

**State:** Arkansas **Filing Company:** Hartford Life and Annuity Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Application Supplement for Term Insurance  
**Project Name/Number:** Application Supplement for Term Insurance/HL-15879(12)

## Filing at a Glance

Company: Hartford Life and Annuity Insurance Company  
Product Name: Application Supplement for Term Insurance  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 08/27/2012  
SERFF Tr Num: HARL-128653429  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: HL-15879(12)  
Implementation: On Approval  
Date Requested:  
Author(s): Jane Chapman, Roberta Chu, Barbara Warren  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 08/30/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
State Filing Description:

**State:** Arkansas **Filing Company:** Hartford Life and Annuity Insurance Company  
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## General Information

Project Name: Application Supplement for Term Insurance Status of Filing in Domicile: Authorized  
Project Number: HL-15879(12) Date Approved in Domicile: 08/21/2012  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 08/30/2012  
State Status Changed: 08/30/2012  
Deemer Date: Created By: Roberta Chu  
Submitted By: Roberta Chu Corresponding Filing Tracking Number:

Filing Description:  
Dear Sir or Madam:

We are submitting the subject form for your review and approval. The Term Insurance Rider Application Supplement is new and is intended to replace the Term Insurance Rider Application Supplement approved by your Department in 2003. The main reason we are submitting the form is to update the MIB language in the authorization section.

The application supplement will be used in conjunction with our main individual life applications to apply for Term Insurance on additional insureds and is intended for use with individual universal and variable life insurance products as approved or as may be approved.

We are including the Notice of Insurance Information Practices (privacy notice) for informational purposes on the Supporting Documentation tab. We have also attached the Fraud Notice for information which contains the required fraud statement and will always be used in conjunction with/attached to the application. Also included in the submission are any required certifications and miscellaneous documents.

Your review and approval of this submission is greatly appreciated. Please feel free to contact me with any questions you may have.

Best regards,

Roberta M. Chu, AIRC  
Sr Compliance Specialist, ILD Compliance  
Phone: (800) 503-3150 or direct (860) 843-4317  
Fax: (860) 843-8547  
E-Mail: roberta.chu@thehartford.com

## Company and Contact

### Filing Contact Information

Roberta Chu, Contract Analyst roberta.chu@hartfordlife.com  
200 HopmeadowRd 860-843-4317 [Phone]  
Simsbury, CT 06089 860-843-5194 [FAX]

**State:** Arkansas **Filing Company:** Hartford Life and Annuity Insurance Company  
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**Filing Company Information**

Hartford Life and Annuity Insurance Company	CoCode: 71153	State of Domicile: Connecticut
200 Hopmeadow Street	Group Code: 91	Company Type: Life
Simsbury, CT 06089	Group Name:	State ID Number:
(860) 547-5000 ext. [Phone]	FEIN Number: 39-1052598	

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50/form  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Hartford Life and Annuity Insurance Company	\$50.00	08/27/2012	62032307

State: Arkansas Filing Company: Hartford Life and Annuity Insurance Company  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/30/2012	08/30/2012

SERFF Tracking #:

HARL-128653429

State Tracking #:

Company Tracking #:

HL-15879(12)

State:

Arkansas

Filing Company:

Hartford Life and Annuity Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Application Supplement for Term Insurance

Project Name/Number:

Application Supplement for Term Insurance/HL-15879(12)

## Disposition

Disposition Date: 08/30/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	FYI - Notice of Insurance Information Practices		Yes
Supporting Document	FYI - Fraud Statement		Yes
Form	Term Insurance Rider Application Supplement		Yes

SERFF Tracking #:

HARL-128653429

State Tracking #:

Company Tracking #:

HL-15879(12)

State:

Arkansas

Filing Company:

Hartford Life and Annuity Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Application Supplement for Term Insurance

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## Form Schedule

Lead Form Number: HL-15879(12)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		HL-15879(12)	AEF	Term Insurance Rider Application Supplement	Initial:	50.100	HL-15879(12).pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

# HARTFORD LIFE AND ANNUITY INSURANCE COMPANY

(herein referred to as "the Company")

Hartford, CT 06104-2999

Name of Proposed Insured 1:



## TERM INSURANCE RIDER — APPLICATION SUPPLEMENT

Note: All Term Rider Applicants Must Complete the Medical Exam Questionnaire

### A. PROPOSED INSURED INFORMATION

#### 1. Proposed Insured 3

a. Name of Proposed Insured		b. Date of Birth	c. Age	d. State/Country of Birth	e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
f. Residence Address <input type="checkbox"/> Same as Proposed Insured 1		g. Employer's Name			
h. Home Phone Number	i. Business Phone Number	j. Occupation/Duties			
k. Term Rider Amount	l. SSN	m. Height	n. Weight	o. Driver's License Number/State of Issue	

