit the type and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number. **You may:**

- **FILE BY PHONE!** Call 1.800.325.4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week, **or**
- **SUBMIT ON THE INTERNET** using the Wellness Claim Form at **coloniallife.com**, or
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "**Wellness Test.**"

**FAX** this to us at 1.800.880.9325 **or MAIL** to P.O. Box 100195, Columbia SC 29202.

**If your Wellness/Cancer Screening test was more than one year ago**, you must fax or mail us a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.

**Please note: If your cancer policy includes a second part to the screening benefit, bills for tests covered and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.**

#### CANCER

Please complete the sections that apply to your coverage.

- For *Internal Cancer* – **Attach** a copy of the **pathology report** from your *initial* diagnosis.
- Attach copies of itemized statements for all medical expenses incurred relating to the diagnosis and treatment of your malignancy. Please clearly write your name and social security number on each bill.
- For *Skin Cancer* – Attach a copy of your pathology report for *each date of service* a lesion was biopsied and/or removed. Also, please include a copy of your itemized bills that provide the surgical procedure code(s) and charges for each lesion removed. This information should provide all doctors complete names, mailing addresses and telephone numbers.
- *Transportation and Lodging* – Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.
- ***If you are claiming disability, please have your employer and doctor provide any applicable information under SECTIONS D & E.***

**If you have any questions while completing this claim form, please call us at 1.800.325.4368. We will assist you with the information and forms needed to successfully complete this process.**

**Your claim must be filed within 12 months of your date of loss.**

Please check the type of claim you are filing below:

- Wellness** - See top of page 2
- Cancer** - See below.
- Routine Pregnancy** - See page 4 if you are filing for benefits for normal post-delivery disability. Pages 5 and 6 are not necessary.
- Total Disability** - (Accident/Sickness/Pregnancy complications) Sections D & E contain parts for both your employer and doctor to complete. See pages 5 and 6. A disability only claim form is now available at our website, www.coloniallife.com.
- Accidental Injury** - Section A, page 4, requests specific information from you about the circumstances of your injury.
- Hospital Confinement, Intensive Care, Outpatient Surgery and/or Rehabilitation Unit** - Have your doctor complete Section C, page 5, and send copies of your hospital, outpatient surgery, and/or Rehabilitation Unit bills.

This claim is for:  Self  Spouse  Dependent: if over 18, name of school \_\_\_\_\_

Name of Claimant \_\_\_\_\_ Name of Policyowner (if not claimant) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Policy Number: \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street (Apt. #) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(must include street address for overnight delivery)

Has your address changed since we last heard from you?  YES  NO

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Fax Number: (\_\_\_\_) \_\_\_\_\_ Policyowner email Address: \_\_\_\_\_

If you are claiming disability, please list the dates you were unable to work: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please print INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL**

Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).

1. \_\_\_\_\_  
**Full name of treating doctor**

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code  
(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone number Fax number

2. \_\_\_\_\_  
**Full name of referring doctor/hospital**

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code  
(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone number Fax number

3. \_\_\_\_\_  
**Full name of primary doctor**

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code  
(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone number Fax number

4. \_\_\_\_\_  
**Other**

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code  
(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone number Fax number

**CERTIFICATION**

**Policyholder/Employee's Name** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the "Claim Fraud Warning and State Versions" form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. 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.

**PLEASE ALSO SIGN AND DATE THE AUTHORIZATION ON PAGE 7.**

**X** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date (mm/dd/yyyy)

**X** \_\_\_\_\_  
PATIENT SIGNATURE

**X** \_\_\_\_\_  
POLICYHOLDER/EMPLOYEE SIGNATURE

CLAIMANT NAME: **X** SOCIAL SECURITY NUMBER: \_\_\_\_\_

**A. ACCIDENTAL INJURY**- please **complete and attach itemized copies** of any related **bills** including **doctor, ambulance, emergency room, hospital, and/or rehabilitation unit**. Bills should include **diagnosis** information from your medical provider.

