Prudential

Group Insurance
Please send the completed form and all attachments to:
The Prudential Insurance Company of America
Beneficiary Services
P.O. Box 70182
Philadelphia, PA 19176
Tel: 800-524-0542 Fax: 844-625-7807

Group Life Insurance Claim Form

How to complete and submit a Group Life Insurance Claim Form

1. **Complete Sections 1, 2, 3, 4, and 5 of the Group Contract Holder Statement portion of the Group Life Insurance Claim Form. Section 1 must be completed if the claim is for an employee/member, or for a dependent of an employee. Please be sure to complete the "Relationship to Employee" block.**
   For Dependent Term Life coverage on children, the employee is always the beneficiary. For Dependent Term Life coverage on a spouse, the employee is usually the beneficiary, except for certain Group Universal Life and Group Variable Universal Life coverage, in which the employee may be able to specify other beneficiaries.
2. **Detach the Beneficiary Statement and give a copy to each beneficiary. Ask each beneficiary to complete it and return it to you.**
   If there are multiple beneficiaries, each beneficiary should complete a beneficiary statement. It is only necessary for you to submit one Group Contract Holder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you have. For Claims for which there is no beneficiary, please refer to the "Beneficiary Rules" section of your Group Life Certificate. *Additional information may be required.*
3. **Return both the Group Insurance Contract Holder Statement and the Beneficiary Statement(s) with the required documents noted below to:**
   The Prudential Insurance Company of America
   Beneficiary Services
   P.O. Box 70182
   Philadelphia, PA 19176

   If you have any questions, please call Group Life Claim Customer Service at 800-524-0542 and a customer service representative will assist you.

Documents to submit to Prudential

Submit the Group Contract Holder Statement, Beneficiary Statement(s), and the following attachments:

1. A certified copy of the death certificate.
2. A copy of the employee's enrollment card, if available.
3. A copy of the most recent beneficiary designation and any beneficiary changes, if applicable.
4. The certificate of insurance, if available.
5. If the insurance was assigned, attach a copy of the assignment and all related papers. If it is a collateral assignment, attach the assignee's statement of indebtedness.
6. If an accidental death claim is being filed, attach supporting information, such as a police report or newspaper clippings.
7. Legal documentation of the beneficiary for the following situations:
   If the beneficiary is
   (a) an estate, minor, or not competent to handle financial affairs: attach a certified copy of the court order appointing the legal representative.
   (b) a trust: attach a letter verifying that the trust is still in effect. If the trust is a testamentary, attach a certified copy of the will and a certified copy of the testamentary.
   (c) no longer living: attach a copy of the death certificate.
8. If a Business Travel Accident (BTA) claim is being filed, attach information requested in (7) together with documentation further substantiating the loss, such as a trip itinerary, travel tickets, etc.

Prudential

Group Insurance Contract Holder Statement

To be completed by Employer/Plan Administrator. Please complete all five sections.

1. Deceased's Information

First name | MI | Last name

Social Security number | Date of birth (mm/dd/yyyy) | Date of death (mm/dd/yyyy) | State of residence

Did decedent have accidental death coverage?

Date of accident (mm/dd/yyyy) | State of accident

AKA: First name | AKA: Last name

2. Employee/Member Information

First name | MI | Last name

Social Security number | Date of birth (mm/dd/yyyy) | **Date last worked (mm/dd/yyyy) *Required Field**

Date of employment (mm/dd/yyyy)

☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Part time ☐ Full time

If not actively at work immediately prior to death, what was the reason?

☐ Disability ☐ Resigned ☐ Leave of Absence ☐ Retired ☐ Vacation ☐ Temporary Layoff ☐ Terminated

☐ Other

Occupation

Where employed

Street address | Apt/Suite (optional)

City | State | ZIP Code

3. Employer/Association Information

Employer's name

Employer's Representative name

Street address

Apt/Suite (optional)

City

State

ZIP Code

– –
Telephone number

Prudential

___ – ___ – ____
Deceased's Social Security number

4. Insurance Coverage

Complete only the coverage(s) that apply to this claim.

