



# Voluntary Student Accident Medical Insurance

## K-12 Schools | 2026-2027

Recess, after-school care, interscholastic sports, field trips, and other school-related activities can all lead to unexpected injuries. Voluntary Student Accident Insurance Plans provide affordable financial protection — helping cover medical expenses so an injury does not become a financial burden. This plan is primary for individuals without insurance or with state-funded coverage (such as Medi-Cal/Medicaid or TRICARE) and secondary for those with private or Medicare insurance.

### Eligibility:

Coverage is available to students enrolled in participating school districts, providing budget-conscious options including a Low, Medium, and High plan.



School-Time Student  
Accident Coverage



24-HR Student  
Accident Coverage



Interscholastic  
Sports Coverage



24-HR Dental  
Coverage



Football-Only  
Coverage

**Online enrollment is easy! To begin, visit:** <https://studentinsuranceusa.com/insurance/k-12-student-accident-insurance-plan-enrollment/>

1. Click **“Enroll Online”**.
2. Select your state and click **“Look Up”**.
3. Choose your school or district.
4. Review plan options and make your selections.
5. Complete the online application.
6. Pay a one-time annual premium by credit or debit card.
7. Print your confirmation as proof of coverage.

## Filing a Claim:

**Complete the Gerber Life claim form, including details surrounding the injury and details of any additional insurance coverage \***

1. Access a claim form at [k12specialmarkets.com/claimforms](https://k12specialmarkets.com/claimforms).
2. Select your state and then your school or district.
3. Claim forms require **both a parent/guardian and a school official's signature**.
4. Be sure to include information about any **other insurance coverage**, if applicable.
5. Submit your completed form by email, mail, fax, or electronically through the claim's website.
6. An acknowledgement letter and claim number will be mailed to the address on file.
7. Reference your claim number when submitting medical bills from providers.

**Please note:** If you are a plan administrator for a school or group and would like to learn more, please email [SIRep@studentinsuranceusa.com](mailto:SIRep@studentinsuranceusa.com).

## About Student Insurance:

Since 1950, Student Insurance (SI) has delivered competitive pricing on comprehensive Student Accident Insurance coverage to the K-12 segment. SI is dedicated to helping families manage the unexpected costs of student injuries through flexible, easy-to-access coverage options. Comprehensive policy details regarding benefits, exclusions, and limitations are available by contacting your school or district office.

**Please note:** Students are able to purchase coverage only if their school district is a policyholder with the insurance company.

## How can we help?

Contact a Student Healthcare Expert at: [SIRep@studentinsuranceusa.com](mailto:SIRep@studentinsuranceusa.com) to learn more.

6320 Canoga Ave, 12th Floor  
Woodland Hills, CA 91367  
[Studentinsuranceusa.com](https://Studentinsuranceusa.com)



**Youth Insurance Agency, Inc. DBA Student Insurance | CA License 0386216**  
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2026 – 2027 STUDENT ACCIDENT INSURANCE COVERAGE

**OPTIONAL SCHOOL TIME ACCIDENT COVERAGE** - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity. No coverage is provided while participating in Interscholastic Sports.

**Annual Premium: Plan “Low” – \$10.00 Plan “Medium” – \$16.00 Plan “High” – \$25.00**

**OPTIONAL 24-HOUR ACCIDENT COVERAGE** - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. No coverage is provided while participating in Interscholastic Sports.

**Annual Premium: Plan “Low” – \$48.00 Plan “Medium” – \$65.00 Plan “High” – \$125.00**

**OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage)** – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is \$25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of \$1,000. The Student must be treated by a legally qualified dentist who is not a member of the student’s Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth.

**Annual Premium: \$8.00**

**COVERAGE PERIOD –** Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending academic classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available)**.

