

**Packet Instructions**

Administrative Office: P.O. Box M, Beattyville, KY 41311
Phone: 888-762-2250 Fax: 888-598-0575

DISABILITY BENEFITS

This packet contains the forms necessary to apply for Disability benefits. For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator.

EMPLOYEE INSTRUCTIONS:

1. Complete and sign your portion of the claim form.
2. Your treating physician should complete the Attending Physician's Statement. If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefit administrator.
3. Sign and date the Authorization for Release of Information and the Fraud Statement and send them, along with the Employee's Statement, to AIG Benefit Solutions at the address listed below.
4. Maintain a copy of all documents for your records.

EMPLOYER INSTRUCTIONS:*

1. Complete and sign your portion of the claim form.
 2. Attach a copy of job description and documentation to support Employee earnings as defined in the certificate.
 3. Submit all forms along with required documents.
 4. Notify the employee's return to work date.
- * If your Policy Number begins with a "V", attach a copy of the employee's Enrollment/Application form.

MAIL/FAX CLAIM TO:

**AIG Benefit Solutions
Connecticut Claims Center
P.O. Box M
Beattyville, KY 41311
(888) 762-2250
(888) 598-0575 FAX**

OTHER BENEFITS THAT MAY REDUCE YOUR DISABILITY BENEFITS

Other benefits you receive may reduce amount of Disability benefits due you. Your group insurance certificate lists these benefits, which may include, but are not limited to, Sick Leave, Workers' Compensation, State Disability, Social Security and Retirement.

To avoid a possible overpayment of your claim, please inform us if you receive these or other benefits.

WHEN YOU RETURN TO WORK

Your Disability benefits usually stop when you return to work. Be sure that you or your employer notify us immediately when you plan to, or have, returned to work to assure no overpayment occurs.

All portions of this form packet must be completed to avoid undue delay in processing the claimant's request for benefits.



**HIPAA Authorization -
New Business and Inforce Operations**

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information**

Claimant's Name _____ Date of Birth _____ Case Number _____

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and any affiliated services company, (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American International Group (AIG) companies which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG Benefit Solutions® Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: AIG Benefit Solutions®, P.O. Box M, Beattyville, KY 41311 06034-0387. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signed of Proposed Insured or
Proposed Insured's Personal Representative

Date ____/____/____

Description of Authority of Personal Representative
(If applicable)



Employee's Statement

Administrative Office: P.O. Box M, Beattyville, KY 41311
Phone: 888-762-2250 Fax: 888-598-0575

* This company does not solicit business in New York

TO BE COMPLETED BY THE EMPLOYEE: PLEASE ANSWER ALL QUESTIONS: FAILURE TO DO SO MAY DELAY YOUR CLAIM										
First Name			Last Name			Maiden Name, if Applicable		MI		
Address				City			State		ZIP	
Home Phone Number			Additional Phone Number		Social Security Number		Date of Birth			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Height		Weight		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced				
Spouse's Name, if Applicable			Date of Birth		Is Spouse Working? <input type="checkbox"/> Yes If Yes, number of hours working <input type="checkbox"/> No					
Dependents you are responsible for (Check all that apply) <input type="checkbox"/> Children under 18 <input type="checkbox"/> Children 18-22 attending Elementary or Secondary school full time <input type="checkbox"/> Handicapped Children of any age										
Name of Child			Date of Birth		Name of Child			Date of Birth		
Your Employer's Name					Human Resources Contact		Phone Number			
Current Occupation/Job Title at Time of Disability					Job Location		Number of Hours Worked per Week			
Last day worked		First day absent from work for this disability			Medical condition preventing you from working					
List the signs and symptoms preventing you from working at any job				Date of Injury		Describe Injury				
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Workers' Compensation Carrier						Phone Number		
Do you expect to return to work? <input type="checkbox"/> Yes Date _____ <input type="checkbox"/> No		Date returned to work full-time to original job		Date returned to work full-time at a different job or same job with modifications			Date returned to work part-time			
Have you applied for or are you receiving benefits from:			Applied Yes No		Receiving Yes No		Date Applied For	Amount Received Weekly Monthly		Effective Date/End Date
Salary Continuance/Sick Time			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>					
Social Security			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>					
Workers' Compensation			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>					
State Disability			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>					
Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Please specify type			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>					
Other _____ (e.g. unemployment, union or no-fault benefits, etc.)			<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>					
Were you hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Hospital					Date Admitted		Date Discharged	
Hospital Address				City		State	ZIP		Phone Number	
If disability is the result of pregnancy or childbirth: Expected Date of Delivery _____ Actual Date of Delivery _____										
Type of delivery: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section		Post-Partum Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:								