#### 2. Proposed Insured 4

a. Name of Proposed Insured		b. Date of Birth	c. Age	d. State/Country of Birth	e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
f. Residence Address <input type="checkbox"/> Same as Proposed Insured 1		g. Employer's Name			
h. Home Phone Number	i. Business Phone Number	j. Occupation/Duties			
k. Term Rider Amount	l. SSN	m. Height	n. Weight	o. Driver's License Number/State of Issue	

#### 3. Proposed Insured 5

a. Name of Proposed Insured		b. Date of Birth	c. Age	d. State/Country of Birth	e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
f. Residence Address <input type="checkbox"/> Same as Proposed Insured 1		g. Employer's Name			
h. Home Phone Number	i. Business Phone Number	j. Occupation/Duties			
k. Term Rider Amount	l. SSN	m. Height	n. Weight	o. Driver's License Number/State of Issue	

#### 4. Proposed Insured 6

a. Name of Proposed Insured		b. Date of Birth	c. Age	d. State/Country of Birth	e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
f. Residence Address <input type="checkbox"/> Same as Proposed Insured 1		g. Employer's Name			
h. Home Phone Number	i. Business Phone Number	j. Occupation/Duties			
k. Term Rider Amount	l. SSN	m. Height	n. Weight	o. Driver's License Number/State of Issue	

<b>B. GENERAL INFORMATION</b>				
Provide details to "Yes" answers in the Additional Information/Details section.			Yes	No
a.	Are all of the Proposed Insureds U.S. Citizens? If not, provide details and type of visa below?		<input type="checkbox"/>	<input type="checkbox"/>
b.	Have any of the Proposed Insureds ever engaged in or do they plan to engage in any aviation activity other than as fare-paying passengers? (If "Yes," complete Aviation Supplement.)		<input type="checkbox"/>	<input type="checkbox"/>
c.	In the past two years, did any of the Proposed Insureds participate in, or do they have plans to participate in skin or scuba diving; land or water vehicle competition or racing; sky diving, hang gliding or ballooning; rock or mountain climbing; or any other sports or activities that would be considered an extreme physical risk or contain a high level of physical danger? (If "Yes," complete Avocation Supplement.)		<input type="checkbox"/>	<input type="checkbox"/>
d.	Have any of the Proposed Insureds had insurance rejected or offered with an extra premium?		<input type="checkbox"/>	<input type="checkbox"/>
e.	Do any of the Proposed Insureds plan to travel or reside outside the United States within the next two years? (If "Yes," state when, where and how long.)		<input type="checkbox"/>	<input type="checkbox"/>
f.	Have any of the Proposed Insureds driver's licenses ever been suspended or revoked?		<input type="checkbox"/>	<input type="checkbox"/>
g.	Within the past 3 years, have any of the Proposed Insureds been convicted of, pled guilty or no contest to three or more moving violations and/or accidents?		<input type="checkbox"/>	<input type="checkbox"/>
h.	Within the past 5 years, have any of the Proposed Insureds been convicted of, pled guilty or no contest to driving under the influence of alcohol and/or drugs?		<input type="checkbox"/>	<input type="checkbox"/>
i.	Have any of the Proposed Insureds ever been convicted of, or pled guilty or no contest to, a Felony or Misdemeanor other than a minor traffic violation?		<input type="checkbox"/>	<input type="checkbox"/>
j.	For questions g, h and i above, do any of the Proposed Insureds currently have charges outstanding or violations pending? (If so, list details below.)		<input type="checkbox"/>	<input type="checkbox"/>
k.	Are any of the Proposed Insureds a member, or do any of the Proposed Insureds intend to become a member of the armed forces, including the reserves?		<input type="checkbox"/>	<input type="checkbox"/>
l.	During the past 5 years, have any of the Proposed Insureds been advised by a physician or health care provider to cease or limit excessive alcohol consumption?		<input type="checkbox"/>	<input type="checkbox"/>
m.	During the past 5 years, have any of the Proposed Insureds seen a physician or health care provider for any reason? (If "Yes", provide the physician or medical facility's name and address, date and reason for visit and results of the visit in the space provided below. If additional space is needed, provide details in the Additional Information/Details section.		<input type="checkbox"/>	<input type="checkbox"/>
n.	Insured Name _____ Reason for Visit _____ Date of Visit _____ Results _____ Physician Name _____ Physician Address _____ Phone ( ) _____			
o.	Insured Name _____ Reason for Visit _____ Date of Visit _____ Results _____ Physician Name _____ Physician Address _____ Phone ( ) _____			
<b>C. NICOTINE USE</b> Provide details below. Add comments in the Additional Information/Details section if more space is needed.				
Within the past 5 years, have any of the Proposed Insureds used any form of tobacco, nicotine or nicotine replacement therapy (for example—cigarette, cigar, pipe, chewing tobacco, Nicorette gum, nicotine patch, or nasal spray)?				
Proposed Insured 3	Within 12 mos. <input type="checkbox"/> Yes Within 3 years <input type="checkbox"/> Yes Within 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No	Type(s)	Amount	
Proposed Insured 4	Within 12 mos. <input type="checkbox"/> Yes Within 3 years <input type="checkbox"/> Yes Within 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No	Type(s)	Amount	
Proposed Insured 5	Within 12 mos. <input type="checkbox"/> Yes Within 3 years <input type="checkbox"/> Yes Within 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No	Type(s)	Amount	
Proposed Insured 6	Within 12 mos. <input type="checkbox"/> Yes Within 3 years <input type="checkbox"/> Yes Within 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No	Type(s)	Amount	



