BOSTON MUTUAL LIFE INSURANCE COMPANY

DISABILITY CLAIM DEPARTMENT: PO Box 14294 • Lexington, KY 40512-4294
Fax Number: 855-864-0530

FAMILY MATTERS. NO MATTER WHAT.®

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

Section 1 **Employer's Statement** - to be completed by the **employer's** authorized representative.

Section 2 **Employee's Statement -** to be completed by the **employee** who is applying for Short Term Disability Benefits.

Section 3 **Authorizations to Obtain Information -** to be signed by the **employee.** If the employee resides in CA, ME, MN, OK, VT or WI, please do not complete page 6. The state specific authorization can be found on our website at www.bostonmutual.com.

Section 4 **Attending Physician's Statement -** to be completed by the physician who is treating the **employee.**

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO:

Boston Mutual Life Insurance Company
Disability Claim Department
PO Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530

BOSTON MUTUAL LIFE INSURANCE COMPANY

Fax completed application to:
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BOSTON MUTUAL LIFE INSURANCE COMPANY® –1891–

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SECTION 1 – EMPLOYER'S STATEMENT *(To be completed by the Employer)*

This claim is for – Employee's Name	Date of Birth *(mo-day-yr)*	Social Security Number

Employee's Address *(Street, City, State, Zip)*

A. Information about the Employer

Company's Name

Address *(Street, City, State, Zip)*

Name and Address of division where employee works *(if different from above)*

Group Policy Number	Class	Location

B. Information about the Employee

Date employee was hired	Date employee became insured under this plan

What was the employee's regularly scheduled work week? Hours per week ____ Scheduled workdays M - F Other: _____

Is employee enrolled in BML's long term disability plan? ❑ Yes ❑ No If, Yes, effective date: _____

Was the employee's STD insurance issued on the basis of a Personal Health Statement? ❑ Yes ❑ No If, Yes, attach copy.

Was the employee insured under your prior STD policy? ❑ Yes ❑ No
If "Yes," please provide the inclusive date of coverage. From _____ Through _____

Was the employee on Qualified Family Leave when disability began? ❑ Yes ❑ No

Did STD & LTD insurance continue while on Family Leave? ❑ Yes ❑ No

Date Leave of Absence started under Family Leave Act: _____

C. Information needed for withholding and reporting taxes

What percent of this employee's STD benefit is taxable? _____ %

What percentage, if any, do you contribute towards the cost of the STD premium? _____ %

Does the employee contribute towards the cost of the STD premium? ❑ Yes ❑ No If "Yes," at what percent? _____ %
Is it on a ❑ Pre or ❑ Post-tax basis?

What percent of this employee's LTD benefits is taxable? _____ %

Does the employee contribute towards the cost of the LTD premium? ❑ Yes ❑ No If "Yes," at what percent? _____ %
Is it on a ❑ Pre or ❑ Post-tax basis?

D. Information about the claim

What was the employee's permanent job on his or her last day at work? *(Please attach a copy of the employee's job description.)*

Last day employee actually worked:	On that day, did the employee work a full day? ❑ Yes ❑ No If "No," how many hours were worked?

Why did employee stop working?

Is the employee's condition work related? ❑ Yes ❑ No

Has a claim been filed with Workers' Compensation? ❑ Yes ❑ No If "Yes," send initial report of illness or injury or award notice.

Date employee is expected to return to work? _____ Full time? ❑ Yes ❑ No

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E. Information about Salary

Employee's weekly/hourly rate of pay: $ _____

Will/is employee receive(ing) workers' compensation payments? ❑ Yes ❑ No

Weekly Amount: $ _____ Date Payments Start: _____ Date Payments Will End: _____

Is employee receiving Salary Continuance or Sick Leave? ❑ Yes ❑ No

F. Information about the physical aspects of the employee's job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

NOT APPLICABLE means the person does not perform this activity.
OCCASIONALLY means the person does the activity up to 33% of the time.
FREQUENTLY means the person does the activity 34% to 66% of the time.
CONTINUOUSLY means the person does the activity 67% to 100% of the time.

