BlueCross BlueShield of Illinois

O'Fallon CCSD#90
P40148 (PPO) P76927 (H.S.A.)

Dearborn National®

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

① **ENROLLEE:**	New Enrollment: ☐ Timely ☐ Special ☐ Late	Open Enrollment: ☐ New Member ☐ Plan Change ☐ Add Dependents

② **EFFECTIVE DATE OF BENEFITS:** ___/___/___	Group Number: *P40148 (PPO) P76927 (H.S.A.)*	Section Number:	Identification Number:
③ **COBRA / ILLINOIS CONTINUATION SECTION**	Employee Status: ☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___		

☐ COBRA: Start Date ___/___/___ Projected End Date ___/___/___

☐ IL Continuation Privilege: Start Date ___/___/___ Projected End Date ___/___/___

Previously covered with group as:

☐ 1. Employee (termination of employment, reduction in hours, other.)
☐ 2. Spouse (divorce from employee, death of employee, other.)
☐ 3. Dependent (reach age limit, other.)
☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ **COVERAGE APPLIED FOR: Check all that apply.****

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

Medical - Please check one

☐ Option 1 - HRA Plan P40148 ☐ Option 2 - High Deductible Plan P40148 ☐ Option 3 - H.S.A. Plan P76927

⑤ **CHANGES TO EXISTING MEMBERSHIP: Check all that apply.**

CHANGES	ADD DEPENDENTS	CANCEL DEPENDENTS	CANCEL (Check all that apply)
Date ___/___/___	Date ___/___/___	Date ___/___/___	Date ___/___/___
☐ Name	☐ Marriage	☐ Divorce	☐ Terminate Coverage
☐ Address	☐ Newborn	☐ Age Limit	☐ Waive Coverage**
☐ Telephone	☐ Adoption/Placement	☐ Other:	☐ Leave/Layoff
☐ Reinstate	☐ Legal Guardianship	_____	☐ Out of Service Area Move
☐ From PPO to HSA	☐ Other: _____		☐ Other: _____
			_____
			_____
			_____
			_____
			_____

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section U.

*After checking the appropriate physician change, circle reason:

☐ PCP
☐ WPHCP

A. Availability
C. Location
E. Dissatisfied with PCP
G. Staff

B. PCP moved office
D. PCP added to Network
F. PCP office/facility undesirable
H. Other _____

**If not electing coverage, please read, complete and sign Section ⑪.

20005.1114

⑥ **EMPLOYEE INFORMATION:**	Company Name: *O'Fallon District 90*	
Last Name:	First Name:	Mid. Initial
E-Mail Address:	Cell Phone Number:	
Street Address:	Apt. No.:	
City:	State:	Zip:

Date of Birth: ___/___/___ Are You Eligible for Family Coverage: ☐ No ☐ Yes

Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security Number: _____ — _____ — _____

Employee Identification Number (if known): _____

Telephone No.: Bus.: (_____) _____ Home: (_____) _____ Date of Hire: ___/___/___

Dept. No.: _____ Payroll Location: _____ Employee Clock No.: _____

Employment Status: ☐ Actively at Work ☐ Retired If retired, retirement date:_____ ☐ COBRA/IL Continuation

Are you covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑦ **FAMILY COVERAGE INFORMATION:**	List All Eligible Dependents.

⑦Ⓐ ☐ Spouse ☐ Domestic Partner ☐ Party to a Civil Union ☐ Male ☐ Female Date of Birth: ___/___/___

Last Name (Only If Different): _____

First Name: _____ Social Security Number: _____ — _____ — _____

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑥ **EMPLOYEE AND DEPENDENT INFORMATION:**	Company Name: *O'Fallon CCSD #90*	Group #: *P40148 / P76927*
Employee Last Name:	Employee First Name:	Mid. Initial
⑦ **FAMILY COVERAGE INFORMATION:**	List All Eligible Dependents.	

⑦Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (Only If Different): ____________________ First Name: ________________ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): ________________________________

Social Security Number: ______ — ______ — __________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (Only If Different): ____________________ First Name: ________________ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): ________________________________

Social Security Number: ______ — ______ — __________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (Only If Different): ____________________ First Name: ________________ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): ________________________________

Social Security Number: ______ — ______ — __________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑧ OTHER INSURANCE INFORMATION:

If you or any of your family members have OTHER GROUP COVERAGE, Check all that apply.

