Group Hospital Indemnity Insurance – Portability Benefit Highlights

Hartford Life and Accident Insurance Company (A stock insurance company)

Home Office: Hartford, Connecticut · Phone: 877-320-0484

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

COVERAGE INFORMATION & PORTABILITY OFFER

Hospital indemnity insurance pays a cash benefit if you or an insured dependent (spouse/partner or child) are confined in a hospital as the result of a covered illness or injury, with optional additional daily benefits for related services. Even with the best primary health insurance plan, out-of-pocket costs from a hospital stay can add up.

The benefits are paid in lump sum amounts to you (or your beneficiary), and can be used to help offset expenses that primary health insurance doesn't cover (like deductibles, co-insurance amounts or co-pays), or benefits can be used for any non-medical expenses (like housing costs, groceries, car expenses, etc.). Hospital indemnity insurance through The Hartford's group hospital indemnity portability policy is available in certain circumstances when insurance under a group accident insurance plan offered by an employer (or other group) ends.

Under The Hartford's group hospital indemnity portability policy, you have a choice of three plans, each with varying levels of benefits. You may also choose to add the Family Care Benefits Package to your plan.* This choice allows you the flexibility to enroll for the coverage that best meets your current financial protection needs. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your insured dependent(s).

If the prior group plan you were insured for included a Short Term Care (STC) Rider, you may also choose to add this rider to the plan you select.* (You are only eligible to add the STC Rider if it was included in your prior group plan.)

**The Family Care Benefits Package is not available to residents of CT, MA, MO, NH, NJ or NY. The STC Rider is not available to residents of CO, CT, MA, MN, NH, NJ, NM, NY or WA. Residents of NJ may only elect Plan 1 – Plan 2 and Plan 3 are not available to residents of NJ due to regulatory requirements in this state.*

BENEFITS		**BENEFIT AMOUNTS**		
Basic Hospital Care Benefits[1,2,3]		**Plan 1**	**Plan 2**	**Plan 3**
First Day Hospital Confinement	Once per year	$500	$1000	$1500
Daily Hospital Confinement (Day two forward)	Up to 90 days per year	$100	$150	$200
Daily ICU Confinement (Day two forward)	Up to 30 days per year	$200	$300	$400
Optional Family Care Benefits Package*		**Amounts are the same for all plans**		
Medical Travel	Up to 3 days per year	$300		
Companion Lodging	Up to 15 days per year	$125		
Family Care	Up to 30 days per year	$25		
Pet Care	Up to 30 days per year	$25		
Optional Short Term Care (STC) Rider*		**Amounts are the same for all plans**		
Short Term Care Facility Confinement	Up to 180 days per lifetime	$200		
Elimination Period	20 days	NA		

SUPPORT SERVICES

In addition to providing a financial benefit, our accident insurance includes access to professionals who can support you in your recovery at no additional cost:

- **HealthChampion℠** [4,5] – Unlimited access to administrative and clinical experts who can guide you through your health concerns and care options.
- **Ability Assist®** [5] – 24/7 access to trained professionals and resources for assistance with the financial, legal and emotional issues that may follow a hospitalization.

PREMIUMS

The amounts shown are **MONTHLY** amounts. If you choose to add the Family Care Benefits Package to your plan, and/or if you are eligible to add the STC Rider to your plan and choose to do so, an additional monthly premium charge applies, as shown in the table below. Rates and/or benefits may be changed on a class basis.

Coverage Tier	**Plan 1**	**Plan 2**	**Plan 3**	**Family Care Package***	**STC Rider***
Primary Insured (PI) Only	$8.80	$15.56	$22.32	+ $2.02	+ $1.81
PI & Spouse/Partner	$18.20	$32.22	$46.23	+ $4.08	+ $4.52
PI & Child(ren)	$17.22	$30.31	$43.39	+ $3.11	+ $1.80
PI & Family	$27.90	$49.18	$70.46	+ $5.33	+ $4.55

**The Family Care Benefits Package is not available to residents of CT, MA, MO, NH, NJ or NY. The STC Rider is not available to residents of CO, CT, MA, MN, NH, NJ, NM, NY or WA. Residents of NJ may only elect Plan 1 – Plan 2 and Plan 3 are not available to residents of NJ.*

ASKED & ANSWERED

Who is eligible? Insurance through The Hartford's group hospital indemnity portability policy is available when a qualifying event under a group hospital indemnity insurance plan offered by an employer (or other group) ends. Please see the portability provision in the prior group plan for specific details.

