UnitedHealthcare

Claim Forms and Instructions for GROUP CRITICAL ILLNESS

EMPLOYER

EMPLOYER – *Form Completion Information*:

NOTICE OF CLAIM – Instructions

1. COMPLETE

- Employer's Report of Claim *(Page 2)*

2. INCLUDE:

- Copy of enrollment card (if employee contributes to premium)
- Copy of approved medical evidence of insurability if required at time of enrollment
- Documentation of earnings (if benefit is based on earnings)

3. TRANSMIT completed forms and attachments to:

UNITEDHEALTHCARE SPECIALTY BENEFITS
PO Box 7466
Portland, ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

4. PROVIDE employee with the accompanying Instructions and Claim Forms *(Pages 3 – 6)*

- Instructions *(page 3)*
- Employee's Critical Illness Statement *(pages 4 – 5)*
- Disclosure Authorization (page 6)
- Authorization of Personal Representative (page 7)
- Attending Physician's Statement (page 8-9) If there is more than one treating physician, an additional claim form should be provided for each.

ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING EMPLOYEE'S REQUEST FOR BENEFITS

1. Employee's Name:	2. Social Security Number:	3. Date of Birth:

4. Address:	City:	State:	Zip Code:

5. Location/Division:	6. Insurance Class:	7. Employee Date of Hire:	8. Effective Date of Coverage:

9. Employee Contribution to premium: ☐ Yes* ☐ No *If EE paid please provide enrollment card	10. If Yes: ☐ Pre-tax ☐ Post-tax	11. If Post-tax*: _____ % paid by employer _____ % paid by employee *If this section is blank, we will assume it is 100% employer contributions and calculate FICA taxes accordingly. Please refer to IRS Publication 15A.

12. Employee's Occupation:	13. Employee's Work Status: ☐ Full-Time ☐ Part-Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal ☐ Temporary

14. Regular scheduled hours per week:	15. Check off Regular work days: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

16. Salary prior to date last worked $ _____ **OR** Flat Benefit Amount $ _____	17. Salary Period (check one): ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

Employer's Name (name of policyholder, if other)	Policy No

Address	City	State	Zip Code

Telephone Number (include area code)	Fax Number (include area code)	Employer (Taxpayer) I.D. No. (EIN) or Public Employer SS No. 69

Name of person completing this form (please type or print)	Title

Signature	Date

Please provide this completed claim form to the Insured Employee or submit to:

UNITEDHEALTHCARE SPECIALTY BENEFITS
PO Box 7466
Portland, ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

Have you provided employee with Instruction and Claims Forms?

- ☐ **Instructions** *(page 3)*
- ☐ **Employee's Critical Illness Statement** *(pages 4 – 5)*
- ☐ **Disclosure Authorization** *(page 6)*
- ☐ **Authorization of Personal Representative** *(page 7)*
- ☐ **Attending Physician's Statement** *(pages 8-9)*

Claim Forms and Instructions
for
GROUP CRITICAL ILLNESS

EMPLOYEE

EMPLOYEE – *Form Completion Information*:

APPLICATION for Group Critical Illness Benefit - Instructions

1. **COMPLETE** Employee's Critical Illness Statement *(Pages 4 & 5)* in FULL.

   ATTACH copies of any supporting medical records you have, in accordance with the policy language*.
   ***PLEASE refer to your certificate of coverage for the definition that applies to each critical illness and ask your physician(s) to provide information in support of that definition. If we do not receive the necessary information with the initial claim, we will request it from your physician(s).**

2. **COMPLETE** Disclosure Authorization *(Page 6)*. This will allow us to secure additional information, if necessary, to make a decision on your claim for benefits. Make a copy to provide to your treating physician(s).

3. **COMPLETE** Authorization of Personal Representative (page 7). This form is optional and **not** required to file a claim. If you would like us to discuss your claim with anyone, we require your authorization prior to us releasing any personally identifiable health information.