Date of accident (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of accident: \_\_\_\_\_ am / pm (circle one)

Tell us how your accident happened:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you at work, working for wage or profit, at the time of your accident?  yes  no

Have you ever had a similar injury? \_\_\_\_\_ If so, please tell us when (mm/dd/yyyy): \_\_\_\_\_

***If you are claiming disability, please have your employer and doctor provide any applicable information under SECTIONS D & E.***

**To be completed and signed by your doctor**

**B. ROUTINE PREGNANCY (6 weeks for vaginal delivery or 8 weeks for c-section, less the elimination period)**

**If disabled due to complications of pregnancy, before or after delivery, complete Section E on page 6.**

Date of Delivery (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Type delivery: Vaginal / C-Section (circle one)

Date you first treated patient for this pregnancy (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

List other treatment dates for this pregnancy \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of Hospital Confinement (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Hospital: \_\_\_\_\_ Hospital Phone Number: (\_\_\_\_) \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

Treating Doctor's Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Mailing address \_\_\_\_\_

CLAIMANT NAME: **X**

SOCIAL SECURITY NUMBER:

**C. HOSPITAL CONFINEMENT, INTENSIVE CARE, SURGERY, AND/OR REHABILITATION UNIT BENEFIT(S).**

Please send an itemized copy of your hospital and/or rehabilitation bill(s), which includes the *diagnosis, admission and discharge dates*. Have your doctor complete this section if your bills do not include diagnosis information. Please send a copy of the anesthesiology bill if outpatient surgery was performed.

**INTENSIVE CARE / HOSPITAL CONFINEMENT / REHABILITATION UNIT**

**Dates of Service**

Place of Confinement	From (mm/dd/yyyy)	To (mm/dd/yyyy)
Intensive Care including Coronary Care Unit		
Hospital (Private, Semi-Private, Other)		
Rehabilitation Unit		

Diagnosis/ICD-9 Code(s): \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Hospital Address: \_\_\_\_\_

Rehabilitation Unit Address: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Date(s) of office visit(s) following confinement: (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

**SURGERY**

**Date(s) of Service**

Type of Surgery	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Procedure Description/Procedure Code
Inpatient			
Outpatient			

Diagnosis/ICD-9 Code(s): \_\_\_\_\_

Date(s) of office visit(s) following outpatient surgery (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

Hospital: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Hospital Address: \_\_\_\_\_

**DOCTOR'S INFORMATION:**

Signature of doctor: **X** \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

**If you are claiming disability, please have your employer complete the section below and have your doctor complete SECTION E.**

**D. To be completed and signed by your EMPLOYER:**

Name of Employer: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Employee working at any other place of employment? \_\_\_\_\_ Employee's Job Title: \_\_\_\_\_

yes  no If yes, where \_\_\_\_\_ Employee's job title duties include:

Dates this employee has been unable to work: \_\_\_\_\_ Lifting  less than 15 lbs.  15 to 44 lbs.  over 45 lbs.

From: \_\_\_/\_\_\_/\_\_\_ am/pm To: \_\_\_/\_\_\_/\_\_\_ am/pm \_\_\_\_\_ Stoop/bending  none  seldom  frequent

From: \_\_\_/\_\_\_/\_\_\_ am/pm To: \_\_\_/\_\_\_/\_\_\_ am/pm \_\_\_\_\_ Crawling/climbing/  none  seldom  frequent kneeling

Date employee returned to main or principal duties: \_\_\_\_\_ Reaching/pulling/  none  seldom  frequent pushing

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Part time \_\_\_\_\_ Number of hours/week \_\_\_\_\_ Repetitive  none  seldom  frequent

Full time \_\_\_\_\_ Management duties  none  seldom  frequent

Date employee returned to light duty: \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_ Sitting (Number of hours each day): \_\_\_\_\_

Monthly salary \$ \_\_\_\_\_ Hourly salary \$ \_\_\_\_\_ \_\_\_\_\_ Standing/Walking (hours each day): \_\_\_\_\_

Did the accident occur while working for wage/profit? \_\_\_\_\_ Has Workers' Compensation been approved?  yes  no

yes  no If yes, list date of injury: \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_

