New York Life Group Benefit Solutions
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

Group / Association — Proof of Loss
Accidental Dismemberment Insurance

GROUP BENEFIT SOLUTIONS

Connecticut General Life Insurance Company
Life Insurance Company of North America
New York Life Group Insurance Company of NY

423244d Rev. 08/2021

NEW YORK FRAUD WARNING: 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 $5000 and the stated value of the claim for each such violation.

CAUTION: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia or Washington.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR ACCIDENTAL DISMEMBERMENT, PARALYSIS, LOSS OF SIGHT OR HEARING BENEFITS.
YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To The Employee/ Association Member:
A. Complete the Employee/Association Member section of this form, review the New York Life Group Benefit Solutions (NYL GBS) Survivor Assurance Disclosure Notice and the Important Claim Notice, and sign the Disclosure Authorization.
B. Have the Physician's Certificate completed and signed by the Attending Physician.
C. Return the fully completed form to your Employer / Administrator who will submit the form to the assigned Claim Office.

To the Employer / Administrator
A. Give the form to the Employee / Association Member for completion as indicated above.
B. Complete Employer's / Administrator's section.
C. Submit completed form to the Pittsburgh Claim office.

SECTION TO BE COMPLETED BY THE EMPLOYER/ADMINISTRATOR FOR EMPLOYEE AND DEPENDENT BENEFITS

Name of Employee/Insured *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code)

Insured's Marital Status ☐ Single ☐ Married ☒ Widow/Widower ☐ Separated ☐ Divorced ☐ Domestic Partner Relationship ☐ Civil Union

Policy Number(s) | Occupation

Please check all of the boxes that apply to the insured's employment status and job classification. Hrs./Wk. _____
☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local # _____ ☐ Salaried ☐ Full-time
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

Basic Annual Earnings | Effective Date of Earnings | Employee's Division/Location

Amount of Insurance Basic AD&D: _____ Voluntary AD&D: _____ NOTE: Please provide proof of enrollment if claiming Voluntary AD&D

Date Hired/Member of Assoc. | Effective Date of Insurance | Date Last Worked | Date of Accident | Premium Paid Through Date

Percentage of Insured's Contribution Toward Premium
Basic: _____ % Voluntary: _____ %

Insured's Contributions Were Made on ☐ Pre-Tax or ☐ Post-Tax Basis

Has an assignment been taken? (If so please attach.) ☐ Yes ☐ No

Was the above considered an Employee/Association Member until the date of the accident? ☐ Yes ☐ No If No, Please Explain

Was the above actively at work until the date of the Dependent's accident? ☐ Yes ☐ No
If No, indicate reason below.

If the employee was not actively at work immediately prior to his/her accident or Dependent's accident, what was the reason?
☐ Disability (STD) ☐ Paid Leave of Absence ☐ FMLA ☐ Temporary Layoff ☐ Resigned ☐ Other: _____
☐ Disability (LTD) ☐ Unpaid Leave of Absence ☐ Vacation ☐ Sabbatical ☐ Discharged

Was Coverage Still in Effect Through the Date of accident? *If Not, Please Explain*

TO BE COMPLETED IF CLAIM IS FOR DEPENDENT BENEFITS

Name of Dependent *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

Relationship to Employee/ Member | Amount of Dependent Insurance | Dependent's Occupation | Was the Dependent Disabled prior to the date of the accident? ☐ Yes ☐ No | If Yes, Date Disability began

Dependent's Employer | Dependent's Employer's Telephone Number | Is Child ☐ Full-time student ☐ Part-time student

Name & Address of School *(Street)* *(City)* *(State)* *(Zip Code)* | School Telephone Number

EMPLOYER'S / ADMINISTRATOR'S CERTIFICATION

Name of Employer / Association | E-Mail Address

Address *(Street)* *(City)* *(State)* *(Zip Code)* | Telephone # ( )

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. | Date Signed

SIGNATURE OF AUTHORIZED REPRESENTATIVE:

The issuance of this form is not an admission of the existence, nor does it recognize the validity, of any claim and is without prejudice to the company's legal rights.

423244d Rev. 08/2021

TO BE COMPLETED BY THE EMPLOYEE / ASSOCIATION MEMBER

Name of Employee/Insured *(Last Name)*	*(First Name)*	*(Middle Initial)*	Social Security No.

