REPORT OF CANCER OR SPECIFIED DISEASE CLAIM

Place a check box beside the name of your insurance company listed below.
❒Central United Life Insurance Company ❒ Manhattan Life Insurance Company

Patient's Name	Date of Birth	Policy Number
Patient's Address		Relationship to Policyholder
Policyholder's Name		Policyholder's Social Security Number
What is the nature of your illness?	Date diagnosed	Date of first treatment
Physician name and address		
Were you hospitalized? ❑Yes ❑No	Date of confinement Through	
Name and address of hospital		
Have you ever had a similar illness? ❑Yes ❑No	If so, when?	

I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by Central United Life, Investors Consolidated or Loyal American or their duly authorized representative to Central United Life, Investors Consolidated or Loyal American. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is valid for 24 months. Revocation of the authorization must be submitted in writing. I or my authorized representative is entitled to a copy of this authorization.

Policyholder's Signature _____ Date: _____

Patient's Signature _____
(Required only if patient is spouse or over age 18)

Policyholder's Address _____
Street City State ZIP Code

❑Check if this is a new address.

Important: Failure to complete this form in its entirety or submit the information requested below may result in delay of processing this claim.

Please send the following information to us at the below address so we can process your claim:

- **Itemized statements from your health care providers showing the treatments, services and procedures you received.**
- **All initial diagnosis of cancer must be supported by positive pathology or lab results.**
- **A pathology report for all surgical procedures.**
- **Documents showing the actual charges paid by you or on your behalf (such as Explanation of Benefit from your primary insurance carrier or Statement of Account from your health care provider.)**
- If your policy has a transportation benefit, please submit a transportation claim form if you think you may be entitled to a transportation benefit.

Claims Department P.O. Box 925309, Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
www.manhattanlife.com

MANHATTAN INSURANCE GROUP

IMPORTANT NOTICE REGARDING CANCER BENEFITS BASED ON ACTUAL CHARGES

In today's health care system, there is often a significant difference between the amount a provider may file as a claim with third-party payors or places on its statement for a service versus the amount the provider, in fact, reasonably expects to be paid at the time of service and is in fact paid for that service.

For example, a provider may generate a statement, claim form or computer print out (collectively, "statements") listing the services rendered along with a dollar amount for the service. If you have primary health insurance, your provider has typically entered into an agreement with your primary health insurer that specifies the amount the provider has agreed to accept and will be paid in full for its services. The amount the provider has agreed to accept in full payment is usually less than the amount the provider puts on its statement or transmits as a claim to your primary health insurer.

Similarly, where Medicare is involved, the amount the provider can charge a health care provider is set by law. The Medicare approved amount a provider can be paid in full for services is often less than the amount shown in the provider's statement or submitted as a claim to Medicare. Additionally, you personally may have requested and received a reduction in the amount the provider has agreed to accept as payment in full.

In all of these cases, the amounts shown on the provider's claim form or statement is not the real amount the provider, in fact, charged for the service and was paid for the service. The actual charge instead will be reflected in an Explanation of Benefits (EOB) from your primary insurance company, in a Medicare Summary if you are on Medicare, or other similar documentation provided to you by the provider showing adjustments to the provider's list price for the service.

In those instances where the benefit amount under your supplemental cancer policy for radiation, chemotherapy and blood benefits are based upon the actual charge and is not subject to a cap, we determine the amount of benefits based upon the amount that the provider has, in fact, charged: that is, the real amount the provider has accepted as full payment by you or on your behalf for the service rendered.

Here's what you can do to expedite the processing of your claim: When making a claim for a benefit that is based on the actual charge for a service, please supply us with documentation reflecting the amount paid to, and accepted by, the provider for the service. This will enable us to determine the amount that was paid by you or on your behalf for covered services and accepted by the provider as payment in full for these services. This information would include, for example, any Explanation of Benefit statements, Medicare Summary, or statements of account showing the amounts the health care providers were paid by you or on your behalf.

Please call us at 1-800-669-9030 if you have any questions. We appreciate your business.

PLEASE READ THIS INFORMATION BEFORE SUBMITTING YOUR CLAIM

If you need assistance, please contact our Customer Service Department at 1-800-669-9030.

PLEASE READ YOUR POLICY CAREFULLY

Cancer policies pay benefits for certain specified treatments, procedures and services rendered to the policyholder or named insured for the treatment of cancer. These limited benefit policies pay benefits only for those items listed in your policy. **Since the cancer policy is a specified benefits policy, it does not pay for all treatments, procedures or services you may receive in connection with your cancer treatment.** Please refer to your policy to determine your eligible benefits.

