

Dental Benefit Summary

Group Number: 00365373

About Your Benefits:

Taking care of your teeth can be expensive. That’s why the right dental insurance is so important — it not only pays for preventive care that can keep you and your family healthy, but it also helps pay for more extensive, costly and often unexpected expenses — such as fillings, crowns and root canals. Plus, you save money and have the assurance that you are getting the right care when you use one of our contracted dentists. Guardian has been providing outstanding dental plans to millions of Americans for more than 50 years. When you enroll with Guardian, you have access to one of the nation’s largest dental networks offering significant discounts so you know there’s always high-quality, affordable dental care close by. From preventive checkups and cleanings, to comprehensive oral care treatments, we have you covered.

With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	PPO	
Your Network is	DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	80%	80%
Basic Care	80%	80%
Major Care	80%	80%
Orthodontia	50%	50%
Annual Maximum Benefit	\$1500	\$1500
Lifetime Orthodontia Maximum	\$1500	
Dependent Age Limits	26	

A Sample of Services Covered by Your Plan:

		PPO	
		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	80%	80%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	80%	80%
	Limits:	Under Age 14	
	Oral Exams	80%	80%
	Sealants (per tooth)	80%	80%
	X-rays	80%	80%
Basic Care	Anesthesia*	80%	80%
	Fillings‡	80%	80%
	Perio Surgery	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%
	Root Canal	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Bridges and Dentures	80%	80%
	Inlays, Onlays, Veneers**	80%	80%
	Single Crowns	80%	80%
Orthodontia	Orthodontia	50%	50%
	Limits:	Adults & Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions may apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic

consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-I-DG2000 et al.

- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Your Guardian VSP Vision Access Program

An eligible person can receive discounts on vision care services or supplies from a vision provider that is under contract with Vision Service Plan's (VSP) Preferred Provider Organization (PPO) network. The eligible person must pay the entire discounted fee directly to the VSP network doctor. Discounts are not available from providers who are not members of VSP's network.

Average Discounts

- Eye Exams: 20% off the VSP doctor's usual charge
- Frames, Standard Lenses and Lens Options: 20% off VSP doctor's usual charge, when a complete pair of prescription glasses is purchased.
- Contact Lens Professional Services: 15% off VSP doctor's usual charge for professional services. The contact lenses are not discounted.
- Laser Surgery: an average of 15% off the laser surgeon's usual charge or 5% off of any promotional price, if it is less than the usual discounted price

No ID cards are required, but the patient must notify the VSP network doctor that they have the Guardian VSP Access Plan at the time of service to receive their discount. Discounts are only available from the VSP network doctor that provided the eye exam to the patient within the last 12 months.

This is not insurance. The eligible person must pay the entire discounted fee directly to the VSP network doctor. There is no charge for the Discount Vision Access program. A person must be enrolled in a Guardian dental plan in order to be eligible for the Discount Vision Access program. When a person is no longer enrolled in a Guardian dental plan, access to the network discounts ends.

To find a VSP network doctor, visit www.guardiananytime.com or call VSP member services at 1-877-814-8970.

ADDITIONAL MATERIALS

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-541-7846 for Dental. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer los documentos y puede que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-541-7846 para servicios odontológicos. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-541-7846 for Dental. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

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خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقرائة الوثائق باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-541-7846 لخدمات طب الأسنان. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար Լեզվական ծառայություններ: Դուք կարող եք թարգման և երբ բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-541-7846 համարով Ատամնաբուժության համար: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。 您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，牙科協助請致電 1-800-541-7846 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Traditional Chinese

Cov Kev Pab Txhais Lus Tsis them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-541-7846 rau Kev Kho Hniav. Yog xav tau kev pab ntxiv hu rau Ca lub Caij Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-541-7846(歯科用)までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-541-7846 សម្រាប់ខាងឆ្នេរ ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ាតាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 치과 서비스 1-800-541-7846 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내전화 1-800-927-4357 번으로 연락해 주십시오. Korean