☐ Health: Policy #: _____

☐ Prescription Drug Coverage: Policy #: _____

If Yes: Is the other insurance: ☐ Single Coverage ☐ Family Coverage

EMPLOYED BY: _____ Insured's Name: _____

Date of Birth: ___/___/___

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone Number: _____

⑩ **I APPLY FOR COVERAGE AS INDICATED ABOVE**, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Dearborn National (providing the life and disability insurance) (the Company). I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary.

I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Date Signed: ___/___/___ Signature of Applicant: _____

⑪ If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Not enrolling for: ☐ Myself ☐ My spouse ☐ My spouse and dependents ☐ My dependents ☐ Myself, my spouse and my dependents

Reason: ☐ Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in ⑧)

☐ Covered under a Medicare supplement plan ☐ Other (please explain)_____

Date Signed: ___/___/___ Signature of Applicant: _____

Guardian The Guardian Life Insurance Company of America
And its Affiliates and Subsidiaries

Enrollment/Change Form

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

Please print clearly and mark carefully.

Employer Name: O'FALLON COMMUNITY CONSOIDATED SCHOOL DISTRICT 90	Group Plan Number: 00483112	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment Re-Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change
Increase Amount Family Status Change

Class: ALL ELIGIBLE EMPLOYEES EXCLUDING RETIREE'S Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You:

First, MI, Last Name: | Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address | City | State | Zip

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

Email Address: Are you married or do you have a spouse? Yes No Date of marriage/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: _____ - _____ - _____

Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

Drop Coverage:

Drop Employee Drop Dependents

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:

Dental	Employee	Spouse	Child(ren)
Vision	Employee	Spouse	Child(ren)
Basic Life			
Voluntary Life	Employee	Spouse	Child(ren)

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

Termination of Employment: _____-_____-_____

Divorce/Separation _____-_____-_____

Death of Spouse _____-_____-_____

Termination/Expiration of Coverage _____-_____-_____

Coverage Lost Dental Vision

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)

Dental Coverage:

You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Option 1: Low Plan	$21.31	$39.14	$74.16
Option 2: High Plan	$47.91	$87.95	$127.77

I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

I am covered under another Dental plan

My spouse is covered under another Dental plan

My dependents are covered under another Dental plan

Vision Coverage:

You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Option 1: VSP	$8.22	$12.47	$21.90
Option 2: Davis	$8.22	$12.47	$21.90

I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

I am covered under another Vision plan

My spouse is covered under another Vision plan

My dependents are covered under another Vision plan

Guardian Group Plan Number: 00483112

Please print employee name:

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):

Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only
☑ $10,000
The Guarantee Issue Amount is $10,000.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

Primary Beneficiaries:

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

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

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

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

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

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

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

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $_____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D):

You must be enrolled to cover your dependents.

Benefit reductions apply. Please see plan administrator.

Employee

Policy Amount *Check one box only*

$10,000	$25,000	$50,000	$75,000	$100,000	$150,000*

Guarantee Issue up to: Employee Less than age 65 $150,000*, 65-69 $10,000, $0.

I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
$35,000	$40,000	$45,000	$50,000*	$55,000	$60,000
$65,000	$70,000	$75,000			

Guarantee Issue up to: Spouse Less than age 65 $50,000*, 65-69 $5,000, $0.

**The amount may not be more than 50% of the employee amount for Voluntary Life.*

I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

$5,000	$10,000*

**Guarantee Issue Amount*

**The amount may not be more than 10% of the employee amount for Voluntary Life.*

I do not want this coverage

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

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

Primary Beneficiaries:

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Signature

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

I understand that my coverage will not be effective until approved by 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.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: 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. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ DATE _____

Enrollment Kit 00483112, 0001, EN

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.

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.

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.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

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.

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 may include imprisonment, fines or a denial of insurance benefits.

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.

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.

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 N.H. Rev. Stat. Ann. § 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.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or 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 or denial of insurance benefits.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Ohio: 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.

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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.