

Please Read Instructions Before Completing

PART A POLICYHOLDER/CLAIMANT'S STATEMENT

1	POLICYHOLDER'S NAME	POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX
2	POLICYHOLDER'S ADDRESS STREET CITY STATE ZIP CODE				
3	CLAIMANT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	RELATIONSHIP TO POLICYHOLDER	POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)	
4	POLICY HOLDER'S OCCUPATION	DESCRIBE WHEN AND HOW YOUR ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS.			
5	IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION <input type="checkbox"/> NO <input type="checkbox"/> YES DATE REPORTED TO YOUR EMPLOYER:		HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> APPROVED <input type="checkbox"/> PENDING <input type="checkbox"/> DENIED <input type="checkbox"/> APPEALING Y		
6	DATE SYMPTOMS FIRST APPEARED	TREATED BY: NAME ADDRESS CITY STATE ZIP CODE			
		IF HOSPITALIZED: NAME ADDRESS CITY STATE ZIP CODE			
		DATES HOSPITALIZED: FROM THROUGH			
7	DATES YOU DID NOT WORK AT ALL. FROM THROUGH	DATES YOU WORKED LESS THAN FULL TIME. FROM THROUGH	DATE YOU RETURNED OR EXPECT TO RETURN TO WORK. FULL-TIME PART-TIME		
8	PRIMARY DOCTOR NAME	TREATING DOCTOR NAME	REFERRING DOCTOR NAME		
	ADDRESS	ADDRESS	ADDRESS		
	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE		
	PHONE NUMBER	PHONE NUMBER	PHONE NUMBER		

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

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

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

9 Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative

Policyholder's Signature: _____ Date: _____ Claimant's Signature: _____ Date: _____

Post Office Box 427
Columbia, South Carolina 29202
Phone (800) 433-3036

PART B**EMPLOYER'S STATEMENT****(To be completed by your Benefits Department unless self-employed)**

1	EMPLOYEE'S NAME:	EMPLOYEE ID NUMBER	DATE OF BIRTH	DATE OF HIRE
2	OCCUPATION AT TIME LAST WORKED _____ EMPLOYEE'S JOB TITLE DUTIES INCLUDE LIFTING <input type="checkbox"/> LESS THAN 15LBS. <input type="checkbox"/> 15 TO 44 <input type="checkbox"/> OVER 45 STOOPING/BENDING <input type="checkbox"/> NONE <input type="checkbox"/> SELDOM <input type="checkbox"/> FREQUENT REPETITIVE <input type="checkbox"/> NONE <input type="checkbox"/> SELDOM <input type="checkbox"/> FREQUENT CRAWLING/CLIMBING/KNEELING <input type="checkbox"/> NONE <input type="checkbox"/> SELDOM <input type="checkbox"/> FREQUENT REACHING/PULLING/PUSHING <input type="checkbox"/> NONE <input type="checkbox"/> SELDOM <input type="checkbox"/> FREQUENT MANAGEMENT DUTIES <input type="checkbox"/> NONE <input type="checkbox"/> SELDOM <input type="checkbox"/> FREQUENT SITTING (NUMBER OF HOURS EACH DAY) _____ STANDING/WALKING (HOURS EACH DAY) _____			
3	DATE EMPLOYEE WAS ACTUALLY LAST PRESENT AT WORK		WORK SCHEDULE AT TIME LAST WORKED: NO. OF DAYS/WEEK: _____ NO. OF HOURS/DAY: _____	
4	DATES EMPLOYEE DID NOT WORK AT ALL: FROM _____ THROUGH _____		DATES EMPLOYEE WORKED LESS THAN FULL-TIME HOURS: FROM _____ THROUGH _____	
5	DATE THE EMPLOYEE RETURNED TO FULL-TIME WORK OR LIGHT DUTY/PART-TIME:		IF THE EMPLOYEE HAS NOT RETURNED, IS LIGHT DUTY AVAILABLE?	
6	DID THE CLAIM RESULT FROM JOB ACTIVITY? (IF "YES," ATTACH FIRST REPORT OF INJURY – ACCIDENT REPORT.) <input type="checkbox"/> NO <input type="checkbox"/> YES	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> APPROVED <input type="checkbox"/> PENDING <input type="checkbox"/> DENIED, IF SO, HAS THE EMPLOYEE APPEALED Y N	WORKER'S COMPENSATION WEEKLY AMOUNT \$ _____	
7	HAS THE EMPLOYEE RECEIVED ANY OTHER INCOME AS A RESULT OF DISABILITY? <input type="checkbox"/> NO <input type="checkbox"/> YES	SALARY CONTINUANCE, SICK PAY OR VACATION WEEKLY BENEFIT _____ DATE CEASED _____	OTHER TYPE _____ WEEKLY BENEFIT _____ DATE CEASED _____	
8	IS ANY PORTION OF THE EMPLOYEE'S POLICY PAID FOR BY THE EMPLOYER? <input type="checkbox"/> NO <input type="checkbox"/> YES IF "YES," WHAT PERCENTAGE? _____	IS THE EMPLOYEE'S POLICY PAID FOR WITH PRE-TAX DOLLARS (SECTION 125)? <input type="checkbox"/> NO <input type="checkbox"/> YES	WHAT IS THE EMPLOYEE'S BASIC MONTHLY EARNINGS? \$ _____	