| SCHEDULE OF BENEFITS                                                                                                   |                                                             |                                   |                                   |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------|-----------------------------------|
| Coverage for Injuries due to Accidents only                                                                            |                                                             |                                   |                                   |
| Maximum Benefit:                                                                                                       | Plan “Low”                                                  | Plan “Medium”                     | Plan “High”                       |
| School-Time Option                                                                                                     | \$25,000                                                    | \$50,000                          | \$100,000                         |
| 24-Hour Option                                                                                                         | \$25,000                                                    | \$50,000                          | \$100,000                         |
| Injuries Involving Motor Vehicles                                                                                      | \$10,000                                                    | \$10,000                          | \$ 10,000                         |
| Death Benefit/Double Dismemberment                                                                                     | \$10,000                                                    | \$20,000                          | \$ 20,000                         |
| Single Dismemberment                                                                                                   | \$ 5,000                                                    | \$10,000                          | \$ 10,000                         |
| Loss Period for Medical Benefits                                                                                       | Treatment must begin within 60 days from the date of Injury |                                   |                                   |
| Benefit Period for Medical and AD&D/Loss of Sight Benefits                                                             | 1 Year                                                      | 1 Year                            | 1 Year                            |
| Excess Coverage Applicability                                                                                          | Full Excess                                                 | Full Excess                       | Full Excess                       |
| <b>Hospital/Facility Services - Inpatient</b>                                                                          |                                                             |                                   |                                   |
| Hospital Room and Board (Semi-Private Room Rate)                                                                       | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Inpatient Hospital Miscellaneous                                                                                       | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| <b>Hospital/Facility Services - Outpatient</b>                                                                         |                                                             |                                   |                                   |
| Free-Standing Ambulatory Surgical Facility                                                                             | 65% RE* to \$500 Maximum                                    | 75% RE* to \$800 Maximum          | 80% RE* to \$1,500 Maximum        |
| Outpatient Hospital Miscellaneous                                                                                      | 65% RE* to \$500 Maximum                                    | 75% RE* to \$800 Maximum          | 80% RE* to \$1,500 Maximum        |
| (Except physician services and x-rays paid as below)                                                                   | 65% RE* to \$500 Maximum                                    | 75% RE* to \$800 Maximum          | 80% RE* to \$1,500 Maximum        |
| Hospital Emergency Room                                                                                                | 65% RE* to \$500 Maximum                                    | 75% RE* to \$800 Maximum          | 80% RE* to \$1,500 Maximum        |
| <b>Physician's Services</b>                                                                                            |                                                             |                                   |                                   |
| Surgical                                                                                                               | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Assistant Surgeon                                                                                                      | 25% of Surgical Benefits                                    | 25% of Surgical Benefits          | 25% of Surgical Benefits          |
| Anesthesiologist                                                                                                       | 25% of Surgical Benefits                                    | 25% of Surgical Benefits          | 25% of Surgical Benefits          |
| Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation                        | 65% RE* / \$25 Visit/5 Visit Max.                           | 75% RE* / \$30 Visit/7 Visit Max. | 80% RE* / \$40 Visit/8 Visit Max. |
| Physician's Non-surgical Treatment (Except as above)                                                                   | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| <b>Other Services</b>                                                                                                  |                                                             |                                   |                                   |
| Registered Nurses' Services                                                                                            | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Prescriptions - outpatient                                                                                             | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Laboratory Tests – Outpatient                                                                                          | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| X-rays, includes interpretation – Outpatient                                                                           | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation                                                        | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Ground Ambulance                                                                                                       | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Durable Medical Equipment (includes Orthopedic Braces & Appliances)                                                    | 65% RE*                                                     | 75% RE*                           | 80% RE*                           |
| Dental Treatment to sound, natural teeth due to covered injury                                                         | 65% RE* to \$500 Maximum                                    | 75% RE* to \$800 Maximum          | 80% RE* to \$1,500 Maximum        |
| Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury. | \$150 Maximum                                               | \$500 Maximum                     | \$700 Maximum                     |
| *RE means Reasonable Expense                                                                                           |                                                             |                                   | GER_0418 ENOSPORTS(0009)          |

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2026 – 2027 ENROLLMENT APPLICATION (please print or type)

|                                                            |                                            |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Student’s Last Name                                        | Student’s First Name                       | Student’s Middle Initial                                                                                                                     | Grade                                                                                                                                                                                                                                                                                                                    |
| Address _____                                              |                                            | City _____                                                                                                                                   | State _____ Zip _____                                                                                                                                                                                                                                                                                                    |
| Telephone Number _____                                     |                                            | Birthdate _____                                                                                                                              |                                                                                                                                                                                                                                                                                                                          |
| School System _____                                        |                                            | Name of School _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                          |
| Check your selection:                                      | Plan “Low”<br>Plan “Medium”<br>Plan “High” | <input type="checkbox"/> School-Time \$10.00<br><input type="checkbox"/> School-Time \$16.00<br><input type="checkbox"/> School-Time \$25.00 | <input type="checkbox"/> 24-Hour Accident \$ 48.00<br><input type="checkbox"/> 24-Hour Accident \$ 65.00<br><input type="checkbox"/> 24-Hour Accident \$125.00<br><br><input type="checkbox"/> 24-Hour Dental \$8.00<br><input type="checkbox"/> 24-Hour Dental \$8.00<br><input type="checkbox"/> 24-Hour Dental \$8.00 |
| Please make check payable to Gerber Life Insurance Company |                                            |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                          |
| Total Enclosed: _____                                      |                                            |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                          |
| Signature of Parent or Guardian _____                      |                                            | Date _____                                                                                                                                   |                                                                                                                                                                                                                                                                                                                          |