Anyone insured under the prior group plan at the time of the qualifying event is eligible under the portability policy, subject to the following: 1) the primary insured under the portability policy must be less than age 80 to be eligible; and 2) your dependent child(ren) must be under age 26 to be eligible. Your coverage tier may change (from what you had under the prior group plan) based on who is eligible when you request portability.

Who is the "primary insured?" If the employee under the prior group plan is eligible to elect portability, then the employee is the primary insured under the portability policy. If the spouse/partner under the prior group plan is eligible to elect portability (in the event of divorce/legal separation from or death of the employee, for example), then the spouse/partner is the primary insured under the policy.

When can I request coverage under the portability policy? Your request form and initial premium payment should be submitted within 31 days from the date group hospital indemnity insurance under the prior group plan ends. An extension of the request period is available in certain circumstances. In any event, a request received more than 91 days after group hospital indemnity insurance under the prior plan ends will not be accepted.

Am I guaranteed coverage? This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health. All you have to do is elect the coverage to become insured.

How much does this insurance cost? Monthly premiums are provided in the Premium section of this form. You have a choice of plan options and a choice of coverage tiers.

How do I request coverage? On the portability request form, select the plan you want and the coverage tier you want by marking your choices in the designated locations on the form.

How do I pay for this insurance? Your initial quarterly premium payment is payable via check or money order at the time you request coverage, as indicated on the portability request form. Upon receipt of subsequent bills, you will have the option to continue receiving paper bills and paying via check/money order, or you can choose to have future premiums paid with automated bank draft.

When does this insurance begin? If your request form and initial premium payment are accepted, insurance under the portability policy begins the first day of the month following the day group hospital indemnity insurance under the prior group plan ends. Your initial quarterly premium payment is applied from this date.

When does this insurance end? This insurance will end when the earliest of the following occurs:

- The date the policy terminates
- The date the required premium is due but not paid
- The last day of the month following the date you request we terminate coverage
- The date you again become insured under the prior group plan (ex. if you return to work with your former employer)
- The last day of the month following the date a covered person enters service in the armed forces or units auxiliary to them
- The first day of the year following the date you attain age 80

Insurance for your dependent(s) will also end when the earliest of the following occurs:

- The last day of the month following the date a child no longer meets the definition of "dependent child" within the certificate
- The last day of the month following the date that you and your spouse are no longer legally married or legally terminate your relationship

LIMITATIONS & EXCLUSIONS

The benefits payable are based on the insurance in effect on the date of the covered event, subject to the definitions, limitations, exclusions and other provisions of the policy. Additional limitations and exclusions are described in the certificate.

Pre-Existing Condition Limitation. Benefits are not payable for any covered event or for any increase in benefits for any covered event for a pre-existing condition, unless at the time of the covered event a covered person has been continuously insured under the policy or any prior group plan for 12 months. Pre-existing condition, as used in this limitation, means any illness or injury for which a covered person receives treatment within the 6 month period prior to the effective date of insurance for a covered person, or prior to the effective date of any increase in coverage for a covered person, under the policy or any prior group plan.

