

**MARKEL INSURANCE COMPANY**

Glen Allen, VA.

*Accident Only***Proof Of Insurance****Blanket Accident Policy 4102AH220317****Policy Term: 01/01/11 - 01/01/12**Suncoast SB LG Inc  
Scott Lenker  
PO Box 151492  
Tampa, FL 33684Effective Date: 1/1/11  
Classification: Adult-Waiver  
Number of Teams: 23**YOU ARE INSURED UNDER AN ACCIDENT-ONLY POLICY. THE POLICY DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.**

We, the Markel Insurance Company, have issued a Blanket Accident-Only Policy to the Policyholder:

**AMATEUR SOFTBALL ASSOCIATION OF AMERICA**

You are covered by the Blanket Accident Policy while you are a member of the class of Covered Persons described below. You should read this Certificate with care in order to understand the coverages provided

SCOPE OF COVERAGE: Accident policy benefits are outlined below:

Accidental Death Benefit	Accidental Dismemberment Benefit Principal Sum	Medical/Dental Expense Benefits	
		Maximum Limit	Deductible
\$5,000	\$10,000	\$250,000	\$250

Additional benefits and conditions of coverage:

- a. **52-week benefit period:** Eligible expenses for treatment are covered for 52 weeks from the date of injury. Any expenses incurred beyond the benefit period are not covered by this policy.
- b. 90/10 Coinsurance.
- c. Medical and Dental services must begin within 60 days from the date of injury.
- d. Claim must be submitted to Bollinger within 90 days of the date of injury to be eligible for payment.
- e. Deductible is a "corridor" deductible, which applies regardless of payments by other primary insurance.
- f. Claims are paid based on a Usual and Customary Basis which means Expenses (a) charged for treatment, supplies or medical services which are Medically Necessary to treat the Insured's condition; and (b) which do not exceed the usual level of charges made for similar treatment, supplies or medical services in the locality where incurred.
- g. Physical Therapy/Chiropractic limit: \$2,500 limit per injury, limited to \$100 maximum per visit
- h. Durable Medical Equipment limit: \$1,000 per injury
- i. Prescription Drug Limit: \$1,000 per injury

**Covered Injuries:** We will pay the benefits described for injuries to the body:

- a) Caused by an accident which happens while you are a covered person under the policy; and
- b) Which directly, and from no other cause, result in a covered loss.

**Covered Persons:** All persons who are currently registered as participants or adult supervisors of the Amateur Softball Association and all persons added to the team/ league during the policy term are Covered Persons.**Covered Events:** We will cover injuries to a Covered Person while taking part in:

- (1) A regularly scheduled game or practice of the Policyholder's team or league; and
- (2) Authorized tournaments, Post Season or Exhibition games or practice; and
- (3) Group travel as a team under the supervision of team authorities directly to or from such games or practices held away from the teams' home field.
- (4) Other incidental activities sponsored by and usual to the operation of a team or league, such as banquets and non-hazardous fundraisers.

*This certificate is a summary of benefits provided under this policy. Nothing contained herein shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the actual Policy.*

## DESCRIPTION OF COVERAGE

### **Coverage A: Accidental Death Benefit**

We will pay the Accidental Death Benefit stated in the Schedule if, within 365 days from the date of an accident covered by the policy, bodily injuries result in your loss of life.

### **Nonparticipating Accident Only Coverage**

### **Coverage B: Accidental Dismemberment Benefit**

We will pay this benefit if bodily injury does not result in your death but results in dismemberment or loss of sight within 365 days from the date of an accident covered by the policy. If you sustain more than one such loss as the result of any one accident, we will pay only the one larger amount to which you are entitled. This amount will not exceed the Maximum Payable for this benefit as stated in the Schedule.

<b>Loss:</b>	<b>Benefit</b>
Two or More Members	100% of Maximum Payable
One Member	50% of Maximum Payable

"Member" means hand, foot or eye.