AUTHORIZED EMPLOYER'S SIGNATURE

9	EMPLOYER'S COMPANY NAME:	TELEPHONE NUMBER:	FAX NUMBER:
10	ADDRESS:	NAME AND TITLE OF PERSON COMPLETING THIS FORM:	
11	SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE:	DATE:	

PART C

ATTENDING PHYSICIAN'S STATEMENT
(To be completed by your current treating physician)

1	PATIENT'S NAME		DATE OF BIRTH
2	WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	DATE PATIENT BECAME DISABLED DUE TO PRESENT CONDITION?	HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____
3	IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF THE PATIENT'S EMPLOYMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF "YES," DATE ACCIDENT OCCURRED: _____		NAMES AND ADDRESSES/ REFERRING OR OTHER TREATING PHYSICIANS

DIAGNOSIS

4	DIAGNOSIS (INCLUDING COMPLICATIONS)	ICD CODE(S):	SUBJECTIVE SYMPTOMS	IF PREGNANT: EDC: LMP:
5	OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS.)			

TREATMENT

6	DATE FIRST TREATED FOR THIS CONDITION	LAST DATE TREATED FOR THIS CONDITION	FREQUENCY <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER
7	NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)		DID PATIENT HAVE SURGERY? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____ DESCRIBE SURGERY: _____ CPT CODE: _____

PROGNOSIS

8	HAS THE PATIENT: <input type="checkbox"/> RECOVERED? <input type="checkbox"/> IMPROVED? <input type="checkbox"/> UNCHANGED? <input type="checkbox"/> RETROGRESSED?	IS THE PATIENT: <input type="checkbox"/> AMBULATORY? <input type="checkbox"/> HOUSE CONFINED? <input type="checkbox"/> BED CONFINED? <input type="checkbox"/> HOSPITAL CONFINED?
9	HAS THE PATIENT BEEN HOSPITAL CONFINED? <input type="checkbox"/> NO <input type="checkbox"/> YES CONFINED FROM _____ TO _____	IF YES, GIVE NAME AND ADDRESS OF HOSPITAL:
10	IS THE PATIENT NOW TOTALLY DISABLED FROM PATIENT'S JOB? <input type="checkbox"/> NO <input type="checkbox"/> YES ANY OTHER WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES	
11	WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE PATIENT'S CONDITION? <input type="checkbox"/> 1 MO. <input type="checkbox"/> 1-3 MO. <input type="checkbox"/> 3-6 MO. <input type="checkbox"/> 6-9 MO. <input type="checkbox"/> 9-12MO. <input type="checkbox"/> NEVER	WHEN DO YOU ANTICIPATE A RETURN TO WORK WITHOUT RESTRICTIONS?
12	WHEN COULD A TRIAL EMPLOYMENT COMMENCE? DATE (PATIENT'S JOB): _____, <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> LIGHT DUTY DATE (ANY OTHER WORK): _____, <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> LIGHT DUTY	

IMPAIRMENTS

13	PHYSICAL IMPAIRMENTS (As defined in the Federal Dictionary of Occupational Titles) <input type="checkbox"/> CLASS 1 - No limitation of functional capacity; capable of heavy work. No restrictions (0-10%) <input type="checkbox"/> CLASS 2 - Medium manual activity. (15-30%) <input type="checkbox"/> CLASS 3 - Slight limitation of functional capacity; capable of light work. (35-55%)	<input type="checkbox"/> CLASS 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%) <input type="checkbox"/> CLASS 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity (75-100%)
14	RESTRICTIONS AND LIMITATIONS (What specific activities is the patient incapable of performing)	

REMARKS

15	REMARKS (Additional comments regarding the patient's condition)
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"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

NAME (Attending Physician) PLEASE PRINT	FAX NUMBER	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	

INSURED: _____ CLAIM #: _____ COVERAGE ID: _____

AUTHORIZATION FOR CONTINENTAL AMERICAN INSURANCE COMPANY

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran’s Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.

I am the individual to whom this authorization applies or that person’s legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of individual subject to disclosure)

(Date of Birth)

(Signature)

(Date Signed)

If applicable, I signed on behalf of the insured as _____ (indicate relationship) if legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of legal representative)

(Signature of legal representative)

(Date Signed)

PRE-EXISTING INVESTIGATION STATEMENT

If you are filing during the first year of your coverage effective date and subject to a pre-existing investigation, complete the below pre-existing statement form in full and return to our office with your claim form. *You will need to provide medical information for the 12 month period PRIOR to your effective date of coverage.*

CLAIMANT NAME: _____

COVERAGE ID #: _____

REQUIRED DOCTOR INFORMATION

DOCTORS NAMES	ADDRESS	TELEPHONE NUMBER	REASON FOR TREATMENT	DATES

REQUIRED HOSPITAL INFORMATION

NAME OF HOSPITAL	ADDRESS	TELEPHONE NUMBER	REASON	DATES

PRESCRIPTION MEDICATIONS

NAME OF MEDICINE	PRESCRIBING DOCTOR	PHARMACY NAME, ADDRESS AND TELEPHONE NUMBER	REASON FOR MEDICATION

MAJOR MEDICAL CARRIER

NAME OF CARRIER	ADDRESS & TELEPHONE NUMBER	POLICYHOLDER NAME	POLICY NUMBER

****PLEASE ATTACH ADDITIONAL PAPER IF NEEDED****

Should you need additional information or instruction on completing this form, please call our Customer Service Department @ 1-800- 433-3036.

Signature and Date: _____

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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

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

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

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing Any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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

ALL OTHER STATES: 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.