CHANGE REQUEST FORM

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

6300 Jefferson St NE, Suite 150
Albuquerque, NM 87109
1 (800) 233-2576 • (505) 222-6400 • Fax: (505) 884-8611

Please see instruction sheet attached and PRINT CLEARLY.

A Retiree Personal Information — *Complete ALL blanks in this section.*

1. Social Security No.	2. PRINT Last Name First Name MI			3. Date of Birth (MM/DD/YYYY)
4. E-Mail Address	5.Mailing Address — *If new, check box in Section B-1*			
6. Effective Date of Change	b. City	c. State	d. ZIP Code	e. Home Phone ( )

B Change Personal Information

1. ☐ CHANGE ***ADDRESS***: *Write* **new** *address & phone no. in Section 5*

2. ☐ CHANGE ***NAME***: a. *Write* **new** *name in Section A-2*
b. *Write* **former** *name here:*

C Change Level of Coverage *(Each enrollee's level of coverage must be the same; unless one party is Medicare eligible).*

1. ***NEW*** *LEVEL OF COVERAGE REQUESTED:* ☐ Single ☐ Two-Party ☐ Family

2. ***ADD*** *DEPENDENT(S)/DOMESTIC PARTNER:* ***List in #4 below***
a. ☐ Marriage date: ____/____/____ ***(attach certificate)*** c. ☐ Newly eligible ***(attach supporting documents)***
b. ☐ Newborn birth date: ____/____/____***(attach certificate)***

3. ***DEPENDENTS***

a. Soc. Sec. #	b. Full name	c. Date of birth (MM/DD/YYYY)	d. Sex	e. Relationship	f. Medicare Part A	f. Medicare Part B
			☐M ☐F		☐Y ☐N	☐Y ☐N
			☐M ☐F		☐Y ☐N	☐Y ☐N
			☐M ☐F		☐Y ☐N	☐Y ☐N

4. **Medical Coverage:**

Please select Yes or No to the following questions for yourself:
1) Do you have End-Stage Renal Disease (ESRD)?
☐**Yes** ☐ **No** -If yes, please contact the NMRHCA at 1-800-233-2576 for further instructions
2) Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**
3) Are you enrolled under private insurance, TRICARE, Federal employee health benefits, VA Benefits, or State Pharmaceutical Assistance Programs? ☐ **Yes** ☐ **No**

Please select Yes or No to the following questions for your Spouse (if applicable):
1) Do you have End-Stage Renal Disease (ESRD)?
☐**Yes** ☐ **No** -If yes, please contact the NMRHCA at 1-800-233-2576 for further instructions
2) Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**
3) Are you enrolled under private insurance, TRICARE, Federal employee health benefits, VA Benefits, or State Pharmaceutical Assistance Programs? ☐ **Yes** ☐ **No**

Non-Medicare Plans

Name_____

Name_____

Choose one plan for all non-Medicare members
(Out-of-state non-Medicare enrollees must select BCBS Premier)
☐ **BCBS Premier PPO**
☐ **Presbyterian Premier PPO**
☐ **Presbyterian Value HMO**
☐ **BCBS Value HMO**

Medicare Plans [1]

([1]Service area for Presbyterian and BCBS Advantage Plans are limited to the State of New Mexico)

☐ **BCBSNM Medicare Supplemental Plan**
☐ **BCBS Advantage Plan I** ☐ **Plan II**
☐ **Presbyterian Advantage Plan I** ☐ **Plan II**
☐ **United Healthcare Advantage Plan I** ☐ **Plan II**
☐ **Humana Advantage Plan I** ☐ **Plan II**

_____

☐ Spouse: _____

☐ Dependent: _____

- **Medicare Parts A and B are required for all Medicare Plans.**
- **Please provide a copy of the Medicare card or Entitlement letter if Medicare card is in process.**

5. **Dental and Vision Coverage** – Note: Any dental and vision changes must be done during the annual switch enrollment period. This option is just for new dependents.

☐ Delta Dental Comprehensive	☐ Delta Dental Basic	☐ Davis Vision

D Cancel Coverage

Note: Monthly deduction will continue unless written notification to cancel is made one month in advance. **Effective date of cancellation is not retroactive.**

Retiree	Spouse/Domestic Partner	Dependent
☐ Cancel my medical plan ☐ Cancel my dental plan[1] ☐ Cancel my vision plan[1] ☐ Cancel my Supplemental Life plan ☐ Cancel ***all*** benefit plans for all members[1]	☐ Cancel medical plan ☐ Cancel dental plan[1] ☐ Cancel vision plan[1] ☐ Cancel Supplemental Life plan	☐ Cancel medical plan ☐ Cancel dental plan[1] ☐ Cancel vision plan[1] ☐ Cancel Supplemental Life plan
	Name: _____	**Name:** _____ **Name:** _____

[1]*If you drop dental or vision coverage you must wait four years before enrolling again.*

E Change Amount of Life Insurance

E. Change Amount of Life Insurance

☐ **Decrease** coverage:

Retiree ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000
Spouse ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000
Child ☐$2,500 ☐$5,000

☐ **Increase*** coverage:

Retiree ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000 ☐$60,000
Spouse ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000 ☐$60,000
Child ☐$5,000 ☐$10,000

Losing Retiree Life coverage from New Mexico Public Schools Insurance Authority (NMPSIA) due to age:
With proof of life insurance amounts lost from NMPSIA and enrolling within 31 days of the loss you may enroll up to the insurance amounts lost.