Please Return To: Student Insurance  
c/o K12Special Markets Plan Administrators  
1055 Main Street, Suite 101  
Stevens Point, WI 54481

2026 – 2027 STUDENT ACCIDENT INSURANCE COVERAGE

**OPTIONAL SPORTS COVERAGE** - Covers Accidents occurring while participating in Interscholastic Sports practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. No coverage is provided while participating in interscholastic tackle football (see below Optional Football Coverage option). **Annual Premium: \$105.00**

**OPTIONAL FOOTBALL COVERAGE** - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. **Annual Premium: \$335.00**

**OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage)** – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is \$25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of \$1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth. **Annual Premium: \$8.00**

**COVERAGE PERIOD** – Coverage under the Optional Sports Coverage, the Optional Football Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional Sports Coverage and Optional Football Coverage ends on the last day of practice or competition. Optional 24-Hour Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available)**.

| SCHEDULE OF BENEFITS                                                                                                   |                                                             |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| Coverage for Injuries due to Accidents only                                                                            |                                                             |
| Maximum Benefit:                                                                                                       | Sports Plan                                                 |
| Sports Option                                                                                                          | \$25,000                                                    |
| Football Option                                                                                                        | \$25,000                                                    |
| Injuries Involving Motor Vehicles                                                                                      | \$10,000                                                    |
| Death Benefit/Double Dismemberment                                                                                     | \$20,000                                                    |
| Single Dismemberment                                                                                                   | \$10,000                                                    |
| Loss Period for Medical Benefits                                                                                       | Treatment must begin within 60 days from the date of Injury |
| Benefit Period for Medical and AD&D/Loss of Sight Benefits                                                             | 1 Year                                                      |
| Excess Coverage Applicability                                                                                          | Full Excess                                                 |
| Hospital/Facility Services - Inpatient                                                                                 |                                                             |
| Hospital Room and Board (Semi-Private Room Rate)                                                                       | 100% Reasonable Expenses                                    |
| Inpatient Hospital Miscellaneous                                                                                       | 100% Reasonable Expenses                                    |
| Hospital/Facility Services - Outpatient                                                                                |                                                             |
| Free-Standing Ambulatory Surgical Facility                                                                             | 100% Reasonable Expenses                                    |
| Outpatient Hospital Miscellaneous                                                                                      | 100% Reasonable Expenses                                    |
| (Except physician services and x-rays paid as below)                                                                   |                                                             |
| Hospital Emergency Room                                                                                                | 100% Reasonable Expenses                                    |
| Physician's Services                                                                                                   |                                                             |
| Surgical                                                                                                               | 100% Reasonable Expenses                                    |
| Assistant Surgeon                                                                                                      | 100% Reasonable Expenses                                    |
| Anesthesiologist                                                                                                       | 100% Reasonable Expenses                                    |
| Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation                        | 100% Reasonable Expenses                                    |
| Physician's Non-surgical Treatment (Except as above)                                                                   | 100% Reasonable Expenses                                    |
| Other Services                                                                                                         |                                                             |
| Registered Nurses' Services                                                                                            | 100% Reasonable Expenses                                    |
| Prescriptions - outpatient                                                                                             | 100% Reasonable Expenses                                    |
| Laboratory Tests – Outpatient                                                                                          | 100% Reasonable Expenses                                    |
| X-rays, includes interpretation – Outpatient                                                                           | 100% Reasonable Expenses                                    |
| Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation                                                        | 100% Reasonable Expenses                                    |
| Ground Ambulance                                                                                                       | 100% Reasonable Expenses                                    |
| Durable Medical Equipment (includes Orthopedic Braces & Appliances)                                                    | 100% Reasonable Expenses                                    |
| Dental Treatment to sound, natural teeth due to covered injury                                                         | 100% Reasonable Expenses                                    |
| Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury. | \$500 Maximum                                               |
| GER_0618 ESPRTS(0009)                                                                                                  |                                                             |

2026 – 2027 ENROLLMENT APPLICATION (please print or type)

Student's Last Name

Student's First Name

Student's Middle Initial

Grade

Address

City

State

Zip

Telephone Number

Birthdate

School System

Name of School

Check your selection:

☐ Sports Option \$105.00

☐ Football \$335.00

☐ 24-Hour Dental \$8.00

Please make check payable to Special Markets Insurance Consultants, Inc.

