Notice of Claim Short Term Disability / Paid Family Leave Benefits

Arch Insurance Company
P.O. Box #26316, Collegeville, PA, 19426
Phone: 877-369-0979 | Fax: 610-977-3216 | Email: archdbl@acitpa.com

Instructions for Filing a Claim

This form is for short term disability / paid family leave benefits. Your claim will be subject to delay or return if these instructions are not followed.

Complete the appropriate sections as they apply to you, and provide to the other designated representatives to complete their sections as indicated below. Submit the completed form to Arch Insurance Company.

Section	Title of Section	To be Completed by	Required For
1	About the Claimant	Employee	All Claims
2	About the Employer	Employer	All Claims
3	Short Term Disability Attending Physician Statement	Physician Treating the Employee	Short Term Disability
4	Bonding Certification	Employee	Bonding with a newly born, adopted or fostered child
5	Release of Information for a Family Member with a Serious Health Condition	Individual Receiving Care	Caring for a family member with a serious health condition
6	Health Care Provider Certification for a Family Member with a Serious Health Condition	Health Care Provider for the Individual Receiving Care	Caring for a family member with a serious health condition
7	Military Qualifying Event	Employee	Assisting when a family member is deployed

Submit the completed form to Arch Insurance Company using the contact information at the top of the page.

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Section 1 - About the Claimant

To be completed by the employee

Part A - Employee Information

Employee's legal name (Last, First, Middle Initial)		Other last names, if any, under which employee has worked
Sex ☐ Male ☐ Female ☐ Non-designated/Other	Date of Birth (mm/dd/yyyy)	Social Security Number or TIN
Home Street Address		
City	State	ZIP / Country (if not USA)
Telephone with Area Code	Email address	

Part B - Leave Request

This claim is for: ☐ Short Term Disability ☐ Paid Family Leave ☐ Short Term Disability and Paid Family Leave (Maternity/Bonding)

If paid family leave is included, what kind?:
☐ Child Bonding
☐ Caring for a Family Member with a Serious Health Condition
☐ Child ☐ Spouse ☐ Domestic Partner ☐ Parent
☐ Parent-in-law ☐ Grandparent ☐ Grandchild
☐ Active Duty Deployment

Will PFL be for a continuous period of time and/or period?

☐ Continuous — PFL State Date _____ PFL End Date _____ ☐ Dates are estimated

☐ Periodic — Identify dates periodic leave will be taken _____ ☐ Dates are estimated

Describe in your own words the reason you are unable to work (if accident, describe the circumstances and advise whether it occurred at work).

If this claim is for Disability Benefits, have you had the same or similar condition in the past? If so, please describe in detail. ☐ Yes ☐ No

If this claim is for Disability Benefits, please list all emergency rooms, hospitals, clinics or physicians that treated you for your illness or injury.

NAME	ADMISSION DATE	DISCHARGE DATE

Please list all benefits you are receiving or eligible to receive under any other sources, such as unemployment benefits, Social Security Disability Benefits, Sick pay or Vacation pay.

TYPE OF BENEFIT	DATE PAYMENT(S) BEGAN	DATE PAYMENT(S) ENDED

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 1 - About the Claimant (continued)

Part C - Employment Information

Employer Name			
Work Location Address			
City	State	ZIP	Country (if not USA)
Email Address		Phone number	
Date of Hire	Average Gross Weekly Wage	# of hours per week	
Job description		What percentage of your job requires physical labor?	
Do you have more than one employer? ☐ Yes ☐ No	If yes, are you taking Disability or PFL from the other employer? ☐ Yes ☐ No	List the states in which you may be liable for filing tax returns	
Are you currently receiving Worker's Compensation Lost Wage Benefits? ☐ Yes ☐ No			

Disclosure statement: Information regarding Disability and PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Part D - Claimant's Certification

I certify that the above information is correct. I was unable to work during the period for which benefits are claims. I further certify that I have not claimed or received benefits or payments form any other source(s) for any period for which I have claimed disability and/or paid family leave benefits. I understand that if the foregoing statement made by me is known to be false, or I willingly failed to disclose material facts, I may be subject to penalties which may include criminal prosecution. You are hereby authorized to obtain medical, employment or insurance information necessary to process this claim.

