Dear Parents/Guardians and Athletes:

Please note that proof of medical or accident insurance coverage is required for students’ participation in LCPS Athletic Programs. Participation in athletic activities can be dangerous and lead to serious injuries requiring very costly medical attention.

Proof of Insurance Coverage: You will be required to provide the name of your insurance carrier on the LCPS Sports Emergency Card. If you don’t already have insurance coverage, you may purchase coverage from any source you desire. There are resources that can be found on-line or through local insurance agents.

In addition, LCPS provides a resource for you to voluntarily purchase coverage for accidental injuries only (there is no coverage for illness or medical conditions).

The Voluntary Student Accident Insurance offers various options on benefit plans of coverage from which you may choose. If you already have insurance coverage through another policy, these accident plans pay benefits for those eligible expenses in excess of and not paid by your primary insurance.

If there is no other available insurance to you, the purchase of the Voluntary Student Accident Insurance coverage will provide primary accident insurance protection for the student athlete.

Your voluntary enrollment in one of these plans should be carefully considered. For further details and to enroll in the K&K Student Accident Insurance coverage please go on-line to this link: www.studentinsurance-kk.com or call 1-855-742-3135.
Protect your child with student accident insurance. If you don’t have other insurance, this student accident insurance is vital. If you have other insurance, student accident insurance can help with deductibles and copays.

K-12 Accident Plans available through your school:
• At-School Accident Only
• 24-Hour Accident Only
• Extended Dental
• Football

How to Enroll Online
Enrolling online is easy and should take only a few minutes.
Go to www.studentinsurance-kk.com and click the “Enroll Now” button.
1. Start by telling us the name of the school district and state where your child attends school.
2. We’ll request each student’s name and grade level.
3. You’ll see the available plans and their rates. Select your coverage and continue to the next step.
4. We’ll request information about you, like your name and email address.
5. Next, you’ll enter information about the child or children to be covered.
6. Enter your credit card or eCheck payment information.
7. Finally, print out a copy of the confirmation for your records.

For further details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the policy may be continued in force, please refer to www.studentinsurance-kk.com. Student is able to purchase the coverage only if his/her school district is a policyholder with the insurance company.

Protecta a su hijo con el seguro de accidentes para estudiantes. Si usted no tiene otro seguro, este seguro de accidentes para estudiantes es fundamental. Si tiene otro seguro, el seguro de accidentes para estudiantes puede ayudarle a pagar los deducibles y copagos.

Planes de accidentes para K-12 disponibles a través de su escuela:
• Sólo accidentes en la escuela
• Solo accidentes, 24 horas
• Dental extendido
• Fútbol

Cómo inscribirse en línea
1. Comience por decirnos el nombre del distrito escolar y el estado en el que su hijo(a) va a la escuela.
2. Solicitaremos el nombre y el grado de cada uno de los estudiantes.
3. Verá los planes disponibles y sus tarifas. Seleccione su cobertura y continúe con el siguiente paso.
4. Le solicitaremos información sobre usted, como su nombre y dirección de correo electrónico.
5. Después, ingresará la información acerca del niño o niños que recibirá(n) cobertura.
6. Ingrese la información de pago de su tarjeta de crédito o eCheck.
7. Finalmente, imprima una copia de la confirmación para sus registros.

Para obtener más detalles, incluso costos, beneficios, exclusiones, y reducciones o limitaciones y los términos en virtud de los cuales esta póliza podría continuar en vigencia, consulte www.studentinsurance-kk.com. Los estudiantes pueden comprar la cobertura únicamente si su distrito escolar es titular de una póliza con la compañía de seguros.
# 2022-2023 Student Accident Coverage

Serviced by: **K&K Insurance Group, Inc.**  
Phone: 855-742-3135

**Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.**

**ACCIDENT ONLY COVERAGE:** The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

**SCHEDULE OF BENEFITS:** Maximum Benefits Paid As Specified Below.

<table>
<thead>
<tr>
<th>Compare and Choose</th>
<th>Low Option Accident Only</th>
<th>High Option Accident Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit:</td>
<td>$25,000 (For Each Injury)</td>
<td>$25,000 (For Each Injury)</td>
</tr>
<tr>
<td>Deductible:</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Inpatient Hospital Services**

| Room & Board Expenses: (Private/Semi-private room rate) | Up to $150 per day | 80% of Usual and Customary Charges |

**Miscellaneous Expenses**

| Physician's Visits: (Limited to one visit per day) | $40 first day/$25 each subsequent day | $60 first day/$40 each subsequent day |

**Ambulatory Medical Center**

| Surgical Maximum per service as shown below. | $1,000 maximum | $1,200 maximum |

**Emergency Room Treatment:** (Treatment must be rendered within 72 hours from the time of the injury)

| Surgery: (*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/ports.) | $1,000 maximum | $1,200 maximum |

**Assistant Surgeon**

| 100% of Usual and Customary Charges (*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.) | 100% of Usual and Customary Charges (*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.) |

