Guardian

BENESCH FRIEDLANDER COPLAN & ARONOFF LLP
ALL ELIGIBLE EMPLOYEES
Group Number: 00481071

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

Your coverage options

Accident insurance	Helping you cover expenses after an accident

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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Watch our video
How accident insurance can get you back on your feet.

Accident insurance

Accidents happen. With accident insurance, you can help them hurt a bit less.

Accident insurance is an extra layer of protection that gives you a cash payment to help cover out-of-pocket expenses when you suffer an unexpected, qualifying accident.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident Insurance pays you lump sum of benefits after you suffer an accident. This could be more than 40 different circumstances, including: emergency treatment, ambulance, burns, dislocations, fractures, hospital confinement, and surgery.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. Accident insurance can be a simple, affordable way to help supplement and cover additional expenses your health and disability insurance may not cover, including x-rays, ambulance services, deductibles, and even things like rent or groceries.

Plus, accident insurance is portable and payments are made directly to you.

Added support during recovery

Amanda breaks her leg falling off her bike and needs emergency treatment.

Average non-surgical broken leg treatment expense: **$2,500**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **$1,700**

Amanda's Guardian Accident policy pays her a benefit of **$1,700,** which covers all of her out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

You will receive these benefits if you meet the conditions listed in the policy.

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Your accident coverage

	ACCIDENT	
COVERAGE - DETAILS	**Option 1: Basic**	**Option 2: Advantage**
Your Semi-monthly premium	$2.48	$4.57
You and Spouse	$4.01	$7.18
You and Child(ren)	$4.23	$7.43
You, Spouse and Child(ren)	$5.76	$10.04
Accident Coverage Type	On and Off Job	On and Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included	Included
ACCIDENTAL DEATH AND DISMEMBERMENT		
Benefit Amount(s)	Employee $10,000 Spouse $5,000 Child $5,000	Employee $50,000 Spouse $25,000 Child $10,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500	$2,500
WELLNESS BENEFIT - Per Year Limit	$50	$50
Child(ren) Age Limits	Children age birth to 26 years	Children age birth to 26 years
FEATURES		
Air Ambulance	$750	$1,000
Ambulance	$200	$300
Blood/Plasma/Platelets	$300	$400
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: $0/$1,000 18 sq inches To 35 sq inches: $500/$2,000 Over 35 sq inches: $1,500/$6,000	9 sq inches To 18 sq inches: $0/$1,700 18 sq inches To 35 sq inches: $850/$3,350 Over 35 sq inches: $2,500/$10,000
Burns - Skin Graft	50% of burn benefit	50% of burn benefit

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Your accident coverage

FEATURES (Cont.)	Option 1: Basic	Option 2: Advantage
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child, age 18 years or younger, is participating in an organized sport that is governed by an organization and requires formal registration to participate.	25% increase to child benefits	25% increase to child benefits
Chiropractic Visits	No Benefit	$50/visit, up to 6 visits
Coma	$5,000	$10,000
Concussion Baseline Study	$25	$25
Concussions	$50	$400
Diagnostic Exam (Major)	$50	$200
Dislocations	Schedule up to $3,000	Schedule up to $6,000
Doctor Follow-Up Visits	$50, up to 6 treatments	$50, up to 6 treatments
Emergency Dental Work	$100/Crown, $25/Extraction	$200/Crown, $50/Extraction
Emergency Room Treatment	$75	$100
Epidural Anesthesia Pain Management	No Benefit	$100, 2 times per accident
Eye Injury	$200	$300
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	No Benefit	$20/day, up to 30 days
Fractures	Schedule up to $3,000	Schedule up to $6,000
Gun Shot Wound	$250	$750
Hospital Admission	$500	$1,000
Hospital Confinement	$100/day - up to 1 year	$200/day - up to 1 year
Hospital ICU Admission	$1,000	$2,000
Hospital ICU Confinement	$200/day - up to 15 days	$400/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	$50	$100
Joint Replacement (Hip/Knee/Shoulder)	No Benefit	$2,500/$1,250/$1,250
Knee Cartilage	No Benefit	$750
Laceration	Schedule up to $200	Schedule up to $400
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	$100/day, up to 30 days for companion hotel stay	$200/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to $500	Schedule up to $500
Outpatient Therapies	$25/day, up to 10 days	$35/day, up to 10 days
Post-Traumatic Stress Disorder	No Benefit	$400
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	No Benefit	$200/day, up to 15 days
Ruptured Disc With Surgical Repair	$500	$1,000
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to $2,000 Hernia: $400	Schedule up to $2,000 Hernia: $400
Surgery (Exploratory or Arthroscopic)	$200	$400

