

SERFF Tracking Number: RENA-126317757 State: Arkansas
 Filing Company: Renaissance Life & Health Insurance Company of America State Tracking Number: 43587
 Company Tracking Number:
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
 Product Name: Delta/Ren Application/Enrollment Form
 Project Name/Number: /

Filing at a Glance

Company: Renaissance Life & Health Insurance Company of America

Product Name: Delta/Ren Application/Enrollment Form SERFF Tr Num: RENA-126317757 State: Arkansas

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved-Closed State Tr Num: 43587

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Denise Chadwell, Bryan Crips Disposition Date: 09/29/2009

Date Submitted: 09/24/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/29/2009

Explanation for Other Group Market Type:

State Status Changed: 09/29/2009

Deemer Date:

Created By: Bryan Crips

Submitted By: Bryan Crips

Corresponding Filing Tracking Number:

Filing Description:

RE: Renaissance Life & Health Insurance Company of America, NAIC# 61700

SERFF Tracking Number: RENA-126317757

On behalf of Renaissance Life & Health Insurance Company of America, I am enclosing for filing a revised Individual Dental Enrollment/Update form, INVD-103A-Delta v3. This form will be used in conjunction with individual dental Policy INVD-100A-Delta. This form will replace the previous form that was submitted under SERFF Tracking Number: RENA-

SERFF Tracking Number: RENA-126317757 State: Arkansas
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 of America
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Delta/Ren Application/Enrollment Form
 Project Name/Number: /

126164725 and approved by your department 5/29/2009.

Should you have any questions, please contact me directly at (517)381-4229 or bcrips@renaissancefamily.com.

Sincerely,

Bryan Joseph Crips
 Administrative Analyst

Company and Contact

Filing Contact Information

Bryan Crips, Administrative Analyst bcrips@renaissancefamily.com
 P.O. Box 30381 517-381-4229 [Phone]
 Okemos, MI 48909-7881 517-347-5433 [FAX]

Filing Company Information

Renaissance Life & Health Insurance Company CoCode: 61700 State of Domicile: Delaware
 of America
 P.O. Box 30381 Group Code: 477 Company Type: Life & Health
 Lansing, MI 48909-7881 Group Name: State ID Number:
 (800) 745-7509 ext. [Phone] FEIN Number: 47-0397286

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Normal fees and rate each \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Renaissance Life & Health Insurance Company of America	\$50.00	09/24/2009	30814042

SERFF Tracking Number: RENA-126317757 State: Arkansas
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TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/29/2009	09/29/2009

SERFF Tracking Number: RENA-126317757 State: Arkansas
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TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: Delta/Ren Application/Enrollment Form
Project Name/Number: /

Disposition

Disposition Date: 09/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: RENA-126317757 State: Arkansas

Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 43587
of America

Company Tracking Number:

TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application/Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: RENA-126317757 State: Arkansas
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 Company Tracking Number:
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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/29/2009	INVD-103A-Delta v3	Application/Enrollment Form	Application/Enrollment Form	Revised	Replaced Form #: INVD-103A-Delta v2 Previous Filing #: RENA-126164725	47.800	Individual Dental Enrollment- Update v3.pdf

Individual Dental Enrollment/Update

Enroll online now at www.xxxxxxxxxxxxxxx.com or complete this form and mail to:

[XXXXX XXXXXX XXXX XX XXXXXXXX, XXX.
 XXXXX XXXXXXXXXXXX XXXXXX XXXXX
 XXXXXXX, XX XXXXX]

If you have any questions about filling out this form, please contact our Customer Service department at [(xxx) xxx-xxxx].

- New Enrollment—Check for first-time enrollment for yourself or your spouse.
- Change/Correction to Information—Check if any changes are being submitted on this form.
- Termination of Benefits—Check only if you are terminating coverage for yourself or your spouse.

[Region 6 New York 3 Digit Zip Code 063,100-119(under 55)]

[Will this policy replace or change any existing policy of dental insurance? Yes No
 If yes, please describe:]

(This section must be completed for us to process your enrollment or update your records. Please print clearly or type.)