**Anesthesia and its Administration**

| 100% of Usual and Customary Charges (*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.) | 100% of Usual and Customary Charges (*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.) |

**Outpatient**

| Outpatient Physician Visits: (Limited to one visit per day) | $40 first day/$25 each subsequent day | $60 first day/$40 each subsequent day |
| Outpatient X-ray: | $200 maximum | $600 maximum |
| Outpatient Diagnostic Imaging Services: (CT Scan, MRI) | $300 maximum | $600 maximum |
| Outpatient Laboratory: | $50 maximum | $300 maximum |
| Outpatient Physiotherapy: (Limited to one visit per day. Includes acupuncture; microtherapy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment) | $30 first day/$20 each subsequent day/5 day maximum | $60 first day/$40 each subsequent day/5 day maximum |
| Ambulance Services: (Air and Ground) | $300 maximum | $800 maximum |
| Medical Equipment Rental: (Includes Orthopedic devices) | $75 maximum | $140 maximum |
| Dental Services: | $10,000 maximum per policy term if extended dental option is purchased. $200 per tooth if extended dental option is not purchased. | $10,000 maximum per policy term if extended dental option is purchased. $500 per tooth if extended dental option is not purchased. |
| Prescription Drugs: | $75 maximum | $200 maximum |
| Consultant: | $200 maximum | $400 maximum |
| Replacement of Eye Glasses, Contact Lenses or Hearing Aids: | 100% of Usual and Customary Charges | 100% of Usual and Customary Charges |

**THIS IS A BLANKET ACCIDENT ONLY POLICY.**

U.S. Insurance coverage is underwritten by AXIS Insurance Company under group policy form series number BACC-001-0909, et al. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy. The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected.

**THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.**
Choose Your Coverage Plan:  

One-Time Payment For Accident Coverage

PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW

Coverage Effective Date: A person’s coverage takes effect at the later of the date his or her completed student accident enrollment form and premium is received by the company or the effective date of the policy issued to his or her school or school district.

Coverage Termination Date: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be an eligible person per the definition below. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

About Your Coverage

1. ELIGIBLE PERSONS: students of the policyholder who enroll and make the required premium contribution for the coverage selected are Eligible Persons under the Policy. Depending on the coverage selected, coverage may continue after graduation and between school years unless the person enrolls at a different school district.

2. The Master Policy is on file with the school district and is a non-renewable policy. The student coverage selected is non-renewable and requires the student to re-enroll each school year.

3. This is a limited benefit policy.

4. COVERAGE EFFECTIVE DATE: Insurance becomes effective for a student who enrolls and makes the required premium contribution on the latest of the following dates:
   a. the Policy Effective Date;
   b. the date the Company receives student’s completed enrollment form and the required premium payment.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

5. COVERAGE TERMINATION DATE: Coverage ends on the earlier of the date: he or she is no longer an Eligible Person, the end of the 1-year coverage term or the date the School’s policy ends. All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible. Termination of coverage for any reason will not affect a claim for a Covered Accident that occurs before the termination date.

6. LATE ENROLLMENT: Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year.

7. CANCELLATION: Your coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company.

Enroll online at:  
www.StudentInsurance-kk.com
or by mail using attached enrollment form.

1. Complete and detach the enrollment form.
2. Make check or money order payable to AXIS Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child’s name on your check or money order.
4. Mail completed enrollment form with payment back to:

K&K Insurance Group,
P.O. Box 2338
Fort Wayne, IN 46801-2338

5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic, and procedural safeguards to ensure the security of your nonpublic personal information.

Administered by:
K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338

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Policy #
Date Paid:
Paid by Check #
Amount Paid:
Date Paid:

Student’s Name

If premium has been paid, the student whose name appears above has been insured under a Policy issued to:

School District:

Accident Only Coverage: ☐ 24-HOUR ☐ 24-HOUR (Summer Only Coverage)
☐ AT-SCHOOL ☐ FOOTBALL ☐ FOOTBALL (Spring Only) ☐ EXTENDED DENTAL

Paid by Check #

Policy #

Underwritten by: AXIS Insurance Company
Claims Questions: K&K Insurance Group, Inc.
1712 Magnavox Way • Fort Wayne, IN 46801 • 800-237-2917
COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
10. the Insured Person’s intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer’s report, or similar items will be considered proof of the Insured Person’s intoxication;
11. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator’s license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver’s education instructor;
12. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person’s Physician;
13. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
14. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
15. benefits will not be paid for services or treatment rendered by any person who is:
   a. employed or retained by the Policyholder;
   b. living in the Insured Person’s household;
   c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person’s Spouse; or
   d. the Insured Person.