**F. AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION (Continued)**

The medical and/or non-medical information shall include, but not be limited to: (1) past or current health conditions including illnesses, sicknesses, diseases, disabilities, disorders, accidents, injuries, and drug prescriptions; (2) confinements in any hospital, medical facility, VA facility or medical clinic; (3) outpatient treatment in any hospital, hospital emergency room, medical facility, VA facility or medical clinic; (4) treatment for alcohol abuse, drug abuse or mental health protected by Federal Law; (5) other life insurance policies or coverages which may be currently applied for or in force on my life or the lives of my minor children; (6) motor vehicle violations; and (7) financial information.

I authorize any person or organization that has such medical or non-medical information to release this information. This includes any doctor, medical professional, health practitioner, therapist, counselor, hospital, clinic or any other medically related facility, pharmacy benefit manager, VA facility or medical clinic, other insurance company, reinsurer, any entity or person that evaluates a person's expected mortality or life expectancy, life settlement company, consumer reporting firm, employer, accountant, motor vehicle division or the MIB, Inc. (formerly known as the Medical Information Bureau). This information may be released to The Company or its legal representative. However, I understand that the MIB, Inc. will release records of information only to The Company.

I understand that the Company may disclose the information in its file(s) to its reinsurer(s), other insurance companies, other persons and/or organizations performing business functions on behalf of the Company, or as required by law, including any mandated reporting to state agencies. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to the MIB, Inc. I understand that I may request details about any of the information gathered about me or my minor children which relates to this application and that such requested information and the identity of the source of the information shall be released to me or in the case of medical information, to a licensed medical person of my choice.

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid for thirty (30) months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. However, I understand that revocation may be a basis for denying my insurance application and/or coverage and benefits. I also acknowledge receipt of the Company's Notice of Insurance Information Practices.

**G. AUTHORIZATION TO RELEASE AND DISCLOSE INFORMATION TO INSURANCE PRODUCER**

I/We, an undersigned Proposed Insured and Owner (if different), hereby authorize Hartford Life and Annuity Insurance Company ("the Company"), to provide information about the applied-for policy and this Life Insurance Application to the writing insurance producer and the insurance producers/agencies being compensated as a result of this policy. This information shall include, but not be limited to, personal information about me (and my minor children who are Proposed Insureds), copies of correspondence from the Company and web access to policy information. Additionally, I authorize the servicing insurance producer to assist the Company in maintaining information about my policy, such as providing updated address information and administering normal servicing producer functions allowed by the Company.

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid until the earlier of the time of my death or until I notify the Company otherwise by appointing a different servicing producer or removing the servicing producer.

**H. DECLARATIONS AND SIGNATURE**

Each of the undersigned Proposed Insured(s) and Owner declare, understand and agree that:

1. All statements and answers contained in this Supplement are complete and true to the best of our knowledge and belief.
2. This Supplement shall be considered part of the Application for Individual Life Insurance to which it is attached.
3. All statements and answers contained in the Application to which this Supplement is attached are hereby adopted and ratified.
4. All statements and answers contained in the Application, this Supplement, as well as any other supplements or amendments, are the basis for any insurance policy that may be issued.