Exclusions. No benefits are payable under the policy for any illness or injury that results from or is caused by a covered person's:

- Suicide or attempted suicide, whether sane or insane, or intentional self-infliction
- Intoxication (as defined by the law of the jurisdiction in which the illness or injury occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instruction of a physician or medical professional
- voluntary commission of or attempt to commit a felony, voluntary participation in a riot, or voluntary engagement in an illegal occupation
- Incarceration or imprisonment following conviction for a crime
- Travel in or descent from any vehicle or device for aviation or aerial navigation, except as a fare-paying passenger in a commercial aircraft (other than a charter airline) on a regularly scheduled passenger flight
- Ride in or on any motor vehicle or aircraft engaged in acrobatic tricks/stunts (for motor vehicles), acrobatic/stunt flying (for aircraft), endurance tests, off-road activities (for motor vehicles), or racing
- Participation in any organized sport in a professional or semi-professional capacity

- Participation in abseiling, base jumping, Bossaball, bouldering, bungee jumping, cave diving, cliff jumping, free climbing, freediving, freerunning, hang gliding, ice climbing, Jai Alai, jet powered flight, kite surfing, kiteboarding, luging, missed climbing, mountain biking, mountain boarding, mountain climbing, mountaineering, parachuting, paragliding, parakiting, paramotoring, parasailing, Parkour, proximity flying, rock climbing, sail gliding, sandboarding, scuba diving, sepak takraw, slacklining, ski jumping, skydiving, sky surfing, speed flying, speed riding, train surfing, tricking, wingsuit flying, or other similar extreme sports or high risk activities
- Travel or activity outside the United States or Canada
- Active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of the policy
- Involvement in any declared or undeclared war or act of war (not including acts of terrorism), while serving in the military or an auxiliary unit attached to the military, or working in an area of war whether voluntarily or as required by an employer

In addition, benefits are not payable under the policy, unless required by law for:

- Elective abortion or complications thereof
- Artificial insemination, in vitro fertilization, test tube fertilization
- Gender change, sterilization, tubal ligation or vasectomy, and reversal thereof
- Aroma therapeutic, herbal therapeutic, or homeopathic services
- Any mental and nervous disorder
- Substance use disorder
- Medical mishap or negligence on the part of any physician, medical professional, or therapist, including malpractice
- Treatment, supplies or services provided by, through or, behalf of any government agency or program, unless payment is required by a covered person
- Custodial care, unless specifically allowed by a benefit provision in the policy or any rider attached to the policy (if applicable)
- Elective or cosmetic surgery or procedures, except for reconstructive surgery: incidental to or following surgery for disease, infection or trauma of the involved body part; or due to congenital anomaly or disease of a dependent child which has resulted in a functional defect
- Dental care or treatment, except for: treatment due to an injury to sound natural teeth within 12 months of an accident; and treatment necessary due to congenital disease or anomaly

NOTICES

THE POLICY IS A HOSPITAL CONFINEMENT INDEMNITY POLICY. THE POLICY PROVIDES LIMITED BENEFITS. This limited health benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

The policy may provide payment of several benefits as a result of claims from a single hospitalization or covered incident. Payment of one benefit under the policy does not constitute acceptance of liability for all claims made under the policy nor does it prohibit us from further investigation of subsequent claims.

Please note: For residents of CA, GA, NJ and NY, since this is a limited benefit health product, persons without comprehensive health benefits from an individual or group health insurance policy or an HMO, or an employer plan providing essential health benefits are not eligible for this insurance. For residents of CT, ID, ME, NH, and WV, a person covered by any Title XIX program (Medicaid or any similar name) is not eligible for this insurance.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

This benefit highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

[1] Hospital means an institution: licensed to operate as a hospital pursuant to law; primarily and continuously engaged in providing or operating either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and Treatment of sick or injured persons on an in-patient basis for which a charge is made; and providing 24-hour nursing service by or under the supervision of registered nurses (RNs). A hospital does not include: convalescent homes, or convalescent, rest or nursing facilities; facilities affording primarily custodial, educational or rehabilitory care; facilities primarily for care of the aged/elderly, care of persons with substance use disorders issues/disorders, or care of persons with mental and nervous disorders; or a distinct unit within a hospital that primarily treats or is dedicated to the care of persons with substance use disorders issues/disorders or mental and nervous disorders.