خدمات مجانی مربوط بہ زبان. شما میتوانید از خدمات يك مترجم شفاهي استفاده کنید و بگوئید مدارك به زبا فارسي براي تان خوانده شوند. براي دریافت کمک، با ما از طریق شماره تلفني که روي کارت شناسائي شما قيد شده است و يا شماره 1-800-541-7846 براي دندانپزشكي تماس بگيريد. براي دریافت کمک بیشتر به CA Dep. of Insurance (اداره بیمه كاليفرنيا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ ਦੰਦਾਂ ਲਈ 1-800-541-7846 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-541-7846 (стоматологическая страховка). Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-541-7846 para sa Dental. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi số 1-800-541-7846 cho dịch vụ nha khoa. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

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To find a VSP network doctor, visit www.guardiananytime.com or call VSP member services at 1-877-814-8970.

Finding a dentist or vision care provider is easy

Go online – it just takes minutes!

The best way to save money through your dental or vision plan is by seeing a provider in your plan's network. Guardian's Find a Provider site makes it easy for you to search for a dental or vision provider meets your needs.

Guardian's Find a Provider site is available to you 24 hours a day, 7 days a week.

Here are just a few things you can do online:

- Customize your search by specialty, languages spoken and more
- Get side-by-side comparisons of provider information (ie. office status, distance)
- Create a quick-list of "favorite" providers — for easy reference online
- Get maps and directions to a providers office location
- View your results online or have them faxed or emailed to you
- Save your search criteria for easy access when you revisit the site
- Create a customized provider directory
- Nominate a dentist to be included in a network

Just go to www.GuardianAnytime.com and click on "Find a Provider". You can also find a provider on the go from your smart phone – simply download our app.

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Guardian Life, P.O. Box 981585,
El Paso, TX 79998-1585

Please print clearly and mark carefully.

Employer Name: CITY OF SEASIDE	Group Plan Number: 00365373	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change		

Class: _____ Division: _____ Subtotal Code: _____ (Please obtain this from your Employer)

About You: First, MI, Last Name:		Social Security Number ____ - ____ - ____	
Address	City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): ____ - ____ - ____	Phone: () -	
Email Address:	Are you married or do you have a spouse/domestic partner? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of marriage/union: ____ - ____ - ____
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		Placement date of adopted child: ____ - ____ - ____

About Your Job:	Hours worked per week: _____	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation	Date of full time hire: ____ - ____ - ____	

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 dependency tax exception. Dependency 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/domestic partner (First, MI, Last Name)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Address/City/State/Zip:			
Phone: () -			
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () -		Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent	
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () -		Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent	

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

<p>Drop Coverage:</p> <p><input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents</p> <p>The date of withdrawal cannot be prior to the date this form is completed and signed.</p> <p>Last Day of Coverage: ____ - ____ - ____</p> <p><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement</p> <p>Last Day Worked: ____ - ____ - ____</p> <p><input type="checkbox"/> Other Event: _____</p> <p>Date of Event: ____ - ____ - ____</p>	<p>Coverage Being Dropped:</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Child(ren)</p>
<p>Loss Of Other Coverage:</p> <p>I and/or my dependents were previously covered under <u>another insurance plan</u>. Loss of coverage was due to:</p> <p><input type="checkbox"/> Termination of Employment: ____ - ____ - ____</p> <p><input type="checkbox"/> Divorce ____ - ____ - ____</p> <p><input type="checkbox"/> Death of Spouse/domestic partner ____ - ____ - ____</p> <p><input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____</p> <p>Coverage Lost <input type="checkbox"/> Dental</p>	<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <p><input type="checkbox"/> Covered under another insurance plan</p> <p><input type="checkbox"/> Other _____</p> <p>(additional information may be required)</p>

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

Employee Only EE, Spouse/domestic partner & Dependent/Child(ren)

PPO

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/domestic partner is covered under another Dental plan

My dependents are covered under another Dental plan

Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- 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.
- 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.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- 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 understand that California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

- I attest that the information provided above is true and correct to the best of my knowledge.
- "California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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

SIGNATURE OF EMPLOYEE X _____

DATE _____

Enrollment Kit 00365373, 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.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 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. (Does not apply to Life Insurance.)

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.

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.