Attending Physician's Name			Specialty		
Address		City	State	ZIP	
Phone Number		Fax Number			
First Office Visit		Last Office Visit		Next Office Visit	
List Additional Providers Name	Phone Number	Fax Number	First Office Visit	Last Office Visit	Next Office Visit
1.					
2.					
3.					
Current Medications					
Pharmacy Name				Phone Number	
Address		City	State	ZIP	
LEVEL OF EDUCATION					
High School Graduate		<input type="checkbox"/> Yes <input type="checkbox"/> No	If No, last grade completed		
College Graduate		<input type="checkbox"/> Yes <input type="checkbox"/> No	Degree	Major	
Post Graduate		<input type="checkbox"/> Yes <input type="checkbox"/> No	Degree	Major	
Other Certificates/Technical Training					
Have you attended, or are you currently attending any trade schools or received other special training? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe					
Were you in the Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No Branch of Service _____ Highest Rank _____ Specialty _____					
List prior or current employers including self employment	From	To	Salary	Job Title/Physical Requirements	
1.					
2.					
3.					
List any interests or hobbies					
If you also have Life coverage with us complete the following: Please consider this an application for waiver of premium under my Life Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No					
ACKNOWLEDGEMENT With the exception of any source(s) of income reported on this form, I certify by my signature that I have not and am not eligible to receive any source of income, expect for my AIG Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period AIG has approved my disability claim, I must report all details to AIG immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be responsible to provide repayment to AIG. AIG has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed. I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.					
Signature*			Date		
*Please sign and date the Authorization for Release of Information and the Fraud Statement and include them with this form.					



Employer's Statement

Administrative Office: P.O. Box M, Beattyville, KY 41311
Phone: 888-762-2250 Fax: 888-598-0575

The United States Life Insurance Company
New York, New York

* This company does not solicit business in New York

TO BE COMPLETED BY THE EMPLOYER: Attach a copy of the Employee's Job Description									
Employer Name					Policy Number			Class/Plan	
Employee First Name		Employee Last Name		Social Security Number		Other AIG Coverages <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Life <input type="checkbox"/> Income Plus		Policy #	
Date of hire	Employee's plan effective date		Did the employee have prior plan coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name of Carrier			
Work status prior to disability <input type="checkbox"/> Full-Time (____) hours <input type="checkbox"/> Part-Time (____) hours			Last day employee worked	First date absent	Reason employee stopped working				
Status as of first day absent: <input type="checkbox"/> Active <input type="checkbox"/> Vacation <input type="checkbox"/> LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Terminated				Date returned to work full time to original job		Date returned to work part time			
Employee's earnings \$_____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual			Additional Earnings <input type="checkbox"/> Commission <input type="checkbox"/> Other			Date of last salary increase			
Has the employee applied for or is he/she receiving benefits from		Applied Yes No	Receiving Yes No	Date Applied For	Amount Received Weekly Monthly		Effective Date/ End Date		
Salary Continuance / Sick Time		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
Social Security		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
Workers' Compensation		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
State Disability		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Specify Type _____		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
FMLA		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
Other _____ (e.g. unemployment, union or no-fault benefits, etc.)		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>						
Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Workers' Compensation Carrier			Phone Number		Contact Person			
List any other source of income to which the employee is entitled as a result of this disability									
Percentage of employee contribution to disability premium _____%		Employee's contributions were made <input type="checkbox"/> Pre tax <input type="checkbox"/> Post tax			Premium paid through date for this employee				
Is employee eligible for Group Pension? <input type="checkbox"/> Yes <input type="checkbox"/> No Monthly amount: _____			Percentage of employee contribution to Group Pension _____%			Effective date			
Employee's job is <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy					Occupation/Job Title prior to disability				
In a work day given two breaks and a meal break, the employee must: Lift (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+ Carry (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+ Total hours _____ With positional change _____ Sit 8 7 6 5 4 3 2 1 (hrs) _____ Stand 8 7 6 5 4 3 2 1 (hrs) _____ Walk 8 7 6 5 4 3 2 1 (hrs) _____ Alternately Sit/Stand 8 7 6 5 4 3 2 1 (hrs) _____				Reach above shoulder <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Climb <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Crawl <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Bend/stoop <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently		Drive cars, trucks, forklifts and/or other equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No Be around moving equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No Walk on uneven ground: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Can employee's job be modified? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____									
I HEREBY CERTIFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF:									
Employer Signature				Title			Date		
Phone Number				Fax Number			Email Address		



