Guardian

Group Number: 00539562

MERRILL AREA PUBLIC SCHOOLS

ALL ELIGIBLE EMPLOYEES

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Critical Illness
- Accident

Questions? Concerns?

Helpline (888) 600-1600
Call weekdays, 8:00 AM to 8:30 PM, EST.
And refer to your plan number: 00539562

Guardian®

Welcome

Dear MERRILL AREA PUBLIC SCHOOLS Employee,

We are happy to have been chosen by MERRILL AREA PUBLIC SCHOOLS to be the provider of your employee benefits this year. For over 150 years, we have helped millions of people plan, secure and look after their families. We believe that life's unexpected surprises should be met with the support, guidance and understanding of someone who truly cares. And, we understand the power of help. It's why we go above and beyond to do what's right for you.
With Guardian® coverage you get:

- Affordable group rates
- Convenient payroll deduction
- Benefits for your unique needs

Take advantage of the benefits offered to you at work. Feel secure knowing that you have the coverage you need from a trusted provider and that it's there when you need it most.

Guardian

2018-71635 (12/20)

Critical Illness Benefit Summary

Group Number: 00539562

A Critical Illness insurance plan through Guardian provides:

- A cash benefit for a range of covered serious illnesses such as Cancer, Stroke and Heart Attack, in addition to whatever your medical insurance may cover
- Payments are made directly to you and can be used for any purpose

About Your Benefits:

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $10,000 to $20,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
ADDITIONAL CONDITIONS	**1st OCCURRENCE ONLY**	
Addison's Disease	30%	
ALS (Lou Gehrig's Disease)	100%	
Alzheimer's Disease	50%	
Coma	100%	
Huntington's Disease	30%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Multiple Sclerosis	30%	
Parkinson's Disease	100%	
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns	100%	
Childhood Conditions	**1st OCCURRENCE ONLY**	
Cerebral Palsy	100%	
Cleft Lip/Palate	100%	
Club Foot	100%	
Cystic Fibrosis	100%	
Down's Syndrome	100%	
Muscular Dystrophy	100%	

CRITICAL ILLNESS	
Spina Bifida	100%
Type 1 Diabetes	100%
Spouse Benefit	May choose a lump sum benefit of $5,000 to $10,000 in $2,500 increments up to 50% of the employee's lump sum benefit.
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue up to: $20,000 For a spouse: $10,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	12 months prior, 12 months after
WELLNESS BENEFIT	
Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

Condition Definitions

- Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Your premium will not increase as you age.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

	Semi-monthly Premiums Displayed *Election Cost Per Age Bracket*					
Issue Age	*< 30*	*30-39*	*40-49*	*50-59*	*60-69*	*70+*
Employee						
$10,000	$4.60	$6.46	$11.87	$21.11	$32.11	$62.11
$15,000	$6.53	$9.26	$17.22	$30.79	$46.94	$91.38
$20,000	$8.45	$12.06	$22.57	$40.46	$61.76	$120.66
Benefit Amount Up To 50% of Employee Amount to a Maximum of $10,000						
Spouse						
$5,000	$2.63	$3.61	$6.46	$11.39	$17.23	$32.78
$7,500	$3.59	$5.01	$9.14	$16.23	$24.65	$47.42
$10,000	$4.55	$6.41	$11.81	$21.06	$32.06	$62.05

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00539562.

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

Health questions are required on late enrollees. This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Critical Illness insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Guardian

MERRILL AREA PUBLIC SCHOOLS

Accident Benefit Summary

Group Number: 00539562

Accident insurance through Guardian provides you:

- A cash benefit for covered injuries, treatments and services, in addition to whatever your medical plan may cover
- Payments go directly to you, not the doctor
- Easy enrollment with no medical questions

About Your Benefits:

	ACCIDENT
COVERAGE - DETAILS	
Your Semi-monthly premium	$7.58
You and Spouse	$12.88
You and Child(ren)	$13.34
You, Spouse and Child(ren)	$18.64
Accident Coverage Type	Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $25,000 Spouse $12,500 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Accident Emergency Room Treatment	$175
Accident Follow-Up Visit - Doctor	$50 up to 6 treatments
Air Ambulance	$1,000
Ambulance	$150
Appliance - Wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck.	$125
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burn - Skin Graft	50% of burn benefit

FEATURES (Cont.)	
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate.	20% increase to child benefits
Chiropractic Visits	$25 per visit up to 6 visits
Coma	$10,000
Concussions	$75
Dislocations	Schedule up to $4,400
Diagnostic Exam (Major)	$150
Emergency Dental Work	$300/Crown, $75/Extraction
Epidural pain management	$100, 2 times per accident
Eye Injury	$300
Family Care	$20/day up to 30 days
Fracture	Schedule up to $5,500
Hospital Admission	$1,000
Hospital Confinement	$225/day - up to 1 year
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$450/day - up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$75
Joint Replacement (hip/knee/shoulder)	$2,500/$1,250/$1,250
Knee Cartilage	$500
Laceration	Schedule up to $400
Lodging - The hospital must be more than 50 miles from the insured's residence.	$125/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$25/day up to 10 days
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$150/day up to 15 days
Ruptured Disc With Surgical Repair	$500
Surgery	Schedule up to $1,250 Hernia: $150
Surgery - Exploratory or Arthroscopic	$250
Tendon/Ligament/Rotator Cuff	1: $500 2 or more: $1,000
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$500, 3 times per accident
X - Ray	$30

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passenger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accomodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Accident Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

UNDERSTANDING YOUR BENEFITS (Cont.):

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00539562

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

We don't pay benefits for any Injury caused by or related to directly or indirectly: Sickness, disease, mental infirmity or medical or surgical treatment; the covered person being legally intoxicated; declared or undeclared war, act of war, or armed aggression; service in the armed forces, National Guard, or military reserves of any state or country; taking part in a riot or civil disorder; commission of, or attempt to commit a felony; intentionally self-inflicted Injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a covered person by a doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Accident resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-1-AC-IC-12

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

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Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: MERRILL AREA PUBLIC SCHOOLS	Group Plan Number: 00539562	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

Class:_____ Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You:

First, MI, Last Name:		Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Address	City	State	Zip
Gender: ❑ M ❑ F	Date of Birth (mm-dd-yy): ____ - ____ - ____	Phone: ( ) -	
Email Address:	Are you married or do you have a spouse? ❑ Yes ❑ No Do you have children or other dependents? ❑ Yes ❑ No	Date of marriage/union:____-____-_____ Placement date of adopted child: ____-____-_____	

About Your Job:

Hours worked per week: _____	Job Title:
Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: _____ - _____ - _____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Jul 07, 2020

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Critical Illness

❑ Accident ❑ Employee ❑ Spouse ❑ Child(ren)

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

Critical Illness Coverage: You must be enrolled to cover your dependents

Benefit reductions apply. Please see plan administrator.

Employee
Insurance Amount: ❑ $10,000 ❑ $15,000 ❑ $20,000

❑ I do not want this coverage.

Spouse
Insurance Amount: Up to 50% of the employee's amount to a maximum of $10,000

❑ $5,000 ❑ $7,500 ❑ $10,000

❑ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount: ❑ 25% of the employee's amount

❑ I do not want this coverage.

IMPORTANT NOTES:

- Based on your plan benefits and age, you may be required to complete an additional evidence of insurability form for Critical Illness.

Accident Coverage You must be enrolled to cover your dependents.

Your Semi-monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
	❑ $7.58	❑ $12.88	❑ $13.34	❑ $18.64

❑ I do not want this coverage.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

Contingent Beneficiary:_____ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Signature

- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: 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. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ DATE _____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and 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.

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.

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.

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

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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

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

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 or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or 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 or denial of insurance benefits.

Ohio: Any person who with intent to defraud or knowing that he/she 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.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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