This is to certify that the facts as indicated above are true to the best of my knowledge and belief.

Signature of Employee	Date Signed

AUTHORIZATION TO RELEASE MEDICAL AND FINANCIAL INFORMATION

I authorize any physician, medical practitioner, hospital, medical or medical related facility, disability management company, insurance company, plan administrator, plan sponsor or employer to furnish to Arch Insurance Company, their respective subsidiaries, affiliates, parents, reinsurers or any person or organization they designate, with information and copies of my records concerning my physical and mental health, including history, findings, diagnosis and treatment for the purpose of investigating and/or adjudicating my claim for disability benefits. I authorize Arch Insurance Company and their respective subsidiaries, affiliates, parents, reinsurers or any person or organization they designate to release information covered by this authorization to any expert, investigator, physician, medical practitioner, hospital, medical related facility, disability management company, insurance company, reinsurer, plan administrator, plan sponsor or employer for the purpose of investigating and/or adjudicating my claim for disability benefits. I authorize any employer to furnish to Arch Insurance Company, their respective subsidiaries, affiliates, parents, reinsurers or any person or organization they designate with information and copies of my records concerning my salary, wages, commission or compensation of whatever type or kind for the purpose of investigating and/or adjudicating my claim for disability and/or paid family benefits. I understand that I may revoke this authorization by written notice to Arch Insurance Company. I understand that I may request a copy of this authorization. I acknowledge that a photocopy of this authorization is as valid as the original.

Signature of Employee	Date Signed

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 2 - About the Employer

To be completed by the employer

Part A - Employer Information

Business's Full Legal Name			Policy Number
Business Address			
City	State	ZIP	Country (if not USA)
Employer's FEIN	Employer's SIC Code	Division	
Employer's contact name for questions relating to Disability and PFL		Contact Phone Number	
Contact Email Address			

Part B - Employee Information

Employee's Occupation

Please check the appropriate boxes:

☐ Exempt ☐ Non Exempt

☐ Full Time ☐ Part Time

☐ Hourly Hrs/Wk:_____

Employees Basic Weekly Earnings	Date of last change in earnings	Date employee was hired
$		

Employee's contributions were made on: ☐ Pre-Tax Basis ☐ Post-Tax Basis

Last date worked	# of hours:
Date returned to work	% of employee contributions to premium

Please list all benefits that the employee is receiving or eligible to receive as a result of his/her disability and/or paid family leave (e.g. salary continuance, sick pay, state disability, worker's compensation, etc.)

BENEFIT	GROSS WEEKLY AMOUNT	DATE BEGAN	PAID THRU DATE

Has employee been laid off? ☐ Yes ☐ No Has employee been terminated? ☐ Yes ☐ No	If Yes, date	Reason

What type of plan does employee participate in? (Check all that apply)

☐ A short term disability plan an employee voluntarily contributes towards.

☐ A short term disability and/or paid family leave plan that covers all employees.

Employee's Normal Work Schedule

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ____Hours/Day _____Hours/Week

If employee received or will receive full wages while on Disability and PFL, will employer be requesting reimbursement? ☐ Yes ☐ No	If Yes, please indicate the dates employee is paid:	Starting From	Going To

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 2 - About the Employer (Continued)

Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage.

Week Number	Week Ending Date (mm/dd/yyyy)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			

In the preceding 52 weeks, has the employee taken leave for: ☐ Disability ☐ PFL ☐ Both Disability and PFL ☐ None

Enter the total number of weeks and days for both Disability and PFL in the last 52 weeks.