Retiree ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000 ☐$60,000
Spouse ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000 ☐$60,000
Child ☐$2,500 ☐$5,000 ☐$10,000

☐ **Add*** coverage:

Retiree ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000 ☐$60,000
Spouse ☐$2,000 ☐$4,000 ☐$6,000 ☐$8,000 ☐$10,000 ☐$15,000 ☐$20,000 ☐$40,000 ☐$46,000 ☐$60,000
Child ☐$2,500 ☐$5,000 ☐$10,000

Note: **Increasing or adding coverage is not allowed for a Survivor member; An Evidence of Insurability Statement is required for Retiree and Spouse to Increase or Add coverage. (Please call 1-800-233-2576 to request an Evidence of Insurability Statement); Spouse and Child coverage amounts may not exceed Retiree coverage amount.*

F Change Method of Premium Payment / Retiree Authorization for Deduction

(ERB retirees are required to select option 2, automatic bank draft, if changing the method of payment)

1. ☐ I hereby authorize a deduction from my pension earnings for NMRHCA insurance plan contributions.
2. ☐ I hereby authorize an automatic bank draft on my checking account for NMRHCA insurance plan contributions.

IMPORTANT: *PLEASE ATTACH A VOIDED CHECK IF CHOOSING BANK DRAFT.*
MONTHLY DEDUCTION WILL CONTINUE UNLESS WRITTEN NOTIFICATION TO CANCEL IS MADE ONE MONTH IN ADVANCE.

G DECLARATION AND SIGNATURE

I hereby declare the information I have provided above is true and complete to the best of my knowledge. I further declare that I have read carefully and understand the statements on the reverse side of this form and that I make the authorizations declared under Section G.
(If signing under power of attorney, please attach authorizing documents if not already on file with NMRHCA.)

Signature_____ **Date**_____

Spouse Signature_____ **Date**_____

CHANGE REQUEST FORM INSTRUCTIONS

Section A

Complete entire section, giving *current* data for retiree (or surviving eligible dependent if retiree is deceased). *Effective Date of Change (#6):* Changes will take effect on the 1st of the month following the qualifying event, except in the case of a newborn or adopted dependent (coverage's will take effect on the 1st of the month of the birth day or adoption). You must submit this Change Request Form within 31 days of the qualifying event.

Section B

*Complete only if you wish to **change** your address (#1) or name (#2).*

Section C

1. *Complete only if you wish to **change** your level of coverage.* Indicate change in #2 or #3.
2. *Complete only if you wish to **add** dependents.* See NMRHCA *Summary of Benefits* or call NMRHCA for definition of eligible dependents. If you add dependent(s) after your initial enrollment, you must attach a loss of coverage letter for each dependent to be added, unless dependent is *newly* eligible (marriage, birth, *involuntarily* termination of health care coverage under another program—see *Summary of Benefits*). Documentation of event causing new eligibility is required (copy of marriage certificate, birth certificate, court decree of adoption or legal guardianship, etc.).
3. *Complete entire section if you are **adding** (#2) dependents.* Attach additional sheet if you are adding additional dependents.
4. Select a medical plan for your dependent(s). **Medicare:** Be sure to submit a copy of a Medicare card showing Parts A and B. Although Medicare allows you to reject Part B, you are ***required*** to purchase it in order to enroll in certain NMRHCA Medicare Plans. If you and/or your dependents are Medicare-eligible but do not carry Medicare Part A and/or Part B please contact the NMRHCA to learn about the consequences. **Non-Medicare**: all out of state non-Medicare enrollees must choose the BCBS Premier option.
5. *Complete only if your coverage has **changed** or if you are **adding** (#2) dependents*.

Section D

*Complete only if you wish to **cancel** coverage.* Future reapplication for NMRHCA medical plan coverage may require submission of a Loss of Coverage letter for retiree and any dependents to be covered. If you cancel only dental or vision coverage, you must wait four years before enrolling again during the subsequent Switch Enrollment Period. If you cancel only retiree and/or dependent additional life, future reapplication will require submission of an Evidence of Insurability Statement for each individual to be covered by additional life insurance.