[2] Confined or confinement means the assignment to a bed in a medical facility for a period of at least 20 consecutive hours. This definition does not include a newborn child's initial Confinement in a Hospital following birth for routine medical and nursing care.

[3] If a covered person is eligible for more than one confinement benefit on any particular day, then only the highest applicable benefit is payable.

[4] HealthChampion℠ and Ability Assist® are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych. Ability Assist is a registered trademark and HealthChampion is a service mark of ComPsych Corporation.

[5] HealthChampion specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment.

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Portability Request Form for Group Hospital Indemnity Insurance

Hartford Life and Accident Insurance Company (A stock insurance company)

Home Office: Hartford, Connecticut · Phone: 877-320-0484

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Instructions: 1) Please print clearly with blue or black ink and provide complete information. Required information is marked with an asterisk (*). Missing information causes delays. **2)** Please review the applicable benefit highlight/summary information prior to electing coverage. You and your dependent(s) (if applicable) are only eligible for coverage as allowed by the portability policy. **3)** Please check the appropriate box(es) to elect coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed at the end of the form. If you have any questions regarding this form, please contact The Hartford toll-free at 877-320-0484.

GROUP INFORMATION

Group/Employer Name*	**Group Policy Number**	**Date of Hire** (MM/DD/YYYY)

PRIMARY INSURED INFORMATION

Name* (FIRST MI LAST)			**SSN or Tax ID***

Date of Birth* (MM/DD/YYYY)	**Gender** ☐ Male ☐ Female	**Married/Partnered** ☐ Yes ☐ No	**Primary Insured Type*** ☐ Employee/Member ☐ Spouse/Partner

Street Address*	**City***	**State***	**Zip Code***

Email Address	**Home Phone**	**Mobile/Cell Phone**

Consent to Email and Phone Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this request via email and/or phone.

REASON FOR PORTABILITY REQUEST*

If you are an employee/member applicant, tell us why you are requesting this insurance and provide the date:

☐ Employment Terminated ☐ Status Change/Reduction in Hours ☐ Retired from Employer ☐ Other: _____

Term Date: _____ Change Date: _____ Ret Date: _____ Date: _____

If you are a spouse/partner applicant, tell us why you are requesting this insurance and provide the date:

☐ Divorce ☐ Death of Employee/Member ☐ Other: _____

Date of Divorce: _____ Date of Death: _____ Date: _____

DEPENDENT INFORMATION (COMPLETE FOR ANY DEPENDENTS THAT ARE TO BE INSURED UNDER THE PORTABILITY POLICY)

Spouse/Domestic Partner Name (FIRST MI LAST) ☐ N/A	**Date of Birth**	**Gender** ☐ M ☐ F	**Date Married/Partnered**

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**
		☐ M ☐ F			☐ M ☐ F
		☐ M ☐ F			☐ M ☐ F

HOSPITAL INDEMNITY INSURANCE ELECTION*

Plan Type – Select One Option	**Coverage Tier – Select One Option**	**Monthly Premium Amount**		
		Plan 1	**Plan 2**	**Plan 3**
☐ Plan 1 ☐ Plan 2 ☐ Plan 3	☐ Primary Insured Only	$8.80	$15.56	$22.32
	☐ Primary Insured & Spouse/Partner	$18.20	$32.22	$46.23
	☐ Primary Insured & Child(ren)	$17.22	$30.31	$43.39
	☐ Primary Insured & Family	$27.90	$49.18	$70.46

Additional Benefits	**Coverage Tier (Tier Selected Above Applies)**	**Additional Monthly Premium Amount**	
		Family Care Package	**STC Rider**
☐ Family Care Package[1] ☐ STC Rider[2]	Primary Insured Only	+ $2.02	+ $1.81
	Primary Insured & Spouse/Partner	+ $4.08	+ $4.52
	Primary Insured & Child(ren)	+ $3.11	+ $1.80
	Primary Insured & Family	+ $5.33	+ $4.55

[1]*The Family Care Benefits Package is not available to residents of CT, MA, MO, NH, NJ or NY.*