FREQUENCY OF OCCURRENCE:

Activity	N/A	Occasionally	Frequently	Continuously
❑ Standing	❑	❑	❑	❑
❑ Walking	❑	❑	❑	❑
❑ Sitting	❑	❑	❑	❑
❑ Balancing	❑	❑	❑	❑
❑ Stooping	❑	❑	❑	❑
❑ Kneeling	❑	❑	❑	❑
❑ Crouching	❑	❑	❑	❑
❑ Crawling	❑	❑	❑	❑
❑ Climbing	❑	❑	❑	❑
❑ Reaching/working overhead	❑	❑	❑	❑
❑ Keyboard Use/Repetitive Hand Motion	❑	❑	❑	❑

Activity	Description	Frequency	Weight
❑ Pushing	_____	_____	_____ lbs.
❑ Pulling	_____	_____	_____ lbs.
❑ Lifting	_____	_____	_____ lbs.
❑ Carrying	_____	_____	_____ lbs.

Can the job be performed by alternating sitting and standing? ❑ Yes ❑ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

_____ _____ %
_____ _____ %
_____ _____ %

G. Information about the job as it relates to the disability

Can the job be modified to accommodate the disability either temporarily or permanently? ❑ Yes ❑ No If "Yes," explain.

Is it possible to offer the employee assistance in doing the job *(e.g., through the use of technology or personal assistance)?* ❑ Yes ❑ No
If "Yes," explain.

H. Signature

Name *(Please print or type)* | Title

Signature | Date

( ) | ( )
Area Code Telephone Number | Area Code Fax Number

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SECTION 2 – EMPLOYEE'S STATEMENT *(to be completed by the Employee)*

(BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information about you

Last name	First	Middle Initial	Gender ❑ M ❑ F	Date of Birth *(mo-day-yr)*	Social Security Number

Address *(Street, City, State, Zip)*

Marital status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Personal Cell Telephone Number: ( ) _____ Alternate Telephone Number: ( ) _____

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ❑ Yes ❑ No

Signature _____ Date _____ Email Address: _____

B. For an injury, answer the following quesions

When *(i.e., date/time)*, where and how did the injury occur?

C. For an illness, injury or pregnancy, answer the following quesions

Name of Physician | Date you were first treated by a physician *(mo-day-yr)*

Address of Physician *(Street, City, State, Zip)* | Telephone Number ( )

Before you stopped working, did your condition require you to change your job, or the way you did your job? ❑ Yes ❑ No If "Yes," explain.

What aspect of your condition made you unable to work?

Are you receiving or eligible for ❑ Workers' Compensation ❑ State Disability ❑ No Fault Disability ❑ Other _____

If "Yes," show policy number _____ and name and address of insurer _____

Weekly Amount $ _____ Date Payments Start _____ Date Payments Will End _____

Is your condition related to your occupation? ❑ Yes ❑ No If "Yes," explain.

Have you filed, or do you intend to file a Workers' Compensation claim? ❑ Yes ❑ No If "Yes," explain.

D. Information about the disability

Last day you worked before the disability | Did you work a full day? ❑ Yes ❑ No If "No," explain.

Your Employer *(include division, if applicable)*

If you have not returned to work, do you expect to? ❑ Yes ❑ No Date you were first unable to work

Since that date, have you done any work? ❑ Yes ❑ No If "Yes," please indicate dates worked, name of employer and amount earned.

Name of employer and amount earned.

E. Information about tax withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only *(minimum is $ 20.00 per week).* $ _____. 00. **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate *(which may be higher than you need)* until we receive asigned state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the properwithholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate *(which may be higher than you need)* until we receive a signed federal Form W-4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtainthe proper withholding form.

F. Signature and Authorization

I CERTIFY that the information provided is true to the best of my knowledge and belief.

I HEREBY AUTHORIZE any benefit plan administrator, business associate, employer, financial institution, governmental agency, insurance and reinsurance company, insurance support organization, the Social Security Administration, Internal Revenue Service and the Veterans Administration, to furnish or release *(verbally or in writing)* or otherwise make available *(for inspection and copying)* to Boston Mutual Life Insurance Company, or its authorized representatives, all non-medical information in its possession about me. Non-medical information includes, but is not limited to: employment earnings and history, financial, insurance benefits, claims or coverage, occupational duties and traffic accident reports.

I UNDERSTAND that any information acquired pursuant to this Authorization will be used by Boston Mutual Life Insurance Company to determine my eligibility for insurance benefits under claims submitted to it, to verify representations made by me in my application for insurance or for any other lawful purpose and may be disclosed or released by Boston Mutual Life Insurance Company to: (1) re-insuring companies, (2) other persons or insurance support organizations performing business or legal services in connection with my claim or application for insurance, or (3) as may be otherwise lawfully required.