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Your accident coverage

FEATURES (Cont.)	Option 1: Basic	Option 2: Advantage
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500	1: $500 2 or more: $1,000
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$0.50 per mile, limited to $300/round trip, up to 3 times per accident	$0.50 per mile, limited to $400/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	No Benefit	$4,000
X - Ray	$15	$40

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passanger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accomodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

We don't pay benefits for any Injury caused by or related to directly or indirectly: Sickness, disease, mental infirmity or medical or surgical treatment; the covered person being legally intoxicated; declared or undeclared war, act of war, or armed aggression; service in the armed forces, National Guard, or military reserves of any state or country; taking part in a riot or civil disorder; commission of, or attempt to commit a felony; intentionally self-inflicted Injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a covered person by a doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Accident resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-1-ACC-18

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Guardian

Your accident coverage

Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides Accident insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
IMPORTANT NOTICE –THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.
Policy Form # GP-1-AC-BEN-12, et al., GP-1-LAH-12R; GP-1-ACC-18

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

Visit
worklife.uprisehealth.com

Access Code
worklife

Call
1 800 386 7055

24 hour crisis help available.
Regular office hours:
Monday-Friday 6am-5pm PST.

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

Legal/financial assistance and resources services are not available in the state of New York.

The Employee Assistance Program is a suite of services solely created and offered by Integrated Behavioral Health, Inc. (IBH), doing business as Uprise Health. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.

2023-158793 (7/25)

Guardian®

Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.
Visit **https://www.guardiananytime.com/notice48** to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.
Visit **https://www.guardiananytime.com/notice46** to read more.

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Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer/Planholder Name: BENESCH FRIEDLANDER COPLAN & ARONOFF LLP	Group Plan Number: 00481071	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Member Dependents/Family Members ❑ Drop/Refuse Coverage ❑ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class: ALL ELIGIBLE EMPLOYEES Division:_____ Subtotal Code:_____ (Please obtain this from your Employer/Planholder)

About You:

Full Legal Name-First, MI, Last Name:

What is the name you go by? (optional)

Employer/Planholder Provided Identification:

_____

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address	City	State	Zip

Gender Identity: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

Are you married or in a civil union? ❑ Yes ❑ No Date of marriage/civil union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job:

Job Title:

Work Status:
❑ Active ❑ Retired ❑ COBRA/State Continuation
Hours worked per week: _____

Date of full time hire: _____ - _____ - _____

About Your Family:

Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse Address/City/State/Zip: Phone: ( ) -	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Oct 18, 2023

Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____

Drop Coverage:

❑ Drop Employee/Member ❑ Drop Dependents/Family Members

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Basic Term Life

❑ Voluntary Term Life

❑ Accident ❑ Employee/Member ❑ Spouse ❑ Child(ren)

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

Accident Coverage

You must be enrolled to cover your family members.

Your Semi-monthly premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
Option 1: Basic	❑ $2.48	❑ $4.01	❑ $4.23	❑ $5.76
Option 2: Advantage	❑ $4.57	❑ $7.18	❑ $7.43	❑ $10.04

❑ I do not want this coverage.

Guardian Group Plan Number: 00481071 Please print employee name:

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records

Primary Beneficiaries:

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

Contingent Beneficiary:_____ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ❑ Yes ❑ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): ____ ____ ____ ____ ____-____ _____ ____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: ( ) -

Signature

- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

Any person who, with intent to defraud or knowing that he/she 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.

SIGNATURE OF EMPLOYEE/MEMBER X _____ DATE _____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

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

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

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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, Indiana and 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.

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

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

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

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

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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 Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Virginia: Any person who with intent to defraud or knowing that he/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.