"Loss" means with regard to a hand or foot, complete severance through or above the wrist or ankle joint. Loss of an eye means total or irrevocable loss of sight. (In South Carolina, the loss of four fingers from one hand equals the loss of one hand.)

### **Coverage C: Medical Expenses Benefit**

If you are injured by an accident covered by the policy, we will pay for the medical services listed below which you need as a direct result of the injury, within 365 days of the accident.

Covered medical services include:

- a) Hospital or ambulance services;
- b) Medical or surgical treatment by a doctor; and
- c) The reasonable and necessary services and any subsequent services of graduate registered nurses.

Medical services must begin within sixty days of the accident. We will pay for the usual and customary charges over the deductible amount (if any) shown in the Schedule. Benefits for physical therapy will be limited to a maximum of \$100 per visit and 25 visits per accident. The total payment for medical and surgical treatment will not exceed the stated Maximum Medical and Dental Expense Benefit in the Schedule.

### **Coverage D: Dental Expense Benefit**

If you are injured by an accident covered by the policy, we will pay for necessary services by a dentist which you need as a direct result of injury to or loss of natural teeth, within a year of the accident. Covered dental services will include the expense for braces, crowns, jackets, inlay, fillings, bridges and root canal therapy.

Dental services must begin within 180 days of the accident. We will pay for the usual and customary charges for such services. The total payment for dental services will be combined with medical and surgical services and be subject to the Maximum Medical and Dental Expense Benefit under Coverage C.

### **Excess Insurance Provision:**

The Policyholder and all Covered Persons understand and agree that the medical/dental expense benefits provided under the policy are excess insurance. This insurance is intended to supplement, and not replace coverage under any other health care plan, regardless of any coordination of benefits provision in the other plans. The Covered Person is required to utilize all other coverage and in no event will this policy pay for that portion of valid and collectible expenses paid or payable under any other health care plan.

If a Covered Person is covered by two or more excess plans, we will pay our pro rata share of those eligible expenses which are covered by both us and one or more other companies. This coverage is subject to the deductible amounts and limited to the maximum benefit amounts set forth in the policy.

**Exclusions:** No benefits will be paid for a loss caused by or resulting from:

- (1) services or treatment rendered by a doctor or any other person employed or retained by the Policyholder;
- (2) eyeglasses or contact lenses or prescriptions therefor;
- (3) hernia;
- (4) injury covered by workers' compensation or similar legislation or automobile no fault law;
- (5) first aid treatment at the scene of the accident;
- (6) bacterial infection, other than pyogenic infections or bacterial infections that result from the accidental ingestion of a contaminated substance;
- (7) air travel except on a commercial aircraft operating on a regular scheduled passenger route; or
- (8) injuries received as a consequence of the injured party's intoxication (alcohol or drug related), as defined by the laws of the jurisdiction where the loss occurred.

This is an accident only policy: We will not pay benefits for loss caused by or resulting from illness or any form of disease.

## DEFINITIONS

**"Doctor"** means a duly licensed practitioner of the healing arts, acting within the scope of his license. It does not include a Covered Person or a member of his immediate family.

**"Health Care Plan"** means any contract, policy or other arrangement for benefits or services, whether insured or uninsured, for medical/dental treatment under:

- a) group or blanket insurance, whether on an insured or self-insured basis;
- b) hospital or medical service organizations on a group basis;
- c) Health Maintenance Organizations on a group basis;
- d) group labor management plans;
- e) employee benefit organization plan;
- f) professional association plans on a group basis;
- g) any other group employee welfare benefit plan, as defined by the Employee Retirement Income Security Act of 1974 as amended;
- h) medical benefit coverage in group or individual automobile no-fault coverage;
- i) Medicare or similar governmental benefits as permitted by law;
- j) Health care benefit plan provided to any individual; or
- k) Medical reimbursement plan.

**"Injury"** means a bodily injury that occurs as the direct result of a covered accident while the policy is in force. All injuries sustained by one accident are considered a single injury.