Group Coverage	Control #	Amount	Effective Date of Coverage (mm/dd/yyyy)	Branch
☐ Basic Term Life		$	___ / ___ / _____	
☐ Optional Term Life		$	___ / ___ / _____	
☐ Dependent Term Life		$	___ / ___ / _____	
☐ Dependent Optional Term Life		$	___ / ___ / _____	
☐ Group Universal Life		$	___ / ___ / _____	
☐ Group Variable Universal Life		$	___ / ___ / _____	
☐ Dependent Group Universal Life		$	___ / ___ / _____	
☐ Accidental Death		$	___ / ___ / _____	
☐ Group Universal Accidental Death		$	___ / ___ / _____	
☐ Dependent Accidental Death		$	___ / ___ / _____	
☐ Optional Accidental Death		$	___ / ___ / _____	
☐ Dependent Optional Accidental Death		$	___ / ___ / _____	
☐ Dependent Group Universal Accidental Death		$	___ / ___ / _____	
☐ Business Travel Accidental Death		$	___ / ___ / _____	
☐ Dependent Business Travel Accidental Death		$	___ / ___ / _____	

Salary Amount on Last Day Worked $ _____ . ___ per ☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned? ☐ Yes ☐ No
If yes, please attach a copy of assignment and all related papers. For collateral assignment, please attach assignee's statement of indebtedness.

Has insurance election increased in last two years? ☐ Yes ☐ No
___ – ___ – ____
If yes, provide date (mm/dd/yyyy)

Was evidence of insurability required to secure current coverage? ☐ Yes ☐ No

Is there contributory insurance? ☐ Yes ☐ No
___ – ___ – ____
Date last premium paid (mm/dd/yyyy)

Was insurance in force on date of death? ☐ Yes ☐ No

Was Conversion Privilege Offered? ☐ Yes ☐ No
___ – ___ – ____
If no, provide date (mm/dd/yyyy)

Did the employee or the covered dependent suffer a loss as defined by the BTA contract? ☐ Yes ☐ No
If yes, an officer of the company must provide a written statement validating the circumstances of the accidental death.

5. Beneficiary Information

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

☐ No Beneficiary Designation On File
If No, please list family point of contact information under Beneficiary #1.

Beneficiary #1

Name of Beneficiary

– – Date of birth (mm/dd/yyyy)

– – Social Security number

– – Telephone number

Street address

Apt/Suite (optional)

City

State

– ZIP Code

Relationship to deceased

Beneficiary #2

Name of Beneficiary

– – Date of birth (mm/dd/yyyy)

– – Social Security number

– – Telephone number

Street address

Apt/Suite (optional)

City

State

– ZIP Code

Relationship to deceased

5. Beneficiary Information (cont.)

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

Beneficiary #3

Name of Beneficiary

Date of birth (mm/dd/yyyy) | Social Security number | Telephone number

Street address | Apt/Suite (optional)

City | State | ZIP Code

Relationship to deceased

Beneficiary #4

Name of Beneficiary

Date of birth (mm/dd/yyyy) | Social Security number | Telephone number

Street address | Apt/Suite (optional)

City | State | ZIP Code

Relationship to deceased

Completed by (name of representative of the employer or benefit administrator)

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud warnings (refer to pages 13 and 14) included as part of this form. I certify that the above statements are true.

Please print or type name

Signature | Date (mm/dd/yyyy)

Group Insurance
Please send the completed form and all attachments to:
The Prudential Insurance Company of America
Beneficiary Services
P.O. Box 70182
Philadelphia, PA 19176
Tel: 800-524-0542 Fax: 844-625-7807

Prudential

Beneficiary Statement—Quick Start Guide

What you'll find in this package

- *Group Life Insurance Claim Form*—Please complete, sign, and return this form to start the claim process.
- *Payment Option Information*—Decide how you would like to receive your claim proceeds.
- *An Authorization to Release Information to Prudential may be required when claiming Accidental Death/Dismemberment Benefits.* Please review and complete this section (Page 12) when claim Accidental Death/Dismemberment Benefits.

Note: On these pages, *I*, *you*, and *your* refer to the person making the claim. *We*, *us,* and *our* refer to the Prudential company that issued the policy. Please note that we will only use phone numbers and email that we collect to keep you updated on the status of your claim.

To submit your claim, follow these steps:

1. Decide how to receive your funds

Be sure to select a payment option when you complete the form. Your options include:

- Open an interest-bearing Alliance Account.
- Elect to receive a single lump sum check by a check mailed to you.
- Elect to deposit funds directly in your chosen bank account via Electronic Funds Transfer (EFT).

See page 9 for more detailed information regarding your payment options.

2. Complete the enclosed form

Fill out the enclosed *Group Life Insurance Claim Form* that begins on the next page. Please follow the instructions and provide all requested information for prompt claim processing. Also, please review the fraud warnings found at the back of this statement.