COMPLETE THE CLAIM FORM IN ITS ENTIRETY

Please do not send documents without a completed claim form. Always include your policy number on the claim form and indicate if you have more than one policy with us. Include the area code and telephone number for you and your physician.

TIMELY CLAIM FILING

All policies have a time period specified in the policy regarding when a claim must be submitted. Please review your policy to ensure you file all claims in accordance with your policy. Failure to file your claim timely may result in the claim being denied.

COMPLETE A HIPAA FORM

Please complete a HIPAA form, found on our web site, and submit it with your claim. You only need to complete this form once and we will keep the form on file. You do not need to submit a new HIPAA form with each claim. This form can assist us in obtaining additional information on your behalf to help process your claim.

ITEMIZED STATEMENTS

It is your responsibility to provide us with all of the information needed to determine if the services received are a benefit under the policy. Attach all relevant information to your claim form, i.e. itemized statements from each medical provider who treated you and your hospital UB-04s. These statements provide detailed information regarding the treatments, procedures, and services you received from the medical provider. Itemized statements must include:

- The name of the person or organization providing the service, their address, telephone number, and tax identification number
- Name of the patient
- Date each service was provided
- Description of each service
- A dollar amount for each service

PATHOLOGY REPORTS

Every diagnosis of cancer must be supported by a positive pathology report, including the initial and any subsequent diagnosis. Also, a pathology report must be submitted with any surgical claim.

CHEMOTHERAPY AND RADIATION

When you submit a claim for chemotherapy and /or radiation, please ensure that the statements from your providers contain the number of units that were administered.

SURGERY/ANESTHESIA

When submitting a claim for surgery performed to remove cancer, please provide the following:

- A copy of the surgeon's statement
- A copy of the anesthesiology statement, if you had anesthesia
- A pathology report should be submitted with any surgical claim.

PRESCRIPTION DRUGS

Please submit an itemized statement from the pharmacy which shows the name of the drug, the identifying drug number, and the amount paid. Cash register or charge slips are not acceptable.

TRANSPORTATION

If your policy has a transportation benefit provision and you had to travel away from your home to obtain cancer treatment, please provide the following:

- Completed transportation claim form. This form can be found on our web site.
- Any appropriate receipts (i.e. hotel receipts, airline tickets)

ACTUAL CHARGE POLICIES

Some policies contain benefits that are paid based on the actual charge. If you are unsure, please review the chemotherapy, radiation, and blood and plasma benefits in your policy.

If your policy pays benefits based on the actual charges, please submit documents showing the amount the medical provider actually charged – that is, the amount that was paid by or on your behalf to the medical provider as payment in full.

Documents which show the actual charges paid by you or on your behalf include an Explanation of Benefits from your primary insurance carrier.

If you need assistance in determining what documentation to provide, please contact our Customer Service Department at 1-800-669-9030.

A WORD ABOUT OUR EXPLANATION OF BENEFITS (EOB) STATEMENTS

Our EOBs only list those services which are covered benefits under the terms of your policy.

For example, if you submit a claim for chemotherapy administered in a hospital, the statement may contain miscellaneous hospital charges which may not be benefits under your policy.

Only those items that are covered services as indicated in your policy will be listed on the EOB.

Submit Completed Form to:
Claims Department, P.O. Box 925309, Houston, TX 77292-5309
Customer Service Department 1-800-669-9030

MANHATTAN INSURANCE GROUP

Claim Form Addendum: Fraud Warning and State Versions

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

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. **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. **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 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. **Hawaii** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both. **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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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 RSA 638:20. **New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New Mexico** Any person who knowingly presents a false or fraudulent claim for payment 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 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. **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. **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** 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. **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.

ManhattanLife
Standing By You. Since 1850.™

DESGLOSE DE MÉDICOS

ÚLTIMOS 24 MESES

Nombre Completo Doctor: _____

Teléfono: _____ Fax: _____ Email: _____

Dirección Postal: _____

_____

Nombre Completo Doctor: _____

Teléfono: _____ Fax: _____ Email: _____

Dirección Postal: _____

_____

Nombre Completo Doctor: _____

Teléfono: _____ Fax: _____ Email: _____

Dirección Postal: _____

_____

Nombre Completo Doctor: _____

Teléfono: _____ Fax: _____ Email: _____

Dirección Postal: _____

_____

Nombre Completo Doctor: _____

Teléfono: _____ Fax: _____ Email: _____

Dirección Postal: _____

_____

Manhattan Life Insurance Company
Family Life Insurance Company
Western United Life Assurance Company
ManhattanLife Assurance Company of America

Worksite Benefits
Claims Department
P.O. Box 925309
Houston, Texas 77092-5309

Authorization to Obtain and Disclose Protected Health Information and Other Information

Name: _____ Policy No: _____
I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to the Company(ies) identified above, hereinafter called the Company including any legal representative designated by the Company, the following protected health information: Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to the Company and any legal representative that it might designate.