[2]*The STC Rider is not available to residents of CO, CT, MA, MN, NH, NJ, NM, NY or WA. You are only eligible to add the STC Rider if it was included in your prior group plan.*

INITIAL PREMIUM PAYMENT CALCULATION*	
(1) Insert the Monthly Premium Amount for the plan and coverage tier elected:	
(2) Insert the Additional Monthly Premium Amount for the Family Care Package (if applicable):	
(3) Insert the Additional Monthly Premium Amount for the STC Rider (if applicable):	
(4) Add rows (1) through (3) to calculate the total Monthly Premium Amount:	
(5) The initial billing frequency is quarterly (3 months):	3
(6) Multiply the monthly amount (4) by the billing frequency (5) to calculate the initial premium due:	

FUTURE BILLING INFORMATION*

Future Billing Frequency – Select One Option	Future Billing Method – Select One Option
☐ Quarterly (4 times a year; Every 3 months) ☐ Semi-Annual (2 times a year; Every 6 months) ☐ Annual (Once per year)	☐ Billed via mail (A bill will be mailed to you for payment) ☐ Electronic Funds Transfer (EFT; Funds are automatically withdrawn from the account you designate) – *You must complete the separate EFT form*

BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for any benefits under the group hospital indemnity portability policy which are due and unpaid at the time of your death. This beneficiary designation replaces any prior designation made by you for group accident coverage through The Hartford. This designation may be changed upon written request.

All information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. **The percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name.

Certain states are community property states. If you live in one of these states – AK, AR, CA, ID, LA, NV, NM, TX, WA or WI – and designate someone other than your spouse as your beneficiary, state law may require that your spouse consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Please consult your legal advisor for additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
3) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
3) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

CONFIRMATION & SIGNATURE

By signing below, I confirm that I understand and agree to the following statements:

- This request is subject to review and acceptance by The Hartford, and may be denied by The Hartford.
- This request must be received by The Hartford within 91 days of the date that group hospital indemnity insurance ceased under the employee's former group plan. Requests received **more than 91 days after insurance under the group plan ceased will be denied**.
- If this request is accepted by The Hartford, this insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the group hospital indemnity portability policy.
- The individuals covered under the group hospital indemnity portability policy must satisfy the policy's requirements to be eligible for benefits. Payment of premium does not ensure eligibility for insurance.
- If this request is accepted by The Hartford, the initial quarterly premium payment is applied from the first day of the month following the date that the insurance ceased under the employee's former group plan. The next premium payment will be due by the first day of the fourth month following the day insurance under the group plan ended.
- If any premium is collected after eligibility for insurance under the group hospital indemnity portability policy ceases, the unearned premium will be refunded in accordance with the terms of the policy.
- Premium amounts may increase if the experience of the policy requires a change for all individuals insured under the policy.
- I have read the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

Primary Insured Signature	**Date of Signature**

FORM SUBMISSION INSTRUCTIONS

1) Submit this completed and signed form (pages 5-7) with the initial quarterly premium payment (as calculated) to The Hartford as soon as possible (but within 91 days) after insurance has ended under the employee's former group plan.
2) Make the check or money order for the initial quarterly premium payment payable to "**The Hartford**." Be sure to include the primary insured's name on the payment.
3) Mail this form and payment to:
   The Hartford Portability & Conversion Unit
   PO Box 43786
   Cleveland OH 44143-0786
   Fax: 440-646-9339
4) Keep a copy of the completed form for your records.

Hospital Indemnity Form Series includes GBD-2800, GBD-2900 or state equivalent.

Portability Request Form for Group Hospital Indemnity Insurance
Important Notice – Fraud Warning Statements

Hartford Life and Accident Insurance Company (A stock insurance company)

Home Office: Hartford, Connecticut · Phone: 877-320-0484

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Please read the statement that applies to your state of residence prior to signing the request form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of 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.

For Residents of California: 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of 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 and denial of insurance benefits.

For residents of 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of 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 by 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 be 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.

For residents of 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.