Disability	Number of Weeks	Number of Days	Specific dates for disability
PFL	Number of Weeks	Number of Days	Specific dates for PFL

Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? ☐ Yes ☐ No

Part C - Declaration and Signature

This is to certify that the facts as indicated above are true to the best of my knowledge.

Signature of Authorized Representative	Date Signed
Printed Name	Title

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 3 - Short Term Disability Attending Physician Statement

To be completed by the employee's physician

Part A - About the Disability

Employee's name (first name, middle initial, last name)

Diagnosis Code and current conditions

Is condition due to pregnancy? ☐ Yes ☐ No

If yes, please provide the following information if applicable: Estimated date of delivery | Estimated date of confinement

Date of Delivery | Type of Delivery | Complications

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

Date symptoms first appeared or accident happened

Date patient first consulted you for this condition

Has patient ever had same or similar condition? ☐ Yes ☐ No

Is patient still under your care for this condition? ☐ Yes ☐ No

If yes, when? Please describe.

Dates of service, include date of next appointment (if previous form submitted to this carrier, you need show only dates since last report).

Has patient been hospital confined? ☐ Yes ☐ No If Yes, confined from: _____ to _____

Hospital name and address

Nature and CPT code of surgical procedure, if any

Surgery was ☐ Inpatient ☐ Outpatient

Date of surgery

Dates patient was continuously totally disabled (unable to work)

From: _____ to _____

If still disabled, date patient should be able to return to work

Part B - Certification and Signature

Physician's Signature | Date Signed

Physician's Name (printed) | Physician Phone Number

Degree | Social Security Number | Tax Identification Number

Physician's Address

City | State | ZIP | Country (if not USA)

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 4 - Bonding Certification

To be completed by the employee

Part A - About the Child

Child's date of birth (mm/dd/yyyy)

Child's sex:
☐ Male ☐ Female ☐ Non-designated/Other

Does child live with the employee requesting PFL?
☐ Yes ☐ No

Child is employee's:
☐ Biological Child ☐ Stepchild ☐ Foster Child
☐ Adopted Child ☐ Legal Ward ☐ Loco parentis
☐ Spouse/Domestic Partner's Child

Select one of the following and attach the document as required as evidence of the relationship:

Parent of newborn child:

Birth Mother:
- ☐ Health care provider certification of pregnancy (include expected due date AND mother's name); OR
- ☐ Health care provider certification of birth (include date of birth AND mother's name); OR
- ☐ Child's birth certificate

Other Parent:
- ☐ **Copy of birth certificate naming second parent; OR**
- ☐ Voluntary acknowledgement of paternity; OR
- ☐ Court order of filiation; OR
- ☐ Birth mother documents (see above) PLUS one of the following:
  - ☐ Marriage certificate; OR
  - ☐ Certificate of civil union; OR
  - ☐ Evidence of domestic partnership
- ☐ OR; Other documentation of parental relationship

Foster Parent:
- ☐ Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive Parent:
- ☐ Court document finalizing adoption
- ☐ Documentation in furtherance of adoption

Date of foster care or adoption placement, if applicable (mm/dd/yyyy)

Part B - Declaration and Signature

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 state value of the claim for each such violation.

I am hereby making a request for paid family leave benefits. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's Signature	Date Signed

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 5 - Release of Information for a Family Member with a Serious Health Condition

To be completed by the individual receiving care

Part A - Authorization

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipients' health care provider.)