EXCLUDED EXPENSES The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational); and (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. treatment in any Veteran’s Administration, Federal, or state facility, unless there is a legal obligation to pay;
5. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
6. repair or replacement of existing artificial limbs, eyes and larynx;
7. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician.
In no event will the Company’s total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the Schedule of Benefits. Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

ACCIDENT ONLY DEFINITIONS:

Covered Injury means Accidental bodily injury:
1. which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person’s coverage under the Policy is in force;
2. which results directly and independently from all other causes from a Covered Accident; and
3. which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Accident or Accidental: means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Covered Expenses: means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

Medically Necessary: means medical services that:
1. are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. are ordered by a Physician and performed under His care, supervision or order.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

<table>
<thead>
<tr>
<th>COVERED LOSS</th>
<th>BENEFIT AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of Two or More Hands or Feet</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of Sight of Both Eyes</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of Speech and Hearing (in Both Ears)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of One Hand or Foot and Sight in One Eye</td>
<td>$10,000</td>
</tr>
<tr>
<td>Loss of One Hand or Foot</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Sight in One Eye</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Speech</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Hearing (in Both Ears)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Loss of Hearing in One Ear</td>
<td>$2,500</td>
</tr>
<tr>
<td>Loss of Thumb and Index Finger of the same Hand</td>
<td>$2,500</td>
</tr>
<tr>
<td>Exposure and Disappearance</td>
<td>Included</td>
</tr>
</tbody>
</table>
Enroll online for quicker service at www.StudentInsurance-kk.com
or complete and mail this form

Student Accident Enrollment Form (School Year 2022-2023)

Student’s Last Name: ________________________________

Student’s First Name: ________________________________

Student’s Middle Name: ____________________________ Date of Birth: ____________________________

Street Address: __________________________________________

City: ___________________________ State: ______ Zip: ______

Name of School District (required): __________________________

Name of School: __________________________

Grade Level: □ Pre-K/Headstart □ Kindergarten/Elementary □ Middle School □ High School/Above

Signature of Parent or Guardian: __________________________

Date: ____________ Email Address: __________________________ Phone Number: __________________________

Student Insurance Plan Options — Check Your Selection:

<table>
<thead>
<tr>
<th>Accident Only Coverage Plans</th>
<th>Low Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-HOUR, with Extended Dental</td>
<td>$92.00</td>
<td>$136.00</td>
</tr>
<tr>
<td>24-HOUR, without Extended Dental</td>
<td>$82.00</td>
<td>$126.00</td>
</tr>
<tr>
<td>24-HOUR, Summer Only, with Extended Dental</td>
<td>$31.00</td>
<td>$44.00</td>
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<tr>
<td>24-HOUR, Summer Only, without Extended Dental</td>
<td>$21.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>AT-SCHOOL, with Extended Dental</td>
<td>$29.00</td>
<td>$37.00</td>
</tr>
<tr>
<td>AT-SCHOOL, without Extended Dental</td>
<td>$20.00</td>
<td>$28.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Full Year, with Extended Dental</td>
<td>$145.00</td>
<td>$221.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Full Year, without Extended Dental</td>
<td>$136.00</td>
<td>$212.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Spring Only, with Extended Dental For New Players</td>
<td>$64.00</td>
<td>$94.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL, Spring Only, without Extended Dental For New Players</td>
<td>$55.00</td>
<td>$84.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and AT SCHOOL, with Extended Dental Covers all athletics</td>
<td>$174.00</td>
<td>$258.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and AT SCHOOL, without Extended Dental Covers all athletics</td>
<td>$156.00</td>
<td>$240.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and 24-HOUR, with Extended Dental Covers all athletics</td>
<td>$237.00</td>
<td>$338.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and 24-HOUR, without Extended Dental Covers all athletics</td>
<td>$218.00</td>
<td>$330.00</td>
</tr>
</tbody>
</table>

Enclose check for total payment payable to: AXIS INSURANCE COMPANY. Checks, money orders, or credit cards accepted.

DO NOT SEND CASH

TOTAL ENCLOSED: $ __________________________

See IMPORTANT NOTICE - FRAUD WARNING on next page

Mail this completed form with payment back to: K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338

Complete this section only if you wish to pay with a Credit Card

Full name as it appears on card

First Name: ___________________________ Mi: ______ Last Name: ____________________________

Billing Address (if different than above)

Street #: ___________________________ Address: ___________________________ Apt #: ______

City: ___________________________ State: ______ Zip: ______

Card Number: ___________________________ Expiration Date: Month: ______ Year: ______

Cardholder signature: ____________________________

Company does not issue refunds nor accept responsibility for cash payments. (Rejection of check or credit card by bank for any reason, will invalidate insurance.)
IMPORTANT NOTICE - FRAUD WARNING

• In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and 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.

• For residents of Alabama: 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 restitution fines and confinement in prison, or any combination thereof.

• For residents of 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.

• For residents of the 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.

• For residents of 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.

• For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

• For residents of Maine, Tennessee and 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.

• For residents of Oregon: Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.

• For residents of Maryland: 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.

• For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

• For residents of 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.

• For residents of 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.

• For residents of 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.

• For residents of 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.

• For residents of 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.

• For residents of 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.

• For residents of Virginia: Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.