1. \_\_\_\_\_ Date Signed: \_\_\_\_\_  
**Signature of Proposed Insured 3** Mo/Day/Yr  
(Parent or Guardian if under 15 years of age)

2. \_\_\_\_\_ Date Signed: \_\_\_\_\_  
**Signature of Proposed Insured 4** Mo/Day/Yr  
(Parent or Guardian if under 15 years of age)

3. \_\_\_\_\_ Date Signed: \_\_\_\_\_  
**Signature of Proposed Insured 5** Mo/Day/Yr  
(Parent or Guardian if under 15 years of age)

4. \_\_\_\_\_ Date Signed: \_\_\_\_\_  
**Signature of Proposed Insured 6** Mo/Day/Yr  
(Parent or Guardian if under 15 years of age)

5. \_\_\_\_\_ Date Signed: \_\_\_\_\_  
**Signature of Owner(s) if other than** Mo/Day/Yr  
**Proposed Insured(s)**

6. \_\_\_\_\_ Date Signed: \_\_\_\_\_  
**Signature of Owner(s) if other than** Mo/Day/Yr  
**Proposed Insured(s)**

>> \_\_\_\_\_ Date Signed: \_\_\_\_\_  
**Signature of Licensed Insurance Producer** Mo/Day/Yr

>> \_\_\_\_\_  
**Print Name of Licensed Insurance Producer**

SERFF Tracking #:

HARL-128653429

State Tracking #:

Company Tracking #:

HL-15879(12)

State:

Arkansas

Filing Company:

Hartford Life and Annuity Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Application Supplement for Term Insurance

Project Name/Number:

Application Supplement for Term Insurance/HL-15879(12)

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification.pdf			
AR Certification - Rule 19.pdf			

		Item Status:	Status Date:
Satisfied - Item:	FYI - Notice of Insurance Information Practices		
Comments:			
Attachment(s):			
FYI - Notice of Insurance Information Practices.pdf			

		Item Status:	Status Date:
Satisfied - Item:	FYI - Fraud Statement		
Comments:			
Attachment(s):			
FRAUD STATEMENT NOTICE.pdf			

## Readability Certificate

I hereby certify that the forms referenced below have each been scored in their entirety using the Flesch Ease of Reading Test and have attained the score indicated. I further certify that, to the best of my knowledge and belief, said forms comply with state readability requirements and are printed in not less than ten point type, one point leaded.

The readability score was calculated by computer. The software used for this calculation was Microsoft Word.

Form Number  
HL-15879(12)

Flesch Score  
50.1

Hartford Life and Annuity Insurance Company  
NAIC Number 71153-091



Signature of Insurance Company Officer

Lenore Paoli, AVP and Chief Compliance Officer, IL Compliance  
Typed Name and Title

**ARKANSAS  
POLICY FORM CERTIFICATION**

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Form Number(s):  
HL-15879(12)

Form Title(s):  
Term Insurance Rider – Application Supplement

By my signature below, I hereby certify that I have reviewed the enclosed policy form(s) and certify that the form(s) submitted meets the provisions of Rule 19 entitled “Unfair Discrimination in Sale of Insurance” as well as all applicable requirements of the Arkansas Insurance Department.

Signed:



\_\_\_\_\_  
Lenore Paoli, AVP and Chief Compliance Officer, IL Compliance

August 27, 2012  
Date

## HARTFORD LIFE AND ANNUITY INSURANCE COMPANY

Individual Life Operations Address: P.O. Box 64271 – St. Paul, Minnesota 55164-0271



### NOTICE OF INSURANCE INFORMATION PRACTICES

#### INVESTIGATIVE CONSUMER REPORTS

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. Information gathered will not be used to determine sexual orientation. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You also have the right to be interviewed in connection with the preparation of the investigative consumer report and receive a copy of that report upon request.

#### PERSONAL HISTORY INTERVIEW

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

#### MEDICAL INFORMATION BUREAU (MIB, Inc.) PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. Hartford Life and Annuity Insurance Company or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc. (formerly known as the Medical Information Bureau), 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 insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

#### ACCESS, CORRECTION AND DISCLOSURE

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

Hartford Life and Annuity Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request.

If you desire further information or access to your personal information, please send your written request to: Hartford Life and Annuity Insurance Company, 50 Bielenberg Drive, Woodbury, Minnesota 55125.

**INSURANCE PRODUCER: THIS NOTICE MUST BE REMOVED AND LEFT WITH THE PROPOSED INSURED(S)**

## FRAUD STATEMENT NOTICE

### THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THIS FRAUD STATEMENT NOTICE TO YOU WITH YOUR APPLICATION:

#### **ARKANSAS, LOUISIANA, RHODE ISLAND:**

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 mis-leading 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 de-fraud 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:**

**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.

#### **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.

#### **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.

#### **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 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.

#### **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:**

Any person who knowingly, and with intent to injury, 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

#### **TENNESSEE, 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.

#### **WASHINGTON:**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.