WHERE AND HOW DID THE ACCIDENT HAPPEN? PLEASE DESCRIBE IN DETAIL.

DATE AND TIME OF ACCIDENT	WHAT DISEASES, ILLNESS OR INJURIES DID THE INJURED PERSON HAVE DURING THE PAST 3 YEARS?

INSURED'S MARITAL STATUS	TELEPHONE #	E-MAIL ADDRESS
☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOW/ WIDOWER ☐ DOMESTIC PARTNER RELATIONSHIP ☐ CIVIL UNION	( )	

PLEASE LIST ANY HOSPITALS, CLINICS OR PHYSICIANS THAT TREATED THE INJURED PERSON DURING THE PAST 3 YEARS

NAME	COMPLETE ADDRESS	TREATMENT PERIOD

Please provide the name of your medical insurance carrier _____

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF EMPLOYEE / ASSOCIATION MEMBER:

DATE SIGNED _____

New York Life Group Benefit Solutions (NYL GBS) Survivor Assurance

If your insurance benefit is $5,000 or more, NYL GBS will automatically open a free, interest-bearing account in your name. This account, called the NYL GBS Survivor Assurance, is a convenient and secure place to keep your proceeds while you decide how to best use them. Please review the attached NYL GBS Survivor Assurance Disclosure Notice for full details about the account.* Account balances are the liability of the insurance company and are not insured by the Federal Deposit Insurance Corporation or any federal agency. The insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than $5,000, NYL GBS will send you a check for the total benefit amount.

*Please read the NYL GBS Survivor Assurance Disclosure Notice before signing below.

I understand that if my benefit is $5,000 or more, I will receive a NYL GBS Survivor Assurance account.

I understand that I may write a draft for the total amount in my account at any time.

I understand that the account balance may be reduced for any benefit payment by the insurance company made in error.

I acknowledge that, if I do not separately sign the NYL GBS Survivor Assurance Section of this Claim Form, I am not participating in the NYL GBS Survivor Assurance and that I will receive a single lump sum check for the proceeds due if my claim is approved.

Signature* _____ Date _____

*Please sign as you would sign on a check, as signature may be used for draft verification.

The issuance of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

Disclosure Authorization

CLEAR FORM

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Claimant's Name: _____

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and relates to information necessary to administer benefits and services under Employer's employee health and welfare plan(s) ("the Plan") and statutory and/or private leave of absence or job accommodation programs. "Employer" is defined to mean your employer, or your family member's employer to the extent benefits, services, or leave are being sought under your family member's employer's Plan. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers may not be able to process your (or your family member's) request for benefits or services under the Plan or statutory and/or private leave of absence or job accommodation programs.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; social security disability advocate or representative; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits, to provide access to or copies of this information (whether by written, telephonic or electronic means) to Life Insurance Company of North America; New York Life Group Insurance Company of NY (Life Insurance Company of North America and New York Life Group Insurance Company of NY shall be collectively referred to as "Insurance Company"); and any other individual or entity (including nonaffiliated third parties) that provides services to or insurance benefits on behalf of the Plan and/or Employer's statutory and/or private leave of absence or job accommodation programs. If I am also covered by Cigna Health and Life Insurance Company or its affiliates ("Cigna"), I authorize Insurance Company to disclose the health and other information described above to Cigna to assist me with my health coverage and to provide its services and benefits. This information will be shared to coordinate benefits and provide other services to you.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes or genetic information.

I agree and understand that any information obtained with this authorization may be used and disclosed for the following purposes: 1) evaluating and administering coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan; 2) evaluating and administering services related to Employer's statutory and/or private leave of absence or job accommodation programs; 3) determining my eligibility for any governmental benefits similar to or that coordinate with benefits available to me under the Plan and assisting me in applying for such benefits; and 4) evaluating and administering benefits or services under any other plans sponsored by or offered through Employer such as health management, disease management, wellness, or employee/member assistance programs.

I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by HIPAA or other federal regulations governing the privacy of health information, although it may continue to be protected by other applicable privacy laws and regulations. I further understand that if any information is used for services relating to Employer's leave of absence or job accommodation programs, that information may be disclosed to Employer at any time. Additionally, I understand that information may be disclosed to the employee who elected my coverage or submitted a claim for benefits under my coverage, or requested leave.