4. **TRANSMIT** completed forms and attachments to:

   UNITEDHEALTHCARE SPECIALTY BENEFITS
   PO Box 7466
   Portland, ME 04112-7466
   Tel 888 299 2070 Fax 888 505 8550

5. **PROVIDE** the Attending Physician's Statement (Pages 8-9) to the physician (s) treating you. If you have more than one physician, you may make copies or obtain additional Attending Physician's Statements from your employer.
6. **PROVIDE** a copy of your completed Disclosure Authorization to your physician(s).

7. **INSTRUCT** your physician(s) to respond to any requests for information from us by sending requested records to:
   UNITEDHEALTHCARE SPECIALTY BENEFITS
   PO Box 7466
   Portland, ME 04112-7466
   Tel 888 299 2070 Fax 888 505 8550

ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING YOUR REQUEST FOR BENEFITS

EMPLOYEE'S CRITICAL ILLNESS STATEMENT

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name (include division if applicable):	2. Employer's Phone Number (include area code)

INFORMATION ABOUT THE COVERED EMPLOYEE:

3. Full Name (First, Last, Middle Initial):	4. Social Security Number:	5. Date of Birth:

6. Address:	City:	State:	Zip Code:

7. Your Occupation:

8. Is claim for Insured Employee or Dependent? (Please check one) ☐ Insured Employee ☐ Spouse ☐ Child

INFORMATION ABOUT THE CLAIMANT (covered employee or dependent):

9. Claimant's Name (if other than insured employee):	10. Social Security Number:

11. Address (if different than insured employee):	City:	State:	Zip Code:

12. Date of Birth:	13. Height:	14. Weight:	15. Sex:: ☐ M ☐ F	16. Date first noticed symptoms of illness/injury:

17. Describe in detail, the nature of and the onset of illness or injury:

18. Date first treated for illness or injury?	19. Date you were diagnosed with this illness?	20. Have you ever had the same or a similar condition in the past? ☐ Yes, When? _____ ☐ No

21. Provide the names, addresses and date you first saw the doctor(s) who are treating you now and/or have treated you for a similar condition in the past. If more space is needed, please attach additional paper.

Physician Name	Phone No.: Fax No.:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No
Physician Name	Phone No.: Fax No.:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No
Physician Name	Phone No.: Fax No.:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No
Physician Name	Phone No.: Fax No.:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No

(Continued on next page)

22. Were you admitted to the hospital as part of your treatment? ☐ Yes* ☐ No *If you answered Yes, please provide the hospital name, address and phone number below.			
Hospital Name:		Date of Admission:	Date of Discharge:
Address	City	State	Zip Code
Phone No.:	Fax No:	Date of Admission:	Date of Discharge:

The above statements are true and complete to the best of my knowledge and belief.

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Date: _____/_____/_____

Signature: _____

Printed Name: _____

Address: _____

Phone (_____) _____ - _____

Participant's Name (Please Print):_____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

Relationship, if other than Claimant: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

At my request, and for my convenience, I, _____ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my critical illness claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

Date: ____/____/_____

Signature: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PHYSICIAN

PO Box 7466, Portland, ME 04112-7466
Tel: 888.299.2070 Fax 888.505.8550

INSTRUCTIONS: FOR EACH CONDITION BELOW FOR WHICH YOU ARE TREATING THIS PATIENT, PLEASE COMPLETE THE APPROPRIATE SECTION AND ENCLOSE THE INFORMATION REQUESTED IN THAT SECTION. ATTACH ADDITIONAL SHEETS IF NECESSARY.

PATIENT INFORMATION

PATIENT'S NAME	DATE OF BIRTH	CLAIMANT'S DATE OF DEATH (IF APPLICABLE)

HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR A SIMILAR CONDITION? ☐ YES, WHEN_____ ☐ NO

IF YES, PLEASE PROVIDE PHYSICIAN'S NAME AND CONTACT INFORMATION: _____

WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	DIAGNOSIS ICD-9 CODE (INCLUDING COMPLICATIONS)	DIAGNOSIS DESCRIPTION (INCLUDING COMPLICATIONS)

CANCER/CARCINOMA IN SITU

DATE OF DIAGNOSIS _____

(DATE THE PATHOLOGICAL SPECIMIN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED)

WAS THE CANCER/CARCINOMA IN SITU?