This form, and the information contained within, is not intended as investment advice and is not a recommendation about managing or investing retirement savings. Neither The Prudential Insurance Company of America, nor the Prudential entity(ies) set forth on this form, are acting as your fiduciary as defined by any applicable laws and regulations. Please consult with your qualified investment professional about managing or investing retirement savings.

3. Return the signed claim form and supporting documentation

Please mail pages 8–10 of your claim form, as well as any additional documents that may be required, **including** a copy of the death certificate to:

The Prudential Insurance Company of America
Beneficiary Services
P.O. Box 70182
Philadelphia, PA 19176

Fax: 844-625-7807
Email: grouplifeclaims@prudential.com

Prudential

Group Life Insurance Claim Form

Group Insurance
Please send the completed form and all attachments to:
The Prudential Insurance Company of America
Beneficiary Services
P.O. Box 70182
Philadelphia, PA 19176
Tel: 800-524-0542 Fax: 844-625-7807

1. About You

Provide information about the person making the claim. Be sure to verify your Social Security number, TIN, or EIN.

First name | MI | Last name

Street address | Apt/Suite (optional)

City | State | ZIP Code

Home phone | Mobile phone | Relationship to deceased

Email address

How do you want us to contact you? (Check all that apply.) ☐ U.S. Mail ☐ Email ☐ Text Alerts ☐ Phone

Date of birth (mm/dd/yyyy) | Social Security number (SSN), Tax ID, or EIN

Taxpayer Identification Number (TIN)

You must include a TIN for the beneficiary. This is:

- A Social Security number (SSN) if the beneficiary is an individual or the owner of a sole proprietorship.
- The employer identification number (EIN) if you represent a trust, estate, corporation, partnership, or tax-exempt organization.
- The TIN of the grantor/trustee if you represent a grantor trust, or that of the actual owner of a trust-like entity not recognized as a legal or valid trust under state law.
- If you are a guardian completing this form for someone else, including a minor, be sure to provide that person's SSN.

2. About the Deceased

Provide information about the deceased.

Control Number | Deceased's Employer name

First name | MI | Last name

Date of birth (mm/dd/yyyy) | Date of death (mm/dd/yyyy) | Social Security number

Prudential

Group Life Insurance Claim Form

Deceased's Social Security number

3. Choose a Payment Option

Please choose ONE of the following settlement or payment options. If you are interested in discussing an annuity settlement option, please call us at **800-524-0542**.

- ☐ Deposit funds in a Prudential Alliance Account, an interest-bearing account that gives you immediate access to your funds. You may transfer or withdraw all or part of the balance at any time and at no cost. Please see page 11 for more information.
- ☐ Receive a single lump sum check—for all funds[1]
- ☐ Deposit funds directly in your chosen bank account via Electronic Funds Transfer (EFT)—for all funds[1]

If you selected the EFT option above, please complete Part 4.

1 Funds are paid net of any assignments, e.g., funeral home. A funeral home assignment is an agreement to pay the funeral home with a portion (or all) of your benefit amount before any remainder is paid to you.

4. Banking Information and Payment Authorization (For EFT Payment Option Only)

Bank name

Branch Telephone

Bank Transit Routing Number (9 digits)

Account Type: ☐ Checking ☐ Savings

Bank Account Number

Bank Location (City and State)

I authorize The Prudential Insurance Company of America (Prudential) to make electronic deposits of my Group Life Plan Insurance Death Claim proceeds into the above account. I understand that any deposit made to an inactive account agreement will be returned to Prudential and a check will be reissued. In addition, if any overpayment of such Death Claim proceeds is credited to this account in error, I authorize Prudential to withdraw the difference between the benefit amount paid and the recalculated amount of the benefit actually due under the terms of the insurance coverage. My eligibility for any such benefits is governed by the terms and conditions of the Group Life Policy, and nothing in this Authorization shall be deemed to be an approval of any such benefits.

This authorization is valid indefinitely until such time as I provide written notice of cancellation to Prudential. Any notice hereunder will not be deemed effective until three business days after Prudential has received my written notice.

Account Owner's First Name | MI | Last Name

Street address

City | State | ZIP Code

Telephone

Account Owner's signature

Date (mm/dd/yyyy)

Return this page with the completed form.