This authorization shall be valid for 12 months or the duration of my claim for insurance benefits, whichever is longer. I also understand that Insurance Company will maintain a copy of this authorization, and that I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan or Employer's statutory and/or private leave of absence or job accommodation programs who rely on this authorization may not be able to evaluate or administer any request for benefits, coverage or services and that any request for benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling the claim.

(Claimant's Signature) _____ (Date Signed) _____

(Print Name) _____ (Date of Birth) _____

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

COMPLETE ONLY IF CLAIMING DISMEMBERMENT BENEFITS

PHYSICIAN'S CERTIFICATE

PATIENT'S NAME	DATE OF BIRTH

1. PLEASE PROVIDE YOUR DIAGNOSIS.

2. PLEASE GIVE FULL DESCRIPTION OF THE INJURY.

3. ON WHAT DATE DID THE ACCIDENT OCCUR?.

4. ON WHAT DATE DID THE PATIENT FIRST CONSULT YOU FOR THIS INJURY?

5. WAS THE PATIENT TREATED BY OTHER PHYSICIANS FOR THE INJURY? IF SO, PLEASE LIST THE NAMES AND ADDRESSES IF KNOWN.

NAME **ADDRESS**

6. IF SURGERY WAS PERFORMED, PLEASE INDICATE THE TYPE OF SURGERY PERFORMED AND THE DATE

7. PLEASE LIST THE NAME AND ADDRESS OF THE HOSPITAL WHERE THE SURGERY WAS PERFORMED IF KNOWN.

8. WERE THERE ANY COMPLICATIONS FOLLOWING SURGERY? IF SO, PLEASE EXPLAIN IN DETAIL

9. WAS THE DISMEMBERMENT / PARALYSIS / LOSS A DIRECT RESULT OF INJURIES SUSTAINED IN AN ACCIDENT, INDEPENDENT OF ALL CAUSES? IF NOT, PLEASE EXPLAIN IN DETAIL.

10. IF THIS CLAIM IS FOR DISMEMBERMENT, PLEASE MARK THE EXACT POINT OF AMPUTATION ON THE DIAGRAM.

11. IF THIS CLAIM IS FOR PARALYSIS, PLEASE INDICATE THE EXTENT OF PARALYSIS ON THE DIAGRAM. ADVISE IF THE PARALYSIS IS PERMANENT, COMPLETE AND IRREVERSIBLE.

12. IF THIS CLAIM IS FOR LOSS OF SIGHT, WHAT IS THE PATIENT'S VISUAL ACUITY? IS THE LOSS TOTAL AND PERMANENT? IS THE LOSS DUE TO THE ACCIDENT? PLEASE EXPLAIN IN DETAIL. CAN THE VISION BE CORRECTED WITH EITHER SURGERY OR LENSES. IF SO, TO WHAT DEGREE?

13. IF THIS CLAIM IS FOR LOSS OF SPEECH OR HEARING, PLEASE ATTACH EXAMINATION AND LABORATORY RESULTS.

14. AT THE TIME OF THE INJURY, HAD THE PATIENT BEEN DIAGNOSED FOR ANY SPECIFIC DISEASE, ILLNESS OR OLD INJURIES? IF SO, PLEASE LIST THE DIAGNOSIS.

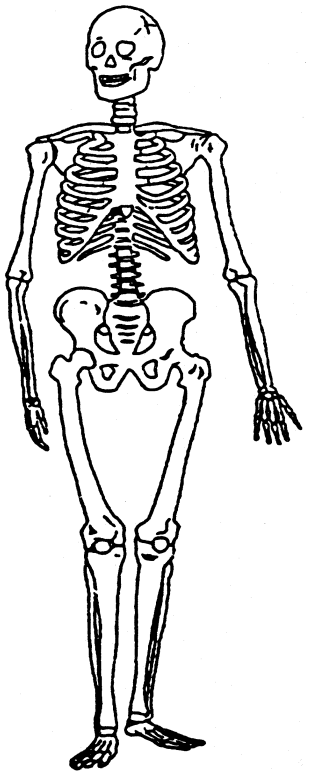
15. IF THIS CLAIM IS IS FOR LOSS OF USE, PLEASE IDENTIFY THE AREAS AFFECTED ON THE DIAGRAM.