☐ PATHOLOGICALLY DIAGNOSED, OR ☐ CLINICALLY DIAGNOSED

IF THE CANCER/CARCINOMA WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

MYOCARDIAL INFARCTION (HEART ATTACK)

DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

1. ARE ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ☐ YES ☐ NO
   ATTACH A COPY OF THE EKG'S AND REPORTS.
2. WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHYSPHOKINASE (CPK)? ☐ YES ☐ NO
   A CPK-MB MEASUREMENT MUST BE USED, ATTACH A COPY OF THE LAB REPORT.
3. DID THE DIAGNOSIS STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ☐ YES ☐ NO
   ATTACH COPIES OF ANY APPLICABLE REPORTS.
4. DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION? ☐ YES ☐ NO

DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION) _____

CORONARY ARTERY BYPASS SURGERY

WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS AND SYMPTOMS OF THIS CONDITION? _____

DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES USING VEINOUS OR ARTERIAL GRAFTS? ☐ YES ☐ NO

IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.

MAJOR ORGAN TRANSPLANT

DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, LUNGS, KIDNEY OR PANCREAS? ☐ YES ☐ NO
IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.

IF THE PATIENT IS/WAS TOO ILL FOR A TRANSPLANT, DID THEY MEET THE CRITERIA FOR PLACEMENT ON THE UNOS LIST? ☐ YES ☐ NO

STROKE

DID THE PATIENT HAVE A STROKE, MEANING A CEREBROVASCULAR EVENT RESULTING IN MEASURABLE PERMANENT NEUROLOGICAL DAMAGE OR IMPAIRMENT, INCLUDING INFARCTION OF BRAIN TISSUE, HEMORRAGE AND EMBOLISM FROM AN EXTRA CRANIAL SOURCE? ☐ YES ☐ NO
STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTERBROBASILAR ISCHEMIA.

DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? ☐ YES ☐ NO
PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN) REPORT, MAGNETIC RESONANCE ANGIOGRAPHY REPORT, MAGNETIC RESONANCE IMAGING (MRI) REPORT, POSITRON EMISSION TOMOGRAPHY REPORT OR AN ARTERIOGRAPHY/ANGIOGRAPHY.

RUPTURED ANEURYSM

DATE OF ANEURYSM:_____

PLEASE PROVIDE ALL MEDICAL RECORDS TO SUPPORT DIAGNOSIS INCLUDING RADIOGRAPHICALLY SPECIFIC DIAGNOSTIC STUDIES THAT SUPPORT THE DIAGNOSIS AS ESTABLISHED BY THE AMERICAN ACADEMY OF RADIOLOGISTS.

PERMANENT PARALYSIS

DID THE PATIENT SUFFER TOTAL AND PERMANENT LOSS OF THE USE OF TWO OR MORE LIMBS (ARMS OR LEGS OR A COMBINATION) DUE TO INJURY OR SICKNESS FOR A CONTINUOUS PERIOD OF AT LEAST 30, DAYS AND NOT THE RESULT OF A STROKE? ☐ YES ☐ NO

CRITICAL ILLNESS CLAIM FORM
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CHRONIC RENAL FAILURE

DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS? ☐ YES ☐ NO

DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION? ☐ YES ☐ NO

DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS)	WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

COMA

DATE OF COMA:_____ DURATION OF COMA: _____ IS THE COMA THE RESULT OF A STROKE? ☐ YES ☐ NO

DID THE PATIENT'S GLASGOW COMA SCALE SCORE REMAIN AT 8 OR BELOW THROUGHOUT THE 30 DAY PERIOD? ☐ YES ☐ NO

PLEASE PROVIDE A COPY OF THE ELECTROENCEPHALOGRAM (EEC)

SEVERE BRAIN DAMAGE

HAS THE PATIENT HAD PERMANENT LOSS OF COGNITIVE ABILITY FOR A CONTINUOUS PERIOD OF AT LEAST 90 DAYS? ☐ YES ☐ NO DATE RANGE:_____