Total Enclosed:

Signature of Parent or Guardian

Date

Please Return To: Student Insurance  
c/o K12Special Markets Plan Administrators  
1055 Main Street, Suite 101  
Stevens Point, WI 54481

**PLEASE READ THIS INFORMATION CAREFULLY. It is important.**

**PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM**

**ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED**

**NOTE:** The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

**Claim Guidelines: The following guidelines must be followed.**

♦Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

♦If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

- 1) HCFA-1500 (standard form used by Providers; sample attached)
- 2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
- 3) ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

♦If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

♦Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident. File claim electronically by clicking [here](#).

♦If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

♦Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

#### **Common Causes For Delays In Processing Claims**

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

**KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CARRIER →

[illegible]

# DENTAL PLAN CLAIM FORM

| American Dental Association Dental Claim Form                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                |                   |                    |                 |         |  |  |  |  |  |                                 |                               |                                |                   |                    |                 |         |   |  |  |  |  |  |  |   |  |  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| <b>HEADER INFORMATION</b><br>1. Type of Transaction (Mark all applicable boxes)<br><input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Preauthorization/Preauthorization<br><input type="checkbox"/> EPIDIO Title XIX<br>2. Preauthorization/Preauthorization Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b><br>3. Company/Plan Name, Address, City, State, Zip Code<br><div style="text-align: center;">Insurance Company Name</div> Address 1<br>Address 2<br>City                      ST                      ZIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| <b>OTHER COVERAGE</b><br>4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)<br>5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)<br>6. Date of Birth (MM/DD/YYYY)    7. Gender    8. Policyholder/Subscriber ID (SSN or ID#)<br><div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Self    <input type="checkbox"/> Issue    <input type="checkbox"/> Dependent Child    <input type="checkbox"/> Other</span> <span><input type="checkbox"/> M    <input type="checkbox"/> F    <input type="checkbox"/> F</span> </div> 9. Plan/Issue Number    10. Patient's Relationship to Person Named in #5<br><div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Self    <input type="checkbox"/> Issue    <input type="checkbox"/> Dependent    <input type="checkbox"/> Other</span> <span><input type="checkbox"/> M    <input type="checkbox"/> F    <input type="checkbox"/> F</span> </div> 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code<br><div style="text-align: center;">Other Insurance Company Name</div> Address<br>City                      ST                      ZIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <b>PATIENT INFORMATION</b><br>12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code<br><div style="text-align: center;">Policyholder Name</div> Address 1<br>Address 2<br>City                      ST                      ZIP<br>13. Date of Birth (MM/DD/YYYY)    14. Gender    15. Policyholder/Subscriber ID (SSN or ID#)<br><div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Self    <input type="checkbox"/> Issue    <input type="checkbox"/> Dependent Child    <input type="checkbox"/> Other</span> <span><input type="checkbox"/> M    <input type="checkbox"/> F    <input type="checkbox"/> F</span> </div> 16. Plan/Issue Number    17. Employee Name<br>18. Relationship to Policyholder/Subscriber in #12 Above<br><div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Self    <input type="checkbox"/> Issue    <input type="checkbox"/> Dependent Child    <input type="checkbox"/> Other</span> <span><input type="checkbox"/> FTS    <input type="checkbox"/> PFT</span> </div> 19. Student Status<br><div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Self    <input type="checkbox"/> Issue    <input type="checkbox"/> Dependent Child    <input type="checkbox"/> Other</span> <span><input type="checkbox"/> FTS    <input type="checkbox"/> PFT</span> </div> 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code<br><div style="text-align: center;">Patient Name</div> Address 1<br>Address 2<br>City                      ST                      ZIP<br>21. Date of Birth (MM/DD/YYYY)    22. Gender    23. Patient ID/Account # (Assigned by Dentist)<br><div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Self    <input type="checkbox"/> Issue    <input type="checkbox"/> Dependent Child    <input type="checkbox"/> Other</span> <span><input type="checkbox"/> M    <input type="checkbox"/> F    <input type="checkbox"/> F</span> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <b>RECORD OF SERVICES PROVIDED</b><br><table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>24. Procedure Date (MM/DD/YYYY)</th> <th>25. Date of Exam (MM/DD/YYYY)</th> <th>26. Teeth Number(s) or Surface</th> <th>27. Tooth Surface</th> <th>28. Procedure Code</th> <th>29. Description</th> <th>30. Fee</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>11</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>12</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>13</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> 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Procedure Date (MM/DD/YYYY) | 25. Date of Exam (MM/DD/YYYY) | 26. Teeth Number(s) or Surface | 27. Tooth Surface | 28. Procedure Code | 29. Description | 30. 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**UNITEDHEALTHCARE SERVICE LLC**  
**GREENSBORO SERVICE CENTER**  
**P O BOX 740800**  
**ATLANTA, GA 30374-0800**  
**PHONE: 1-800-838-8010**  
**VISIT WWW.UHHC.COM FOR SELF SERVICE**