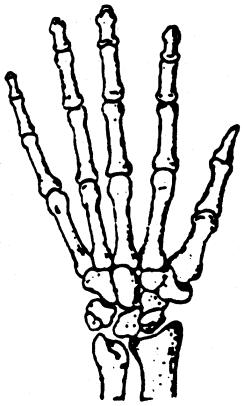
16. WHAT PERIOD WAS THE PATIENT CONTINUOUSLY DISABLED? **FROM** **THROUGH**

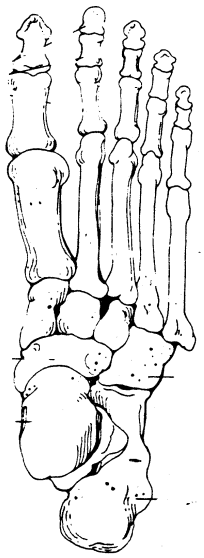
17. HAS THE PATIENT BEEN RELEASED TO RETURN TO WORK? IF SO, PLEASE EXPLAIN IN DETAIL.

18. WOULD YOU CONSIDER THE INJURY TO BE WORK-RELATED? IF SO, PLEASE EXPLAIN IN DETAIL.

19. HAVE YOU PREPARED A REPORT OF THIS NATURE FOR ANY OTHER INSURANCE COMPANY? IF SO, PLEASE PROVIDE NAME AND ADDRESS







20. **REMARKS**

DATE	PHYSICIAN'S NAME (Please Print)	SIGNATURE	DEGREE / SPECIALTY	TAX ID #

STREET ADDRESS	CITY / TOWN	STATE / PROVINCE	ZIP CODE	TELEPHONE NO.

New York Life Group Benefit Solutions (NYL GBS) Survivor Assurance Disclosure Notice

NYL GBS Survivor Assurance Disclosure

If your insurance benefit is $5,000 or more, NYL GBS will establish a free, interest-bearing draft account in your name. This account is a convenient and secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts (checks) will be mailed to you, once your claim has been approved. Personalized drafts are provided free of charge, and there are no per-draft fees, maintenance charges or penalties for withdrawal. There are charges for the following special services: drafts returned unpaid ($10), stop payment ($12) and copy of draft or statement ($2).

You will receive a quarterly statement for your NYL GBS Survivor Assurance account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. You may also check your account balance online at any time at www.nylgbssurvivorassurance.com.

Drafts are cleared through a draft account at BNY Mellon Bank (contact information on next page). NYL GBS's obligation to pay is satisfied by depositing the total proceeds in the retained asset account. Drafts draw upon funds held by NYL GBS (whereas a "check" draws upon funds held by a banking institution). You may write an unlimited number of drafts, in any amount, at any time up to your account balance. If you wish to withdraw the proceeds in full, you can write a draft for the total amount of the account at any time. You also have the right to receive an initial lump-sum payment in the form of a bank check. Please note that NYL GBS reserves the right to reduce account balances for any payment made in error. You also have the right to name a beneficiary to your account. If an account becomes inactive (as defined by your State's Department of Insurance), NYL GBS will return any remaining balance held in a RAA to your State of residence if no named beneficiary can be located.

This account is not insured by the Federal Deposit Insurance Corporation or any federal agency, but is guaranteed by the state guarantee association. Please contact the National Organization of Life and Health Insurance website (www.nolhga.com) to learn more about the coverage limitations to the account under a state guaranty association.

All funds are held by the insurance company, or one of its affiliates, which, like a bank, may earn money on the invested amounts that exceed the interest credited to the account and the cost of the additional benefits and services described below. For beneficiaries under policies issued by Connecticut General Life Insurance Company (CGLIC) and Life Insurance Company of North America (LINA), the custodian of the account funds will be CGLIC. For beneficiaries under policies issued by New York Life Group Insurance Company of NY (NYLGICNY), the custodian of the accounts funds will be NYLGICNY.

Disclosure on Interest Earned

You earn an attractive interest rate on the funds in your NYL GBS Survivor Assurance Account from the day it is established until the date it is closed. The NYL GBS Survivor Assurance interest rate is reviewed weekly and will be based upon the previous week's Bank Rate Monitor Index (BRM) or any successor money market index. The BRM Index is the average annual effective yield earned on the money market accounts offered by 100 large US Bank and Thrifts across the country. Any amount that remains in the account will continue to earn interest at a rate equal to the national average bank money market rate.