Enrollee Name		Example A B C D E F 1 2 3 4 5 6	
(First)	(M.I.)	(Last)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Birth Date	Sex	Enrollee Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Street Address		<input type="checkbox"/> Check here if this is a new address	
<input type="text"/>			
City	State	ZIP Code	
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	
E-mail Address (Optional)		Telephone Number	
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>	
Coverage Effective Date			
<input type="text"/> - <input type="text"/> - <input type="text"/>		[List company you retired from:]	
(date coverage takes effect for you and/or your spouse)			

Spouse Information *(Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)*

Spouse Name (First)		(M.I.)	(Last)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Birth Date	Sex	Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	

Dependent Child Information

#1- Dependent Child Name (First)

(M.I.)	(Last)
<input type="text"/>	<input type="text"/>
Birth Date	Sex
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Social Security Number	
<input type="text"/> - <input type="text"/> - <input type="text"/>	

Dependent Child Information Continued:

#2- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

 - -

#3- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

 - -

#4- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

 - -

#5- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

 - -

Payment Information (The amount payable for coverage varies based on the coverage option selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling):

Rates:

	<u>Single</u> Monthly/Annual	<u>Two-Person</u> Monthly/Annual	<u>Family</u> Monthly/Annual
<input type="checkbox"/> Option I – PPO (Point-of-Service) – High Option	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]	[\$xxx.xx/\$xxxx.xx]
<input type="checkbox"/> Option II – PPO (Standard) – Low Option	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]	[\$xxx.xx/\$xxxx.xx]
<input type="checkbox"/> Option III – xxx (xxxxxxxx) – xxx xxxxxx	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]	[\$xxx.xx/\$xxxx.xx]

Payment Frequency:

- Annual (If you are paying by check, you **must** choose this option and pay the amount due in full)
- Monthly (If you are paying by credit card or automatic withdrawal, you may choose this option)

Choose the payment method:

Check payable to Delta Dental (**you may pay by check only if you choose an annual payment**)

MasterCard VISA Discover]

Card Number

Exp. Date

 -

Cardholder Name (as it appears on card)



- - - CVV Code (last three digits on the back of your Credit Card)

Credit Card Billing Address (if different from mailing address)

Street Address

[Grid for Street Address]

City

[Grid for City]

State

[Grid for State]

ZIP Code

[Grid for ZIP Code]

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for premiums due. This authorization will remain in effect until Delta Dental has received written notice from me of its termination. If the billing amount changes, Delta Dental will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature _____ Date _____

John J. Doe 1-1983 1234
Jane K. Doe
4321 Main St.
Anytown, MI 45678
Pay to the order of _____ \$ _____
XYZ Bank DOLLARS
For _____ MP

[] Automatic withdrawal from bank account

! :01 0123456! : 9876543210!!" 1234
Routing number Account number

Bank Name

[Grid for Bank Name]

Routing Number

Account Number

[] Checking Account

[Grid for Routing Number]

[Grid for Account Number]

[] Savings Account

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature _____ Date _____

Validation Question (choose ONE and answer below):

[] Mother's maiden name (last name only) OR [] City in which you were born OR [] Name of first pet

[Grid for Validation Question]

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (Please see the following page for state-specific variations of this fraud notice.)

Applicant's Signature _____ Date _____

Please mail enrollment form (and check, if applicable) to:

[XXXXXX XXXXXX XXXX XX XXXXXXXXX, XXX.

XXXXXX XXXXXXXXXXXX XXXXXX XXXXXX

XXXXXXXX, XX XXXXXX]

Fraud Warning Notices: (If the proposed insured or owner lives in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Arkansas/Louisiana/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 fines and confinement in 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 certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate 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 regulatory agencies.

DC: 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.

Kentucky/Ohio: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.

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 denial of insurance benefit.

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 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.

Oklahoma: 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.

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 omits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee/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.

Required California Notice: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____(Owner's Initials)

SERFF Tracking Number: RENA-126317757 State: Arkansas
 Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 43587
 of America
 Company Tracking Number:
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Delta/Ren Application/Enrollment Form
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	09/29/2009
Comments:		
Attachment: Read Cert Flesch Score.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	09/29/2009
Comments:		
Attachment: Individual Dental Enrollment-Update v3.pdf		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	09/29/2009
Bypass Reason: NA - Does not apply		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	09/29/2009
Bypass Reason: NA - Does not apply		
Comments:		

**ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Renaissance Life & Health Insurance Company of America

This is to certify that the forms referenced below have achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of the state of Arkansas.

FORM NUMBER	SCORE
INVD-103A-Delta v3	47.8



John-Michael Hyden, Esq.
Legal Counsel and Director of Administration

9/24/2009

Date

Individual Dental Enrollment/Update

Enroll online now at www.xxxxxxxxxxxxxxx.com or complete this form and mail to:

[XXXXX XXXXXX XXXX XX XXXXXXXX, XXX.
 XXXXX XXXXXXXXXXXX XXXXXX XXXXX
 XXXXXXX, XX XXXXX]

If you have any questions about filling out this form, please contact our Customer Service department at [(xxx) xxx-xxxx].

- New Enrollment—Check for first-time enrollment for yourself or your spouse.
- Change/Correction to Information—Check if any changes are being submitted on this form.
- Termination of Benefits—Check only if you are terminating coverage for yourself or your spouse.