**"Usual and Customary Charge"** means that charge which, in our experience, is most often incurred for services covered under the policy for cases of comparable severity and nature in the geographical area in which the services are furnished.

## PROVISIONS

**Notice of Claim:** If a covered loss occurs or begins, you must send us written notice within 30 days (Kentucky; 60 days) or as soon after that as is reasonably possible. This notice should state your name, address and policy number. Send this notice to us at our home office or to our agent.

**Claim Forms:** When we receive the notice of claim, we will send you forms for filing proof of loss. If claim forms are not sent within 15 days, you will meet the proof of loss requirements by submitting, within 90 days after the loss began, a written statement of its nature and extent.

**Proof of Loss:** Written proof of loss must be sent back to us no more than 90 days after the end of the period for which benefits are claimed. If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible.

**Payment of Claims; When Paid:** We will pay claims as soon as we receive proper written proof of loss. If a claim covers benefits for more than a month, we will pay all amounts due at the end of each month. If there are benefits due at the end of the claim period, we will pay them as soon as we receive due proof of loss.

**Payment of Claims; To Whom Paid:** Benefits will be paid to you, if living. Otherwise the claim will be paid to your estate. If you are a minor, benefits will be paid to someone related to you by blood or marriage whom we believe to be entitled to the benefits. Any such payment we make in good faith will meet our legal duty to pay that amount. We may, at our option, pay any medical expense benefits directly to the hospital or other health care provider; this does not apply if you request otherwise, in writing, by the time that you send the claim forms back to us.

**Change of Beneficiary; Assignment:** You have the right to select or change the beneficiary. You do not need the consent of the beneficiary to make such a change or to assign rights or benefits. No change or assignment is binding on us until we receive written notice.

**Physical Examination:** At our expense, we may have the person claiming benefits examined as often as reasonably necessary while the claim is pending.

**Legal Action:** No legal action to get policy benefits may be brought less than 60 days, nor more than 3 years (Kansas: 5 years; South Carolina: 6 years; Florida: the applicable statute of limits time period) after written proof of loss has been furnished as required by the policy.

**Conformity with State Statutes:** Any provision of the policy in conflict on its effective date with the laws of the state where the policy is delivered is amended to meet the minimum requirements of such laws.

**Workers' Compensation Insurance:** The policy is not in lieu of and does not affect any requirements for coverage under Workers' Compensation Insurance.

COMPLETE AND RETURN THIS FORM TO:



P.O. Box 390 Short Hills, NJ 07078

Medical/Dental Accident CLAIM FORM



TEAM

90/10 co-insurance

52 week benefit period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

1. NAME: (first) \_\_\_\_\_ (last) \_\_\_\_\_

2. ADDRESS: \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code) \_\_\_\_\_

3. TELEPHONE #: \_\_\_\_\_ SS#: \_\_\_\_\_

4. BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ SEX:  Male  Female FASTPITCH  SLOWPITCH

5. CLAIMANT IS:  Youth  Coach/Manager  Other \_\_\_\_\_

6. NAME OF TEAM: Suncoast SB LG Inc

Deductible:	\$250.00
Effective Date:	1/1/11
Certificate#:	41850

7. NAME OF LEAGUE: \_\_\_\_\_

8. ACCIDENT INSURANCE ID#: \_\_\_\_\_

9. ACCIDENT DATE: \_\_\_/\_\_\_/\_\_\_ ACCIDENT TIME: \_\_\_\_\_  am  pm

10. BODY PART INJURED: \_\_\_\_\_

11. ACCIDENT OCCURRED DURING:  Game  Practice  Tournament  Camp/Clinic  Other \_\_\_\_\_

12. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: \_\_\_\_\_

13. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED: \_\_\_\_\_

\*\*IF THIS SECTION IS NOT FILLED OUT, BOLLINGER CANNOT PROCESS AND WILL RETURN CLAIM FORM\*\*

SECTION II VERIFICATION (Must be signed by Team/League Official)

I CERTIFY THAT THE ABOVE NAMED CLAIMANT IS AN INSURED MEMBER OF THE TEAM NAMED ABOVE AND THAT THE INJURY OCCURRED DURING OFFICIAL TEAM ACTIVITIES AS STATED.

