2017 Open Enrollment

Dental/Vision Insurance

NEW CASTLE COMMUNITY SCHOOL CORPORATION
EMPLOYEE COMMUNICATION

The 2017 Open Enrollment period will begin on **Monday, July 17, 2017 and will end on Wednesday, August 16, 2017.** Open Enrollment communications including carrier information and plan summaries are posted on the corporation website at: www.nccsc.k12.in.us

EFFECTIVE DATES

All changes and additions must be turned in to Jena Schmidt before **Noon** on **Wednesday August 16, 2016**. Changes and additions will be effective **September 1, 2017**.

DENTAL/VISION COVERAGE

The Corporation will continue to offer two plans for Dental Insurance and one plan for Vision Insurance. All plans are in the ***Guardian*** network. Each plan has differences in premium costs, deductibles, and out-of-pocket maximums. Here are the differences at a glance:

	Dental High Plan	Dental Low Plan	Vision Plan
Deductible	$50.00	$75.00	Not Applicable
Preventable Services	100%	100%	Co-Pay
Monthly Premiums			
Employee Only	$47.99	$26.67	$9.11
Employee/Spouse	$101.78	$56.56	$15.35
Employee/Children	$122.17	$67.90	$15.65
Employee/Family	$175.96	$97.96	$24.75

DEPENDENT ELIGIBILITY

Adult children may be covered under the above plans **until their 26th birthday**. A dependent's last day of coverage will be the end of the month they turn 26 years old. Dependents will still be offered COBRA when they lose eligibility. Spouses of ***adult children*** (deemed "Children-in-law") and grandchildren are not eligible for this coverage.

Disabled dependents under the age of 26 can be enrolled in any of your desired plans during the Open Enrollment period.

Once your dependent turns 26 years old, you will have **120 days** from the day of your disabled dependent's 26th birthday to submit the "**Verification of Dependent Disability**" form (which must be signed and completed by a physician) to your school's benefit coordinator.

Please note: In order for a disabled dependent to continue coverage past 26 years old, that dependent child must have been deemed disabled **prior to age 19**. If a dependent child was deemed disabled after age 19, they will not be eligible to continue coverage past age 26.

QUALIFYING EVENTS/ MAKING CHANGES AFTER OPEN ENROLLMENT

After August 15, 2016 you will not be able to make changes to your benefits. This means you must be certain you have made all the best choices and remembered to add all eligible dependents. After Open Enrollment, you can only make changes due to a qualifying event. Qualifying events are governed by the IRS; examples of qualifying events are:

- Changes in your legal marital status (marriage, divorce, separation, annulment or death of spouse).
- Changes in the number of dependents (birth, adoption, placement for adoption or death).
- Changes in employment status for you or your spouse, such as termination of or change in employment, a strike or lockout, start or end of an unpaid leave of absence, or a change in worksite.

If you experience a qualifying event, please contact your school's benefit coordinator **within 30 calendar days**. Failure to report the qualifying event and complete any necessary paperwork within 30 calendar days means you will not be able to make changes until the next open enrollment period.

CHECKLIST FOR A SUCCESSFUL OPEN ENROLLMENT

- ✓ Educate yourself on the medical options available to you effective September 1, 2017.
- ✓ Confirm or update your personal information including your home and/or mailing address and phone number with your school corporation.
- ✓ Carefully read the information.
- ✓ Review your eligible dependents. If you are making changes for 2017, please be sure to check Add Dependents or Remove Dependents on the application.
- ✓ **Submit your application to your school's benefit coordinator.**

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Dental-Vision Election Form

Due Date: August 16, 2017

Name: _____ Building: _____

I have received Open Enrollment information and understand any additions or deletions must be submitted to the Community Education Center by **NOON** on the date indicated above. The coverage for this enrollment period will be effective September 1, 2017.

I would like to (please check the appropriate election):

_____ No Change to Current Coverage – (Indicate plan below)

_____ I would like to **WAIVE ALL COVERAGE**

_____ I would like to **add or delete** dependents to current coverage (complete change form)

_____I would like to enroll for coverage (contact CEC for enrollment form)

Please verify your Plan of Choice:

Dental –High Plan:	**Employee**	_____	**Employee/Children**	_____
	Employee/Spouse	_____	**Employee/Family**	_____
Dental –Low Plan:	**Employee**	_____	**Employee/Children**	_____
	Employee/Spouse	_____	**Employee/Family**	_____
Vision:	**Employee**	_____	**Employee/Children**	_____
	Employee/Spouse	_____	**Employee/Family**	_____

Signature: _____

Date: _____

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NEW CASTLE COMMUNITY SCHOOL CORP.