Section E

Complete only if you wish to **change** the amount of your life insurance coverage (**decrease** amount in #1, **increase** amount in #2 or #3; or **add** that line of coverage for the first time in #4). If you wish to **increase or add** life insurance for the retiree and/or dependents, you **must submit an Evidence of Insurability Statement for each enrolled individual affected**. It may take up to two (2) months for determination. You need not submit an Evidence of Insurability Statement to decrease or cancel life insurance for the retiree and/or dependents.

Section F

*Complete only if you wish to **change** your method of paying your NMRHCA premium contributions*. If you do not change it, adjustments will automatically be made in your *current* method of payment to reflect any changes you make in your coverage. ERB retirees are required to select option 2, automatic bank draft.

Section G

You MUST sign and date this form. Send original to NMRHCA, 6300 Jefferson St NE, Suite 150, Albuquerque NM 87109; keep a copy for your records.

DECLARATION *(please read before signing)*: I understand that my submission of this application does not constitute acceptance by the NMRHCA and that service will be available subject to the exclusions, limitations, and conditions described in the Retiree Health Care Act, the insurance carrier Benefit Booklets, and the Group Policy Certificate. I understand my premiums may be adjusted to reflect the changes I have requested on this form and that they may be adjusted from time to time, and I authorize that adjustment in my pension deduction or bank draft. I understand that I may be direct-billed and should pay the billed amount directly until any change in my deduction or draft amount is processed. I authorize my insurance carriers to coordinate benefits and/or reimbursements with other health plans or insurance carriers. I authorize my medical insurance carrier to obtain information from the Social Security Administration regarding my and my dependents' Medicare eligibility. I authorize any health care provider to furnish, when applicable, medical information regarding me and my dependents.

If you have questions about the information contained or requested in this form, please contact the NMRHCA at 1-800-233-2576, Fax: 505-884-8611
www.nmrhca.org

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

New Mexico Retiree Healthcare Authority
Medical History Statement

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. A separate form must be submitted for each applicant (Retiree and/or, Spouse) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 3. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

RETIREE INFORMATION

Name of Group	Group Number	Check who is Applying (One per form)
New Mexico Retiree Healthcare Authority	**645743**	☐ Retiree ☐ Spouse

Retiree Name	Birth Date (Mo/Day/Year)	Date Retired (Mo/Day/Year)

Social Security Number

APPLICANT INFORMATION

Applicant's Name (Person to be insured)	Email Address

Street Address	City	State/Province	ZIP/Postal Code

Sex	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Cell Phone ( )
☐M ☐F				Home Phone ( )

APPLICATION INFORMATION

Check the type and provide details on the amount of coverage you are requesting.

☐ Retiree Plan 2 Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Dependents (Spouse) Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

PHYSICIAN INFORMATION *(Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address)*

Doctor First Name	Doctor Last Name		

Clinic Name	Doctor Phone	

Doctor Address	City	State/Province	ZIP/Postal Code

Date Last Consulted

Reason Last Consulted

Applicant Name	Social Security Number

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

1. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to any sickness, surgery, injury, mental or emotional condition? ☐ Yes ☐ No
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal disorder, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder? ☐ Yes ☐ No
   - E. Emphysema, asthma, chronic bronchitis, sleep apnea, or other lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back or spine, or arthritic conditions? ☐ Yes ☐ No
   - H. Endocrine (including thyroid or adrenal), diabetes? ☐ Yes ☐ No
   - I. Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or HIV antibodies? ☐ Yes ☐ No
4. During the past five years have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease, disorder, condition or injury? ☐ Yes ☐ No
5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, illness, injury, surgery or pregnancy? ☐ Yes ☐ No
6. Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition (including pregnancy) or disease other than cold or allergies not disclosed above? ☐ Yes ☐ No

Height _____ **Weight** _____

DETAILS OF ANY "YES" ANSWERS ABOVE

Include diagnosis, start and end dates, duration, type and frequency of treatment, hospitalization, physician visits, cause, location of disorder, residuals, acute or chronic status, work loss, and operations.

Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State

Applicant Name	Social Security Number

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any supplemental information, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I authorize The Standard to release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Retiree: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Retiree, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and Fraud Notice (if applicable), and I have made a copy of this Medical History Statement.

Signature of Applicant	**Date**

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

Applicant Name	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

  Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

  Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

FRAUD NOTICE

- ARKANSAS, MAINE, OHIO: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- 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 kindly provides false, incomplete, or misleading facts or information to the 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.
- DISTRICT OF COLUMBIA: 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.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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, NEW MEXICO: 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.
- MARYLAND, RHODE ISLAND: 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.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy 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 act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- 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.
- PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or any other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
- TENNESSEE, VIRGINIA, 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 include imprisonment, fines, and denial of insurance benefits.