Please call our toll-free number 855.836.0697 for the current rate. Both your principal and any interest you earn are guaranteed by the insurance company. Any interest earned on the account may be taxable and you should consult a tax, investment, or other financial advisor regarding tax liability and investment options. Interest earned on your account is compounded daily and is credited to your account at the end of each month. All funds, including earned interest, are fully guaranteed by the insurance company.

If you have additional questions or would like additional information about the NYL GBS Survivor Assurance, you can **call us at 800.570.3778**

Or write us at: NYL GBS Survivor Assurance
PO Box 534029
Pittsburgh, PA 15253-4029

For further information, please contact your State Department of Insurance using the information provided on the next page.

Draft Accounts are setup by BNY Mellon Bank, located at 500 Ross Street, Pittsburgh, PA 15262.

The issuance of this notice is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights with respect to the insurance.

NYL GBS Survivor Assurance Disclosure Notice

State Insurance Department Contact Information

Alabama
PO Box 303351
Montgomery, AL 36130
(334) 269-3550
www.aldoi.gov

Alaska
PO Box 110805
Juneau, AK 99811
(907) 465-2515
https://www.commerce.alaska.gov/web/ins/

Arizona
100 N. 15th Ave, Suite 261
Phoenix, AZ 85007-2630
(602) 364-3100
https://insurance.az.gov

Arkansas
1 Commerce Way, Bldg 4, STE 502
Little Rock, AR 72202
(800) 282-9134
www.insurance.arkansas.gov

California
300 South Spring Street, 14th Floor
South Tower
Los Angeles, CA 90013
(800) 927-4357
www.insurance.ca.gov

Colorado
1560 Broadway, STE 850
Denver, CO 80202
(800) 930-3745
https://doi.colorado.gov/

Connecticut
153 Market Street, 7th Floor
Hartford, CT 06103
(800) 203-3447
www.ct.gov/cid/site/default.asp

Delaware
Delaware Dept of Insurance
351 W. North Street. Suite 101
Dover, DE 19904
(800) 282-8611
http://insurance.delaware.gov

District of Columbia
1050 First Street, NE, Suite 801
Washington, DC 20002
(202) 727-8000
http://disb.dc.gov

Florida
The Larson Building
200 East Gaines Street, RM 1001A
Tallahassee, FL 32399
(850) 413-3089
www.floir.com

Georgia
Office of Insurance and
Safety Fire Commissioner
Two Martin Luther King, Jr. Drive
West Tower, Suite 704, Floyd Bldg.
Atlanta, Georgia 30334
(800) 656-2298
www.oci.ga.gov

Hawaii
PO Box 3614
Honolulu, HI 96811
(808) 586-2790
http://cca.hawaii.gov.ins

Idaho
700 West State Street
PO Box 83720
Boise, ID 83720
(208) 334-4250
www.doi.idaho.gov

Illinois
122 S. Michigan Avenue, 19th Floor
Chicago, Illinois 60603
(312) 814-2420
http://insurance.illinois.gov/

Indiana
311 W Washington Street
STE 103
Indianapolis, IN 46204
(317) 232-2385
http://www.in.gov/idoi

Iowa
1963 Bell Avenue, Suite 100
Des Moines, Iowa 60315
(502) 564-3630
www.iid.state.ia.us

Kansas
1300 SW Arrowhead Road
Topeka, Kansas 66604
(800) 432-2484
www.ksinsurance.org

Kentucky
PO Box 517
Frankfort, KY 40602
(800) 595-6053
http://insurance.ky.gov/

Louisiana
PO Box 94214
Baton Rouge, Louisiana 70804-9214
(800) 259-5300
www.ldi.louisiana.gov

Maine
34 State House Station
Augusta, ME 04333
(800) 300-5000
www.maine.gov/pfr/insurance

Maryland
200 St. Paul Place, STE 2700
Baltimore, MD 21202
(800) 492-6116
http://insurance.maryland.gov

Massachusetts
1000 Washington Street, 8th Floor
Boston, MA 02118
(617) 521-7794
http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/

Michigan
PO Box 30220
Lansing, MI 48909
(877) 999-6442
www.michigan.gov/ofir

Minnesota
85 7th Place East, STE 280
Saint Paul, MN 55101
(651) 539-1500
http://mn.gov/commerce