Dental Benefit Summary

Group Number: 00470509

About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400[1]? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

[1]http://health.costhelper.com/dental-crown.html.

Option 1 or 2: With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	**Option 1: PPO**		**Option 2: PPO**	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Monthly premium	**$47.99**		**$26.67**	
You and spouse/domestic partner	$101.78		$56.56	
You and child(ren)	$122.17		$67.90	
You, spouse/domestic partner and child(ren)	$175.96		$97.76	
Calendar year deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$50	$50	$75	$75
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	50%	50%
Major Care	50%	50%	25%	25%
Orthodontia		Not Covered		Not Covered
Annual Maximum Benefit	$1000		$500	
Maximum Rollover	Yes		Yes	
Rollover Threshold	$500		$200	
Rollover Amount	$250		$100	
Rollover In-network Amount	$350		Not applicable	
Rollover Account Limit	$1000		$500	
Lifetime Orthodontia Maximum	Not Applicable		Not Applicable	
Dependent Age Limits	26		26	

A Sample of Services Covered by Your Plan:

		Option 1: PPO *Plan pays (on average)*		Option 2: PPO *Plan pays (on average)*	
		In-network	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 14		Under Age 14	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
		X-rays other than bitewings in Basic 80%		X-rays other than bitewings in Basic 50%	
Basic Care	Fillings‡	80%	80%	50%	50%
Major Care	Anesthesia*	50%	50%	25%	25%
	Bridges and Dentures	50%	50%	25%	25%
	Inlays, Onlays, Veneers**	50%	50%	25%	25%
	Perio Surgery	50%	50%	25%	25%
	Periodontal Maintenance	50%	50%	25%	25%
	Frequency:	Once Every 6 Months (Standard)		Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%	25%	25%
	Root Canal	50%	50%	25%	25%
	Scaling & Root Planing (per quadrant)	50%	50%	25%	25%
	Simple Extractions	50%	50%	25%	25%
	Single Crowns	50%	50%	25%	25%
	Surgical Extractions	50%	50%	25%	25%

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 filing 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. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub 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-1-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

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NEW CASTLE COMMUNITY SCHOOL CORP.

Vision Benefit Summary

Group Number: 00470509

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Pearle®, and Visionworks®.

Your Vision Plan	**Full Feature - Designer**	
Your Network is	Davis Vision	
Your Monthly premium	**$ 8.85**	
You and spouse/domestic partner	$ 14.91	
You and child(ren)	$ 15.20	
You, spouse/domestic partner and child(ren)	$ 24.05	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for non-formulary elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $50
Single Vision Lenses	$0	Amount over $48
Lined Bifocal Lenses	$0	Amount over $67
Lined Trifocal Lenses	$0	Amount over $86
Lenticular Lenses	$0	Amount over $126
Frames	80% of amount over $120*‡	Amount over $48
Contact Lenses *(Elective and conventional)*	85% of amount over $120*	Amount over $105
Contact Lenses *(Planned replacement and disposable)*	85% of amount over $120*	Amount over $105
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Cosmetic Extras	Avg. 40-60% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	Courtesy discount from most providers	No discounts
Laser Correction Surgery Discount	Up to 25% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years	
Network discounts *(cosmetic extras, glasses and contact lenses.)*	Applies to first purchase & courtesy discount from most providers on subsequent purchases.	
Dependent Age Limits	26	

Visit www.GuardianAnytime.com and click on "Find a Provider"

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

Davis

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- *Due to lower prices available at Wal-mart and Sam's Club locations, discounts do not apply. Members will pay 100% of the amount over their allowance.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- [2]Extra $50 at Visionworks stores

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub 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.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

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-1-DAVIS-05-VIS et al.

Laser Correction Surgery:

Up to 25% off for vision laser surgery.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

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

Please print clearly and mark carefully.

Employer Name: **NEW CASTLE COMMUNITY SCHOOL CORP.**	Group Plan Number: **00470509**	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 HOURLY EMPLOYEES WHO WORK AT LEAST 20 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: Hours worked per week: _____ Job Title:

Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: ___ - ___ - ___	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. 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) ❑ 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) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jul 14, 2017

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) ❑ 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) ❑ 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)

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 _____-_____-_____

❑ 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	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: PPO	❑ $47.99	❑ $101.78	❑ $122.17	❑ $175.96
Option 2: PPO	❑ $26.67	❑ $56.56	❑ $67.90	❑ $97.76

❑ 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	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	❑ $8.85	❑ $14.91	❑ $15.20	❑ $24.05

❑ 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: **00470509**

Please print employee name:

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** _____

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 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