Attending Physician's Statement

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TO BE COMPLETED BY THE EMPLOYEE:					
First Name		Last Name		Date of Birth	
Employer Name			Current Occupation		
TO BE COMPLETED BY THE ATTENDING PHYSICIAN <i>Provide Copies of Medical Records, Consultative Reports and Diagnostic Tests</i>					
Primary Diagnosis		ICD-9	Secondary Diagnosis		ICD-9
Symptoms		Height	Weight	B/P	Dominant Side <input type="checkbox"/> Right <input type="checkbox"/> Left
PREGNANCY <i>(if applicable)</i>					
Expected date of delivery		Actual date of delivery		Type of delivery <input type="checkbox"/> Normal <input type="checkbox"/> C-section	
Significant complications, if any (ante-partum/post-partum)					
HISTORY					
Patient referred by				Phone number	
Date of first visit	Date(s) of subsequent visits		Date of most recent visit	Date of next visit	
Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when?					
Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No		
When did symptoms first appear or injury happen?			Date you advised the patient to cease/and or modify work activity		
Planned course and duration of treatment <i>(include surgery and medications, if any)</i>					
HOSPITALIZATION <i>(if applicable) Attach admission and discharge summaries</i>					
Date admitted		Reason			
Name of Hospital		Address		City	State
				ZIP	
PROGNOSIS					
Since onset of symptoms, the patient's condition has: <input type="checkbox"/> Improved <input type="checkbox"/> Not changed <input type="checkbox"/> Retrogressed					
PHYSICAL IMPAIRMENT <i>(*As defined in Federal Dictionary of Occupational Titles)</i>					
<input type="checkbox"/> Class 1 No limitation of functional capacity; capable of heavy work* no restrictions (0-10%) <input type="checkbox"/> Class 2 Medium manual activity* (15-30%) <input type="checkbox"/> Class 3 Slight limitation of functional capacity; capable of light work* (35-55%) <input type="checkbox"/> Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity* (60-70%) <input type="checkbox"/> Class 5 Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)					
In a work day given two breaks and a meal break, the patient can: Lift <i>(in pounds)</i> <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+ Carry <i>(in pounds)</i> <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+ Total hours _____ Sit 8 7 6 5 4 3 2 1 <i>(hrs)</i> _____ Stand 8 7 6 5 4 3 2 1 <i>(hrs)</i> _____ Walk 8 7 6 5 4 3 2 1 <i>(hrs)</i> _____ Alternately Sit/Stand 8 7 6 5 4 3 2 1 <i>(hrs)</i> _____			Reach above shoulder <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Climb <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Crawl <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Bend/stoop <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Drive cars, trucks, forklifts and/or other equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No Be around moving equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No Walk on uneven ground: <input type="checkbox"/> Yes <input type="checkbox"/> No		

CARDIAC (if applicable) Functional Capacity (American Heart Association)

Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Complete Limitation)
 Blood Pressure (latest reading) _____ / _____ as of _____ Date Is patient in a cardiac rehabilitation program? Yes No

MENTAL/NERVOUS (if applicable)

Define "stress" as it applies to this patient

What effect has stress and, or problems in interpersonal relations had on the patient's ability to perform her/his job functions, if any?

- Class 1 – Patient is able to function under stress and engage in interpersonal relations (No Limitations)
 Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (Slight Limitations)
 Class 3 – Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations (Moderate Limitations)
 Class 4 – Patient is not able to engage in stress situations or engage in interpersonal relations (Marked Limitations)
 Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Severe Limitations)

Axis I _____ Axis II _____ Axis III _____ Axis IV _____

Most recent GAF Score _____ Date of assessment _____ Highest GAF Score in the last year _____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? Yes No

REHABILITATION/RETURN TO WORK When could trial employment begin?**PATIENT'S JOB:**

- Full-time Part-time Date _____
 Unable to Determine: Follow-up in _____ weeks
 Never

ANY OTHER WORK:

- Full-time Part-time Date _____
 Unable to Determine: Follow-up in _____ weeks
 Never

Would job modification enable patient to work with impairment? Yes No If Yes, explain under Remarks.

Is the patient a suitable candidate for: (check as many as apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Cardiac Rehabilitation Program | <input type="checkbox"/> Work Hardening Program |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Cardiopulmonary Program | <input type="checkbox"/> Job Modification |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Pain Management Program | <input type="checkbox"/> Other |
| <input type="checkbox"/> Vocational Rehabilitation | <input type="checkbox"/> Psychological Counseling | |
- Was this discussed with the patient? Yes No

Are you aware of any other disability income policies? Yes No If Yes, list Insurance Company Name and Policy Number

Insurance Company Name _____
 Insurance Company Name _____

Policy Number _____
 Policy Number _____

REMARKS**OTHER TREATING PHYSICIANS OR CONSULTANTS**

Physician Name	Specialty	Phone Number

Name of Physician Completing This Form (Print)		Phone Number	
Specialty	Tax ID Number	Fax Number	
Address	City	State	ZIP

I HEREBY CERTIFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature _____ Date _____



Fraud Statement

Administrative Office: P.O. Box M, Beattyville, KY 41311
Phone: 888-762-2250 Fax: 888-598-0575

* This company does not solicit business in New York

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

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.

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 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.

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.

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.

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

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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.

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.

SIGNATURE OF INSURED _____

DATE _____