Mississippi
PO Box 79
Jackson, MS 39205
(800) 562-2957
www.mid.state.ms.us

Missouri
PO Box 690
Jefferson City, MO 65102
(800) 726-7390
www.insurance.mo.gov

Montana
840 Helena Ave.
Helena, MT 5960
(800) 332-6148
http://csimt.gov

Nebraska
PO Box 82089
Lincoln, NE 68501
(877) 564-7323
www.doi.nebraska.gov

Nevada
1818 E. College Pkwy., STE 103
Carson City, NV 89706
(888) 872-3234
https://doi.nv.gov

New Hampshire
21 South Fruit Street, STE 14
Concord, NH 03301
(800) 852-3416
www.nh.gov/insurance

New Jersey
20 West State Street
PO Box 325
Trenton, NJ 08625
(800) 446-7467
www.state.nj.us/dobi/index.html

New Mexico
PO Box 1689
Santa Fe, New Mexico 87504-1689
(855) 427-5674
www.osi.state.nm.us

New York
One State Street
New York, NY 10004
(212) 709-3500
www.dfs.ny.gov

North Carolina
1201 Mail Service Center
Raleigh, NC 27699
(800) 662-7777
www.ncdoi.com

North Dakota
600 E. Boulevard Ave., 5th Floor
Bismarck, ND 58505
(800) 247-0560
www.nd.gov/ndins

Ohio
50 W. Town Street, STE 300
Columbus, OH 43215
(800) 686-1526
www.insurance.ohio.gov

Oklahoma
400 NE 50th Street
Oklahoma City, Oklahoma 73105-1816
(800) 522-0071
www.ok.gov/oid

Oregon
PO Box 14480
Salem, OR 97309
(888) 877-4894
http://dfr.oregon.gov

Pennsylvania
1326 Strawberry Square
Harrisburg, PA 17120
(877) 881-6388
www.insurance.pa.gov

Puerto Rico
361 Calle Calaf
P.O. Box 195415
San Juan, Puerto Rico 00919
(787) 304-8686
English: https://ocs.pr.gov/English
Spanish: https://ocs.pr.gov

Rhode Island
1511 Pontiac Avenue, Building 69-2
Cranston, RI 02920
(401) 462-9500
http://www.dbr.ri.gov/divisions/nsurance

South Carolina
PO Box 100105
Columbia, SC 29202
(803) 737-6160
www.doi.sc.gov

South Dakota
124 South Euclid Avenue, 2nd Floor
Pierre, SD 57501
(605) 773-3563
http://dlr.sd.gov/insurance

Tennessee
Davy Crockett Tower Twelfth Floor
500 James Robertson Pkwy.
Nashville, TN 37243
(800) 342-4029
www.tn.gov/commerce/insurance

Texas
PO Box 149104
Austin, TX 78714
(800) 578-4677
www.tdi.texas.gov

Utah
PO Box 146901
Salt Lake City, Utah 84114-6901
(800) 439-380
www.insurance.utah.gov

Vermont
89 Main Street
Montpelier, VT 05620
(800) 964-1784
www.dfr.vermont.gov

Virginia
PO Box 1157
Richmond, VA 23218
(800) 552-7945
www.scc.virginia.gov/boi

Virgin Islands
For St. Croix
1131 King Street, 3rd Floor, Suite 101
Christiansted, St. Croix, VI 00820
(340) 773-6459

Washington
PO Box 40255
Olympia, WA 98504
(800) 562-6900
www.insurance.wa.gov

West Virginia
PO Box 50540
Charleston, WV 25305
(888) 879-9842
www.wvinsurance.gov

Wisconsin
PO Box 7873
Madison, WI 53707
(800) 236-8517
www.oci.wi.gov

Wyoming
106 East 6th Avenue
Cheyenne, WY 82002
(800) 438-5768
http://doi.wyo.gov

The issuance of this notice is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights with respect to the insurance.

IMPORTANT CLAIM NOTICE

California Residents: 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 Residents: 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 settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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 Residents: 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 Residents: Any person who knowingly and with intent to defraud any insurance company or other person (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: 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 Residents: 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.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Pennsylvania Residents: 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.

Puerto Rico Residents: Caution: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island Residents: 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.

Tennessee Residents: 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 Residents: 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 Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents*:* 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.