ADDITIONALLY, I have read and signed the HIPAA Authorization form to allow Boston Mutual Life Insurance Company to obtain my medical information, as allowed by the HIPAA Authorization form, and I have received and read a copy of the Boston Mutual Life Insurance Company Notice of Information Privacy Practices.

This authorization is valid for (24) twenty four months from the date of signature below.

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to the "Fraud Warning Notices" insert for your state.

X _____ _____
Signature Date

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL STREET • CANTON, MASSACHUSETTS 02021 • 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____ , the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____

Consumer Report Authorization

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my claim may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my claim, I will be informed by Boston Mutual of my rights, concerning that action. This authorization will be valid for twelve (12) months, or, if approved, the duration of my claim, whichever is greater.

Claimant Name printed

Date

Claimant Signature

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SECTION 4 – ATTENDING PHYSICIAN'S STATEMENT - HISTORY

Patient's Name	Date of Birth *(mo-day-yr*	Last 4 digits of Social Security Number

Patient's condition is the result of: ❑ Illness ❑ Injury ❑ Pregnancy ❑ Mental/Nervous Condition

Is condition due to an illness or an injury that is work related? ❑ Yes ❑ No Height _____ Weight _____

If pregnancy, what is the expected date of delivery? Month _____ Day _____ Year _____ LMP Date _____

DIAGNOSIS

Diagnosis: *(including any complications)*	ICD10 Codes

Subjective Symptoms

Physical Findings: *(list all test results, or enclose test)*

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Blood Pressure: (Systolic) _____ (Diastolic) _____ (Date) _____

Remarks:

TREATMENT

Date of onset of this condition?	List all dates of treatment for this condition since patienct eased work:	Date of next office visit:

Has patient been referred to any other physician? ❑ Yes ❑ No If "Yes," Date(s) _____ _____

Name:	Specialty:

Address:

Nature of treatment for this condition: *(including surgery/medications)*

Was patient hospitalized for this condition? ❑ Yes ❑ No If "Yes," Date(s) admitted: _____

Name of Hospital(s): _____ Date(s) discharged: _____

Address:

Was surgery performed? ❑ Yes ❑ No If "Yes," Date: _____ Procedure: _____ CPT Code: _____

Progress: *(please check one)* ❑ Recovered ❑ Improved ❑ Unchanged ❑ Retrogressed

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SECTION 4 – ATTENDING PHYSICIAN'S STATEMENT - HISTORY... cont.

IMPAIRMENT

What are the patient's current physical limitations and restrictions?

- ❑ No limitation of functional capacity; capable of heavy work, no restrictions.
  (Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)
- ❑ Medium manual activity.
  (Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)
- ❑ Slight limitation of functional capacity; capable of light work.
  (Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.) Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.
- ❑ Moderate limitation of functional capacity; capable ofc lerical/administrative *(sedentary)* activity.
  (Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)
- ❑ Severe limitation of functional capacity; incapable of minimal *(sedentary)* activity.

What is the psychiatric impairment *(if applicable)*?

- ❑ Inadequate information to make assessment.
- ❑ Essentially good functioning in all areas. Occupationally and socially effective.
- ❑ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- ❑ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
- ❑ Major impairment in several areas – work, family relations. Avoidant behavior, neglects family, is unable to work.
- ❑ Inability to function in almost all areas.

Date patient ceased work due to this impairment: _____

If physical or psychiatric limitations exist, indicate the date limitations lasted, or will last through: _____

Attending Physician's Name:	Telephone Number:	Fax Number:
	( )	( )
Address: *(Street,City, State & Zip Code)*		
Social Security Number or E.I.N. Number:	Degree:	Specialty:
Signature:		Date Signed:

NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company
(Herein referred to as "we", "us", "our")

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

FAMILY MATTERS. NO MATTER WHAT.®

PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us
- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- ***We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf
- ***We may also share your information with:***
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street • Canton, MA 02021

420-012 3/15

FRAUD WARNING NOTICES – For Use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

ALASKA: 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.

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.

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.

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.

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.

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.

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.

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.

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.

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: 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.

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: 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 NH Rev. Stat. Ann. §638:20.

see other side

FRAUD WARNING NOTICES – For Use with Claim Forms *(cont.)*

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

PUERTO RICO: 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 extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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 and may be subject to fines and confinement in prison.

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 a crime and may be subject to fines and confinement in state prison.

VIRGINIA: ANY PERSON WHO, WITH THE 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 HAVE VIOLATED THE STATE LAW.

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.

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.