NAME OF TEAM/LEAGUE OFFICIAL: \_\_\_\_\_ TITLE: \_\_\_\_\_

SIGNATURE OF TEAM/LEAGUE OFFICIAL: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE: \_\_\_\_\_

SECTION III VERIFICATION (Must be signed by ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner)

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS ON A REGISTERED TEAM WITH THE AMATEUR SOFTBALL ASSOCIATION OF AMERICA FOR THE CURRENT SEASON.

NAME OF COMMISSIONER: \_\_\_\_\_ TITLE: \_\_\_\_\_

SIGNATURE OF COMMISSIONER: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE: \_\_\_\_\_

Was this injury a result of an ASA event?  YES  NO If no, indicate name of Organization that held event: \_\_\_\_\_

**SECTION IV STATEMENT OF OTHER INSURANCE (Required)**

**Father/Claimant**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
SELF EMPLOYED  UNEMPLOYED   
EMAIL: \_\_\_\_\_

**Mother/Claimant**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
SELF EMPLOYED  UNEMPLOYED   
EMAIL: \_\_\_\_\_

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND/OR DENTAL INSURANCE POLICY?  YES  NO  
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID?  YES  NO

INSURED NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ INSURED GROUP# /NAME: \_\_\_\_\_  
INSURANCE COMPANY NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**\*\*Please include a copy of insurance card (both sides)**

NOTE: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: \_\_\_\_\_

**SECTION V ASSIGNMENT OF BENEFITS**

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

**SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (Required)**

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantive civil penalty to the extent allows by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF PARENT/CLAIMANT (required): \_\_\_\_\_ DATE: \_\_\_\_\_

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Bollinger Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PARENT/CLAIMANT (required): \_\_\_\_\_ DATE: \_\_\_\_\_

## HOW TO FILE A CLAIM: INSTRUCTIONS

### IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc.) in order for this policy to consider your expenses for payment. Payment under this policy will be made according to **usual and customary guidelines**. This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **90 days** from date of injury to submit claim form.  
For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.

**Benefit Period:** This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**

- a) Advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
- b) Attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
- c) **Itemized bills are required:** You must submit itemized bills; balance due bills or notices do not provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicated that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.

- HCFA-1500 is the standard form used by Providers, such as doctors and dentists, to show the medical treatments and charges made for each service.
- UB-04 or UB-92 is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy.

5. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HSA):** Please read below and follow the steps appropriately to submit information.

- a) **Employer contribution to flex account** – Send to Primary insurance first, then flex account, then Bollinger.
- b) **Employee contribution to flex account** – Send to Primary insurance first, then Bollinger, then flex account. If monies have been paid out of your flex account before Bollinger, then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Bollinger, proof of reimbursement to your flex account is needed.

**For further information contact:**

Bollinger, Inc.  
Sports Claims Department  
PO Box 390  
Short Hills, NJ 07078-0390  
Phone: 1-866-267-0093  
Fax: Attn. Sports Claims 973-921-2876  
[www.BollingerInsurance.com](http://www.BollingerInsurance.com)  
[www.BollingerASA.com](http://www.BollingerASA.com)



## FRAUD STATEMENTS

**GENERAL:** 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.

**ALASKA:** Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**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.

**ARKANSAS:** 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.

**CALIFORNIA:** For your protection, California law requires the following to appear on this form: 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.

**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.

**DELAWARE:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**DISTRICT OF COLUMBIA RESIDENTS:** 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.

**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**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:** 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.

**MAINE:** 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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 RSA 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 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.

**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.

**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.

**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.

**OREGON:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

**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 act, which is a crime and subjects such person to criminal and civil penalties.

**TENNESSEE:** 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.

**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.

**VIRGINIA:** 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.

**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.