Prudential

Group Life Insurance Claim Form

Deceased's Social Security number

5. Tax Certification

Please complete any applicable portions of (a) or (b). See Definitions below for more information.
(a) Under penalties of perjury, I certify that:

- I am a U.S. person (including resident alien);
- The Social Security/Tax ID number provided in Part A above is my correct SSN/TIN;
- I am not subject to backup withholding due to failure to report interest or dividend income; and
- I am not subject to FATCA reporting.

(b) Check the boxes below, if applicable:
I am not a U.S. person (including resident alien). I am a citizen of _____.
Attach the applicable IRS Form W-8 (BEN, BEN-E, ECI, EXP, IMY).

- ☐ I am subject to backup withholding due to the failure to report interest or dividend income (see "Backup Withholding" in the Tax Certification Information section)
- ☐ I am subject to FATCA reporting

Definitions

Backup Withholding

You must tell us if the IRS has notified you that you are subject to backup withholding because you didn't report all your taxable interest and dividends on your tax return. You are not subject to backup withholding if either (a) you did not receive such a notice from the IRS, (b) the IRS told you that you are no longer subject to a backup withholding order, or (c) you are exempt from such withholding. If you have been notified that you are subject to backup withholding, please check the box as indicated.

Foreign Account Tax Compliance Act (FATCA)

Any entity making a payment of U.S. source income must consider whether it is subject to FATCA. A payor must collect documentation about the payee's status or withhold at 30%. Nontaxable payments, such as income tax-free death benefits from nonqualified life insurance contracts, are not subject to FATCA.

Citizenship

You must indicate if you are not a U.S. person (including resident alien). In that case, you must state the country in which you are a citizen and submit the applicable IRS Form W-8 (BEN, BEN-E, ECI, EXP, IMY). In most situations, the IRS Form W-8BEN will be the appropriate IRS Form W-8.

6. Signature

FLORIDA RESIDENTS—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.

NEW YORK RESIDENTS—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.

I have read and understand the terms and requirements of the Claim Fraud Warnings included with this form.
The Internal Revenue Service does not require your consent to any provision in this document other than the certifications required to avoid backup withholding.

Beneficiary's or Claimant's signature

Date (mm/dd/yyyy)

Do not return this page with the completed form.

Prudential

Group Life Insurance Claim Form

Deceased's Social Security number

7. How the Alliance Account Works **Do not return this page with the completed form.**

Your Funds: All funds are held within Prudential's general account. It is not Federal Deposit Insurance Corporation (FDIC) insured because it is not a bank account or a bank product. Funds held in the Alliance Account are guaranteed by State Guaranty Associations. Please contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) at 703-481-5206 to learn more about coverage limitations on your accounts. State guaranty fund coverages are not determined by the insurance company.

Beneficiary Designation: After electing an Alliance Account, you may designate a beneficiary for your account by completing and returning the beneficiary designation in your Alliance Account kit.

How Interest Is Earned: The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily, and credited every month. The interest rate may change and will vary over time, subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support. The interest rate credited to the Alliance Account is adjusted by Prudential at its discretion based on variable economic factors (including, but not limited to, prevailing market rates for short-term demand deposit accounts, bank money market rates, and Federal Reserve interest rates) and may be more or less than the rate Prudential earns on the funds in the account.

Account Statements: You will receive regular (either monthly or quarterly) statements showing your current balance, the interest you earned, the drafts you have written, your current interest rate, and any other account activity. The frequency at which the statements are mailed to you is determined by the activity in your Alliance Account.

Special Service Fees: There are fees for special services, which are subject to change, and include stop payments ($12 per draft/$25 maximum for three or more per day)' cashed draft copy or statement copy ($2 per draft)' drafts returned for insufficient funds ($10 per draft)' and overnight delivery (based on carrier's charge).

Minimum Balance: If the balance falls below $250, you will receive a check for the remaining balance plus interest at the end of the monthly cycle in which the balance fell below $250. You can close the Alliance Account at any time by calling the Customer Service office. A check for the remaining balance and interest will be sent to you. Or, you can close the account by writing an Alliance draft for the balance and cashing it or depositing it at your own bank. Since interest accrues daily, a check for the remaining accrued interest will be sent to you.

Inactive Accounts: State law requires that if there is no account activity and we have had no contact with you regarding your Alliance Account after a number of years (time period varies by state), your Alliance Account may be considered "dormant." If your Alliance Account becomes "dormant," you will be mailed a check for the remaining balance plus interest, at your last address shown on our records. If you do not cash that check in a timely manner, your funds will be transferred to the state as unclaimed property. If your funds are transferred to the state, you may claim those funds from the state but you may be charged a fee by the state. Once your funds are transferred to the state, we no longer have any liability or responsibility with respect to your Alliance Account. For Alliance Account funds paid under the Servicemembers' Group Life Insurance program, the treatment of those "dormant" funds may be different.

FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. Alliance Account balances are not insured by the FDIC. The Bank of New York Mellon is not a Prudential Financial company.

Prudential

Group Life Insurance Claim Form

Deceased's Social Security number

Please complete only if filing an AD&D claim.

Authorization to Release Information

For the purposes of evaluation of a claim for insurance benefits, I authorize all physicians, hospitals, clinics, medical providers, other health providers, insurance companies, pharmacies, pharmacy benefit managers, employers, investigative consumer reporting agencies, and other agencies, including governmental organizations and the Social Security Administration, to provide to Prudential the insured's entire medical record (excluding psychotherapy notes), employment record, pharmacy record, insurance claim record, and insurance policy information. Upon the presentation of the original or photocopy of this signed authorization, I request the Social Security Administration to release to Prudential any and all information regarding earnings and any other information that may determine eligibility for benefits under the Social Security Act.

You are authorized to permit the Prudential or its authorized representative to obtain a copy of the entire medical record including but not limited to, treatment for communicable diseases such as the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), drug and alcohol use and all other information relative to the physical health, mental health, dental care, or employment pertaining to:

Insured's name

First name | MI | Last name

Date of birth (mm/dd/yyyy)

Date of death if applicable (mm/dd/yyyy)

This authorization will remain valid while the claim is pending, but not for more than two years and can be revoked by giving written notice to Prudential. Prudential may be unable to complete the claim process and may deny benefits if this form is unsigned or revoked. Prudential will not release this information to any other entity other than its reinsurers or service providers without written authorization, unless required or allowed by law or ordered by a court of law. A copy of this authorization form will be provided to you upon request. A photocopy of this authorization is as valid as the original.

Once disclosed to Prudential, this information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information. For purposes of this authorization, I hereby revoke any prior restriction on disclosure of medical records provided to any medical provider and authorize the release of the Insured's entire medical record to Prudential, excluding psychotherapy notes.

X _____
Signature

Date (mm/dd/yyyy)

X _____
Witness

_____
Relationship

Return this page with the completed form.

Prudential

Group Life Insurance Claim Form

Deceased's Social Security number}

About the Beneficiary

Indicate who is claiming the life insurance proceeds. If there is more than one beneficiary, each beneficiary must complete a separate form. We only need one copy of the death certificate. Please note that we will only use phone numbers and emails that we collect to keep you updated on the status of your claim.

Please also note:

- For representatives of the insured's estate, if estate is not being administered through the courts, we may be able to pay the insured's heirs directly if permitted by law.

Important Information

COLORADO RESIDENTS—Funds held by insurance companies are guaranteed by the Colorado Life and Health Insurance Protection Association, but are not guaranteed by the Federal Deposit Insurance Corporation (FDIC). Please contact the Colorado Life and Health Insurance Protection Association (www.colifega.org), the National Organization of Life and Health Guaranty Associations, or the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about the coverage limitations to your account.

ILLINOIS RESIDENTS—Payment on accidental death and dismemberment claims made after 31 days from the day we receive proof of accidental death or dismemberment of the insured, under the policies issued in Illinois, will include interest at the rate of 10% per year. The interest will be payable from the date of accidental death or dismemberment to the date of payment.

LOUISIANA RESIDENTS—The Louisiana Department of Insurance is located at 1702 N. 3rd Street, Baton Rouge, LA 70802 and can be reached by calling 800-259-5300. Written inquiries can be sent to the Louisiana Department of Insurance, Post Office Box 94214, Baton Rouge, LA 70804.

Prudential

Claim Fraud Warnings

For residents of all states and jurisdictions except Alabama, Arizona, Arkansas, California, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Texas, Utah, Vermont, Virginia, and Washington: WARNING — Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS—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.

ARIZONA RESIDENTS—For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, and RHODE ISLAND RESIDENTS—Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA and TEXAS RESIDENTS—For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

KENTUCKY RESIDENTS—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.

MAINE and WASHINGTON RESIDENTS—Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

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

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

NORTH CAROLINA RESIDENTS—Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

PENNSYLVANIA and UTAH RESIDENTS—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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS—Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS—Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS—Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Do not return this page with the completed form.

GLGE2114