**UnitedHealthcare**  
A UnitedHealth Group Company

DATE: 1 OF 1  
DATE: 04/29/19  
SSN/ID #:  
EMPLOYEE:  
CONTRACT:  
BENEFIT PLAN: PFIZER INC

## EXPLANATION OF BENEFITS

| PATIENT/RELAT CLAIM NUMBER             | PROVIDER/SERVICE | DATE OF SERVICE | AMOUNT CHARGED | NOT COVERED   | AMOUNT ALLOWED | COPAY / DEDUCTIBLE | PLAN COVERS | BENEFIT AVAILABLE | REMARK CODE |
|----------------------------------------|------------------|-----------------|----------------|---------------|----------------|--------------------|-------------|-------------------|-------------|
| 9061512101                             | MEDICAL SERVICES | 03/19/10        | 379.00         | 297.83        | 81.17          |                    | 80%         | 64.94*            | 4C          |
|                                        |                  | <b>TOTAL</b>    | <b>379.00</b>  | <b>297.83</b> | <b>81.17</b>   |                    |             |                   |             |
| MEDICARE PAID 44.64<br>PLAN PAYS 20.30 |                  |                 |                |               |                |                    |             |                   |             |

(\*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE" (4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION

\$20.30

| SATISFIED 2019 TO-DATE | DEDUCTIBLE                         | OUT OF POCKET                       |
|------------------------|------------------------------------|-------------------------------------|
| FAMILY                 | \$1000.00                          | \$1328.77                           |
| SP                     | \$500.00                           | \$1281.45                           |
| PLAN YEAR 2010         | FAMILY \$1000.00<br>INDIV \$500.00 | FAMILY \$4900.00<br>INDIV \$4900.00 |



## CLAIM FORM

### SIGNED CLAIM FORM IS REQUIRED

1. PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
2. ATTACH HCFA/UB04-MEDICAL BILLS & EOB'S FROM ANY OTHER INSURANCE YOU HAVE
3. SEND ALL CORRESPONDENCE TO:

WEB-TPA  
P.O. Box 2415  
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468  
Fax: 469-417-1969  
Email: [benefit.assist@webtpa.com](mailto:benefit.assist@webtpa.com)  
File Electronically: Click [Here](#)

#### IMPORTANT NOTICE:

This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: **The accident policy benefits are limited and may not provide 100% coverage.**

◀ IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED ▶

#### PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
School/Team/League Name \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_  
Address \_\_\_\_\_ Email \_\_\_\_\_  
\_\_\_\_\_ Type of Activity/Sport \_\_\_\_\_

If Athletics, designate ☐ P.E. Class ☐ Intramural ☐ Interscholastic ☐ Intercollegiate ☐ Game ☐ Jr. Varsity ☐ Varsity  
☐ Youth ☐ Adult ☐ Practice ☐ Other \_\_\_\_\_

Name of injured person/student \_\_\_\_\_

Date of Accident \_\_\_\_\_ Accident Time \_\_\_\_\_

Date of First Treatment \_\_\_\_\_ Has treatment been completed? ☐ Yes ☐ No

Where and how did accident occur? (Please be specific) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Part of body Injured \_\_\_\_\_ ☐ Right or ☐ Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? ☐ Yes ☐ No