Name and address of Workers' Compensation carrier: \_\_\_\_\_

Is modified or light duty available?  yes  no If yes, date available. \_\_\_\_\_

Signed: **X** \_\_\_\_\_ Title: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

(To be signed by your employer)

CLAIMANT NAME: **X**

SOCIAL SECURITY NUMBER: \_\_\_\_\_

**E. DISABILITY BENEFITS. To be completed and signed by the DOCTOR treating you for this disability:**

Diagnosis/ primary disabling condition/ ICD9 Code(s): \_\_\_\_\_

Secondary conditions contributing to this disability: \_\_\_\_\_

Would the patient be disabled without regards to these secondary conditions?  yes  no

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment: \_\_\_\_\_

Is this condition the result of an accidental injury?  yes  no If yes, please provide us with the date and description. \_\_\_\_\_

Dates of Inpatient Hospital Confinement: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital: \_\_\_\_\_  
Name Address

List any surgeries performed and submit a copy of the operative report. \_\_\_\_\_

Is this patient permanently disabled?  yes  no If yes, what are the permanent restrictions/limitations? \_\_\_\_\_

How soon do you expect significant improvement in the patient's medical condition? \_\_\_\_\_ # weeks/months (circle one)

Dates unable to work: Full Duty: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates unable to work: Partial Duty: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

List Restrictions/Limitations preventing work \_\_\_\_\_

Is this patient considered to be house confined (unable to perform normal daily activities) or unable to perform 2 or more activities of daily living? Yes / No (circle one) If yes, which ADLs cannot be performed? *\*(dressing, eating, transferring, toileting, and meal preparation)* \_\_\_\_\_

For what period? From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

(This information will be used in accordance with state regulations and policy provisions.)

Anticipated return to work/release date: \_\_\_\_\_ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

If due to complications of pregnancy prior to delivery, what is EDC? \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of office visits (mm/dd/yyyy): \_\_\_\_\_

Recommended frequency of treatment: \_\_\_\_\_

Signature of doctor: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Acct. #: \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

**Full name of referring doctor**

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

**NOTE: Please make a copy of the patient's signed authorization to release information for your records. If your facility requires a special authorization, please have your patient sign the form and include it with this claim.**

**Authorization for Colonial Life & Accident Insurance Company**

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 forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms 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 governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life 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. Colonial Life 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 earlier and a copy 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 Colonial Life 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 revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____	_____	<b>X</b>	<b>X</b>
(Printed name of individual subject to this disclosure)	(Social Security Number)	(Signature)	(Date Signed)

If applicable, I signed on behalf of the insured as \_\_\_\_\_(indicate relationship).  
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____	_____	_____
(Printed name of legal representative)	(Signature of legal representative)	(Date Signed)

## Claim Fraud Warning and State Versions

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

### Resident State State Version of Fraud Warning

<b>Alaska</b>	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.
<b>Arkansas</b>	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.
<b>Arizona</b>	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.
<b>California</b>	For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.
<b>Colorado</b>	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.
<b>District of Columbia</b>	<i>WARNING:</i> 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.
<b>Delaware</b>	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.
<b>Florida</b>	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.
<b>Idaho</b>	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
<b>Indiana</b>	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.
<b>Kentucky</b>	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.
<b>Louisiana</b>	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.
<b>Maine</b>	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.
<b>Maryland</b>	Any person who knowingly and willfully presents a false or fraudulent claim for payment of 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.
<b>Minnesota</b>	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Resident State State Version of Fraud Warning**

<b>New Hampshire</b>	Any person who, with a 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.
<b>New Jersey</b>	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
<b>New Mexico</b>	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.
<b>New York</b>	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.
<b>Ohio</b>	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.
<b>Oklahoma</b>	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.
<b>Oregon</b>	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
<b>Pennsylvania</b>	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.
<b>Puerto Rico</b>	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 (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are 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.
<b>Tennessee</b>	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.
<b>Texas</b>	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.
<b>Virginia</b>	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.
<b>Washington</b>	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.
<b>West Virginia</b>	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.