IS THE PATIENT UNABLE TO SAFELY AND COMPLETELY PERFORM THREE OR MORE OF THE FOLLOWING ACTIVITES OF DAILY LIVING WITHOUT ANOTHER PERSON'S ACTIVE ASSISTANCE OR VERBAL CUEING? CHECK ALL THAT APPLY:

- ☐ BATHING: THE ABILITY TO WASH ONESELF BY SPONGE BATH; OR IN EITHER A TUB OR SHOWER, INCLUDING THE TASK OF GETTING IN AND OUT OF THE TUB OR SHOWER
- ☐ DRESSING: THE ABILITY TO PUT ON AND TAKE OFF ALL ITEMS OF CLOTHING AND NECESSARY BRACES, FASTENERS, OR ARTIFICAL LIMBS
- ☐ TOILETING: THE ABILITY TO GET TO AND FROM THE TOILET, GET ON AND OFF THE TOILET AND PERFORM ASSOCIATED PERSONAL HYGENE
- ☐ TRANSFERRING: THE ABILITY TO MOVE INTO OUR OUT OF A BED, CHAIR OR WHEELCHAIR
- ☐ CONTINENCE: THE ABILITY TO MAINTAIN CONTROL OF BOWEL AND BLADDER FUNCTIONS; OR, WHEN UNABLE TO MAINTAIN CONTROL OF BOWEL AND BLADDER FUNCTIONS, THE ABILITY TO PERFORM ASSOCIATED PERSONAL HYGIENE INCLUDING CARING FOR A CATHETER OR COLOSTOMY BAG
- ☐ EATING: THE ABILITY TO FEED ONESELF BY GETTING FOOD INTO THE BODY FROM A RECEPTACLE (SUCH AS A PLATE, CUP, OR TABLE) OR BY A FEEDING TUBE OR INTRAVENOUSLY

WAS THE DIAGNOSIS BASED ON OBJECTIVE LABORATORY AND CLINICAL FINDINGS, INCLUDING A SCORE OF 7 OR BELOW ON THE RANCHO LOS AMIGOS SCALE THROUGOUT THE 90 DAYS? PLEASE PROVIDE THE OBJECTIVE DATA TO SUPPORT A YES ANSWER. ☐ YES ☐ NO

SEVERE BURNS

WAS THE PATIENT DIAGNOSED WITH THIRD DEGREE BURNS COVERING AT LEAST 20% OF THE SURFACE AREA OF THE BODY? ☐ YES ☐ NO

HIV OCCUPATIONAL INJURY

DATE OF INJURY:_____ DATE OF INITIAL HIV ANTIBODY TEST:_____ RESULTS_____

PLEASE PROVIDE A COPY OF EACH TEST RESULT DATE OF FOLLOW-UP HIV ANTIBODY TEST:_____ RESULTS_____
(90-180 DAYS AFTER INJURY)

ATTENDING PHYSICIAN'S SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE DESCRIBED INFORMATION IS BASED UPON REASONABLE MEDICAL PROBABILITY AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

NAME (ATTENDING PHYSICIAN) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
SIGNATURE	DATE	MEDICAL ID#	

FRAUD WARNING NOTICES: (Please review notice that applies in your state

For claimants in 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.

For claimants in 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.

For claimants in 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.

For claimants in California:

UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

For claimants in 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.

For claimants in Connecticut:

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in 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.

For claimants in 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

For claimants in Hawaii:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For claimants in 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.

For claimants in 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.

For claimants in Kansas:

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 may be guilty of fraud as determined by a court of law.

For claimants in 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.

For claimants in 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.

For claimants in Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

For claimants in Minnesota:

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

For claimants in 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.

For claimants in New Jersey:

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

For claimants in 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 penalties.

For claimants in 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.

For claimants in Oklahoma:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For claimants in Oregon:

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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in Tennessee and 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.

For claimants in 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.

For claimants in Vermont:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:

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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:

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.