Under whose supervision? \_\_\_\_\_ Was he/she a witness? ☐ Yes ☐ No

Authorized Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

#### PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name \_\_\_\_\_ Preferred/Nickname: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade Level \_\_\_\_\_ ☐ Male ☐ Female

Claimant is a ☐ Student ☐ Player ☐ Coach ☐ Official/Umpire ☐ Volunteer ☐ Child Care ☐ Participant ☐ CE Student (# of credits \_\_\_\_\_)

Address of Injured Person or Parents/Guardian \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone No. ( ) \_\_\_\_\_ Email Address \_\_\_\_\_

If Injured party is over age 18: Employer Name and Address \_\_\_\_\_  
\_\_\_\_\_

Phone No. ( ) \_\_\_\_\_ ☐ Self Employed ☐ Unemployed

Father/Guardian Name \_\_\_\_\_

Employer Name and Address \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

☐ Self Employed ☐ Unemployed

**PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL**

Mother/Guardian Name \_\_\_\_\_  
Employer Name and Address \_\_\_\_\_ Phone No. (     ) \_\_\_\_\_  
\_\_\_\_\_ ☐ Self Employed    ☐ Unemployed

If Dental Injury: Please submit verification from the dentist that the tooth/teeth are whole, sound and natural.

Is claimant covered under any other medical and or dental insurance policy?    ☐ Yes    ☐ No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid?    ☐ Yes    ☐ No

Name of all companies providing claimant insurance coverage or prepaid health plans

| Name of Company | Address | Policy # |
|-----------------|---------|----------|
| _____           | _____   | _____    |
| _____           | _____   | _____    |
| _____           | _____   | _____    |

Are benefits due for this claim under these other insurance coverages?    ☐ Yes    ☐ No    (See IMPORTANT NOTICE at top of form on page 1)

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree?    ☐ Yes    ☐ No    If yes, please give name, address and phone number of responsible party \_\_\_\_\_  
\_\_\_\_\_

**AFFIDAVIT:** I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

**Signature:** Injured Person, Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
*SIGNATURE IS REQUIRED*

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

**Signature:** Injured Person, Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

## FRAUD NOTICE STATEMENTS

**NOTICE TO APPLICANTS:** "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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

**RESIDENTS OF 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 OF FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

**RESIDENTS OF ALASKA APPLICANTS:** "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."

**RESIDENTS OF ARKANSAS APPLICANTS:** "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."

**RESIDENTS OF ARIZONA APPLICANTS:** "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."

**RESIDENTS OF CALIFORNIA:** "FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

**RESIDENTS OF COLORADO APPLICANTS:** "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."

**RESIDENTS OF 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."

**RESIDENTS OF DISTRICT OF COLUMBIA APPLICANTS:** "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."

**RESIDENTS OF FLORIDA APPLICANTS:** "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."

**RESIDENTS OF IDAHO:** "ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECIEVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

**RESIDENTS OF INDIANA:** "ANY 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."

**RESIDENTS OF KANSAS APPLICANTS:** "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

**RESIDENTS OF KENTUCKY APPLICANTS:** "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILED 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."

**RESIDENTS OF LOUISIANA APPLICANTS:** "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."

**RESIDENTS OF MAINE APPLICANTS:** "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."

**RESIDENTS OF MARYLAND APPLICANTS:** "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."

**RESIDENTS OF MINNESOTA APPLICANTS:** "ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

**RESIDENTS OF NEW HAMPSHIRE:** "ANY PERSON WHO, WITH THE 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."

**RESIDENTS OF NEW JERSEY APPLICANTS:** "ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

**RESIDENTS OF NEW MEXICO APPLICANTS:** "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."

**RESIDENTS OF NEW YORK APPLICANTS:** "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."

**RESIDENTS OF OHIO APPLICANTS:** "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

**RESIDENTS OF OKLAHOMA APPLICANTS:** "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."

**RESIDENTS OF OREGON APPLICANTS:** "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."

**RESIDENTS OF PENNSYLVANIA APPLICANTS:** "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."

**RESIDENTS OF 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 OR MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

**RESIDENTS OF TENNESSEE APPLICANTS:** "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."

**RESIDENTS OF TEXAS APPLICANTS:** "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."

**RESIDENTS OF VERMONT APPLICANTS:** "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

**RESIDENTS OF VIRGINIA APPLICANTS:** "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."

**RESIDENTS OF WASHINGTON APPLICANTS:** "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

**RESIDENTS OF WEST VIRGINIA APPLICANTS:** "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."