I authorize the Company to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of the Company or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, the Company pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to the Company at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____ _____

Date Authorization Signed

Signature of Claimant or Authorized Personal Representative
(e.g., parent or guardian, if minor)

10777 Northwest Freeway, Suite 600
Houston, TX 77092
www.manhattanlife.com

Phone: 713-529-0045
Toll Free: 800-669-9030

Authorization for Policyholder Initiated Request for Release of Protected Health Information to Other

Name or Employer	Policy Number

Primary Policyholder Covered by the Health Plan (Last, First)

Name of Person Granting Authorization (Last, First) Leave blank if same as Primary Member	Relationship to Primary Policyholder (self, spouse, dependent child or designated personal rep)

My protected health information is information about me that was collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; Iii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

For my purposes and at my request, I authorize Manhattan Life Insurance Company, Family Life Insurance Company, Western United Life Assurance Company and ManhattanLife Assurance Company of America to disclose my protected health information to the following Individual, organization, or class of persons (e.g., group Individuals within the organization) (check all that apply):

❑ My Spouse: (specify)
The protected health information that may be used and disclosed to my Spouse is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status or Protected Health Information related to Claims Status
- ❑ Other (specify) _____

❑ My Employer/ Plan Sponsor:
The protected health information that may be used and disclosed to my Employer/Plan Sponsor is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status
- ❑ Other (specify) _____

❑ Agent: (specify)
The protected health information that may be used and disclosed to my Broker is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status
- ❑ Other (specify) _____

❑ Other: (specify) _____
The protected health information that may be used and disclosed to this specified Individual(s) is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status
- ❑ Other (specify) _____

[If choosing "Other", describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

I understand that I may refuse to sign this authorization. I further understand that the above named health plan will not condition enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to the above named health plan at the address located below, and this revocation will be affective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that the above named health plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the above named health plan and, by law, the above named health plan has a right to contest the coverage.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires at the earlier of: 1) 12 months from the date when it was signed or 2) when I am no longer an active policyholder of the above named health plan.

_____
Signature of Person Granting Authorization or Personal Representative

_____
Date

Printed Name_____
(Last) (First)

_____
Description of Personal Representative's Authority (if applicable)

You may contact me at the address below if you have questions concerning my responses in the Authorization

_____
Street Address City State

Phone: (_____) _____

Email: _____

Send your completed authorization or notice of revocation to the following address:
Claims Department
P.O. Box 925309, Houston, Texas 77092-5309
or
FAX to (713) 583-8508

NOTE: All authorizations granted by this document are in addition to any uses and disclosures of protected health information permitted or required under the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy regulations.

This form is not to be used for obtaining records from providers for underwriting or risk rating.

First Occurrence Benefit Claim Form

Please check the box next to your insurance company's name.

❑ Central United Life ❑ Investors Consolidated ❑ Loyal American ❑ Unum

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You have chosen to obtain coverage for first occurrence of internal cancer. Should you ever become diagnosed with internal cancer, this form is to help you receive your benefit early to help cover some of the unexpected out of pocket expenses that you might incur. Please use this form to receive your initial payment. Once received with all the information completed below, we will gladly expedite your benefit to you.

Policy Number: _____

Named of Insured: _____

Claimant's Name if different from Insured: _____

Social Security Number: _____

Address: _____

City, State, ZIP: _____

IMPORTANT: Please include the Pathology Report showing the diagnosis of the malignancy. We are unable to process your request without this information.

Signature of Insured: _____

Date: _____

Submit Completed Form to:
Claims Department
P.O. Box 925309
Houston, TX 77292-5309

Customer Service Department 1-800-669-9030
www.manhattanlife.com

FOB 0509

MANHATTAN INSURANCE GROUP

PLEASE READ THIS INFORMATION BEFORE SUBMITTING YOUR CLAIM

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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 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. **Hawaii** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both. **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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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 RSA 638:20. **New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New Mexico** Any person who knowingly presents a false or fraudulent claim for payment 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 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. **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. **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** 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. **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.