I, _____, authorize my health care provider listed on this form to release my personal health information
Care recipient's (patient's) name (First, MI, Last)

to _____ and their employer's PFL insurance carrier, Arch Insurance.
Employee's name

Records subject to release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Part B - Health Care Provider Information

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

Health care provider's name			
Health care provider's mailing address			
City	State	ZIP	Country (if not USA)
Health care provider's telephone number (with area or country code)			

Part C - Care Recipient Information

Care recipient's mailing address			
City	State	ZIP	Country (if not USA)
Care recipient's email address			
Care recipient's Telephone	Care recipient's social security number		

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 5 - Release of Information for a Family Member with a Serious Health Condition (Continued)

Part D - Read and Sign Below

I hereby request that the health care provider listed give a completed Health Care Provider Certification For Care of Family member With Serious Health Condition to the employee identified. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

Care Recipient's Signature	**Date Signed**

Authorized Representative

I, _____, represent the care recipient in this matter as authorized by:
Care recipient's (patient's) name

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized Representative's Signature	Date Signed

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 6 - Health Care Provider Certification for Care of Family Member With Serious Health Condition

To be completed by the health care provider for the care recipient (patient) and returned to the employee identified above

Part A - Diagnosis and Treatment

Care recipient's name (first name, middle initial, last name)

Does patient require care by the employee requesting PFL? ☐ Yes ☐ No (if no, skip to "Health Care Provider Information")

Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a charge in care, assistance with essential daily living matters, and personal attendant services.

Primary ICD-10 Code	Date patient's condition commenced (mm/dd/yyyy)
Diagnosis:	First date care for patient is needed (mm/dd/yyyy)
Estimated number of days per week OR days per month patient requires care Days/Week: _____ Days/Month: _____	Expected date patient will no longer require care (mm/dd/yyyy)

Health care provider name

Health care provider mailing address

City	State	ZIP	Country (if not USA)

Phone Number with Area code	Fax Number with area code	Email Address

State or country (if not USA) in which health care provider is licensed to practice:

Specialty

Health care provider's license number

Type of health care provider:

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathy (DO)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Doctor of Chiropractic Medicine (DC)
- ☐ Dentist (DDS/DDM)
- ☐ Physician's Assistance (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker (LMSW/LCSW)
- ☐ Other (specify) _____

Part B - Certification and Signature

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.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's Signature	Date Signed

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 7 - Military Qualifying Event

To be completed by employee

Part A - About the Military Event

Employee's name (first name, middle initial, last name)

Name of military member on covered active duty or impending call to covered active duty status (international deployment) (first name, middle initial, last name)

Military Member's Date of Birth (mm/dd/yyyy)	Military Member's Gender
	☐ Male ☐ Female ☐ Non-designated/Other

Military member's mailing address

City	State	ZIP	Country (if not USA)

Military Member's relationship to employee:
☐ Spouse ☐ Domestic Partner ☐ Child ☐ Parent

Period of military member's covered active duty (mm/dd/yyyy)
From To

Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status:
☐ Covered active duty orders ☐ Letter of impending call or order to covered duty
☐ Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

What is the reason employee is requesting PFL? (One or more may be selected)

☐ Arranging for child care
☐ Arranging for parental care
☐ Counseling
☐ Making financial arrangements
☐ Making legal arrangements
☐ Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
☐ Attending any event sponsored by the military or military service organizations
☐ Other _____

Is written documentation supporting this request for leave is available and attached?
☐ Yes ☐ No ☐ None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or e-mail address of the individual or entity.

Part B - Declaration and Signature

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I am hereby making a request for paid family leave benefits. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's Signature	Date Signed

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

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Section 7- Military Qualifying Event (continued)

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e. either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

Part C - Please submit this documentation for each required meeting/event.

Name of individual with whom employee is meeting			
Title			
Organization			
Telephone Number (provide area or country code)	Fax Number (provide area or country code)		
Email address			
Mailing Address			
City	State	ZIP	Country (if not USA)
Describe nature of meeting, include dates, if known:			

Employee Last Name	Employee First Name	Date of Birth (mm/dd/yyyy)

State Notices

The laws of some states require us to furnish you with the following notices:

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland	Any person who knowingly 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	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire	Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
New Jersey	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
New York	Auto claims: Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation. All others: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
Pennsylvania	Motor vehicles: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000. All others: 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.
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.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Texas	Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Utah	Workers' Compensation Claims Only: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.
Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
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.

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