[Region 6 New York 3 Digit Zip Code 063,100-119(under 55)]

[Will this policy replace or change any existing policy of dental insurance? Yes No
 If yes, please describe:]

(This section must be completed for us to process your enrollment or update your records. Please print clearly or type.)

Enrollee Name		Example A B C D E F 1 2 3 4 5 6	
(First)	(M.I.)	(Last)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Birth Date	Sex	Enrollee Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Street Address			<input type="checkbox"/> Check here if this is a new address
<input type="text"/>			
City	State	ZIP Code	
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	
E-mail Address (Optional)		Telephone Number	
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>	
Coverage Effective Date			
<input type="text"/> - <input type="text"/> - <input type="text"/>		[List company you retired from:]	
(date coverage takes effect for you and/or your spouse)			

Spouse Information *(Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)*

Spouse Name (First)		(M.I.)	(Last)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Birth Date	Sex	Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	

Dependent Child Information

#1- Dependent Child Name (First)

(M.I.)	(Last)
<input type="text"/>	<input type="text"/>
Birth Date	Sex
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Social Security Number	
<input type="text"/> - <input type="text"/> - <input type="text"/>	

Dependent Child Information Continued:

#2- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

#3- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

#4- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

#5- Dependent Child Name (First)

(M.I.) (Last)

Birth Date

Sex

Social Security Number

Male

Female

Payment Information (The amount payable for coverage varies based on the coverage option selected, the number of people enrolled, and the payment frequency. You may choose only one option, regardless of the number of people enrolling):

Rates:

	<u>Single</u> Monthly/Annual	<u>Two-Person</u> Monthly/Annual	<u>Family</u> Monthly/Annual
<input type="checkbox"/> Option I – PPO (Point-of-Service) – High Option	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]	[\$xxx.xx/\$xxxx.xx]
<input type="checkbox"/> Option II – PPO (Standard) – Low Option	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]	[\$xxx.xx/\$xxxx.xx]
<input type="checkbox"/> Option III – xxx (xxxxxxxx) – xxx xxxxxx	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]	[\$xxx.xx/\$xxxx.xx]

Payment Frequency:

- Annual (If you are paying by check, you **must** choose this option and pay the amount due in full)
- Monthly (If you are paying by credit card or automatic withdrawal, you may choose this option)

Choose the payment method:

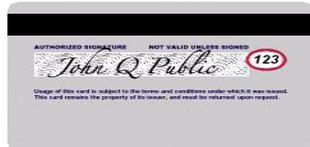
Check payable to Delta Dental (you may pay by check only if you choose an annual payment)

MasterCard VISA Discover]

Card Number

Exp. Date

Cardholder Name (as it appears on card)



____ - ____ - ____ CVV Code (last three digits on the back of your Credit Card)

Credit Card Billing Address (if different from mailing address)

Street Address

[Grid for Street Address]

City

[Grid for City]

State

[Grid for State]

ZIP Code

[Grid for ZIP Code]

I hereby authorize Delta Dental, subsidiaries, and affiliates to charge my credit card for premiums due. This authorization will remain in effect until Delta Dental has received written notice from me of its termination. If the billing amount changes, Delta Dental will provide a minimum of 10 days' notice to the cardholder.

Cardholder's Signature _____ Date _____

Form with fields for Name, Address, City, State, ZIP, and Payment Information (Pay to the order of, XYZ Bank, For, MP).

Automatic withdrawal from bank account

Routing number: 01 01234561; Account number: 987654321011 1234

Bank Name

[Grid for Bank Name]

Routing Number

Account Number

Checking Account

[Grid for Routing Number]

[Grid for Account Number]

Savings Account

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above. This authorization will remain in effect until Delta Dental has received written notification from me of its termination and/or my payment obligation has been satisfied. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Accountholder's Signature _____ Date _____

Validation Question (choose ONE and answer below):

Mother's maiden name (last name only) OR City in which you were born OR Name of first pet

[Grid for Validation Answer]

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (Please see the following page for state-specific variations of this fraud notice.)

Applicant's Signature _____ Date _____

Please mail enrollment form (and check, if applicable) to:

[XXXXXX XXXXXX XXXX XX XXXXXXXXX, XXX.

XXXXXX XXXXXXXXXXXX XXXXXX XXXXX

XXXXXXXX, XX XXXXX]

Fraud Warning Notices: (If the proposed insured or owner lives in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Arkansas/Louisiana/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 fines and confinement in 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 certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate 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 regulatory agencies.

DC: 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.

Kentucky/Ohio: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.

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 denial of insurance benefit.

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 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.

Oklahoma: 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.

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 omits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Required California Notice: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____(Owner's Initials)