

# How to submit a **long-term care claim**

We realize having to submit an insurance claim can be an inconvenience, especially during what may be a stressful time for you and your family. We're here to help walk you through the claim process, and answer any questions you may have along the way.

## **STEP 1: COMPLETE AND SUBMIT CLAIM FORM**

Once your care has started, you will need to complete your claim form. Be prepared to list all your providers you want to file for. **Upload, fax or mail in your completed claim form along with any other claim documents you may have.** Reference the contact information below when submitting your claim.

## **STEP 2: RECEIPT OF CLAIM**

*Within one to two weeks\**

Once we receive your claim documents, we will begin the claim review process. *You will be sent a letter of acknowledgement.*

## **STEP 3: CLAIM ASSIGNED**

*Within two to three weeks\**

Your claim will be assigned to a claims associate who will begin to gather additional information for review, if needed.

## **STEP 4: ADDITIONAL INFORMATION**

*Over the next three weeks\**

We will continue to reach out to you and your providers over the next three weeks to gather any missing information, if needed. *All request letters that are sent to your providers will also be sent to your home for reference. For claim document examples, reference page two in the Long-Term Care and Short-Term Care Packet.*

## **STEP 5: REVIEW CLAIM**

Once all requested information is received, your claims associate will review the documents and make a decision on your claim.

## **STEP 6: CLAIM DETERMINATION**

*Within six weeks\**

*You will receive an explanation of benefits document explaining your benefit eligibility.* If you are eligible for benefits, any due payment will be sent via check in the mail.

*Please send in ongoing bills for processing.*



### **Contact Information**

Bankers Life and Casualty Company  
Policy Benefits Department  
P.O. Box 1902  
Carmel, IN 46082-1902  
Phone: (800) 621-3724  
Fax: (312) 396-5952  
BankersLife.com/Service-Support

\*Time frames provided are estimates only, are dependent upon obtaining necessary claim documentation in a timely manner, and may vary based on State regulations.

Bankers Life is the marketing brand of Bankers Life and Casualty Company, Medicare Supplement insurance policies sold by Colonial Penn Life Insurance Company and select policies sold in New York by Bankers Consec Life Insurance Company (BCLIC). BCLIC is authorized to sell insurance in New York.

**BankersLife.com**

---

## **FILING A LONG-TERM CARE/SHORT-TERM CARE (LTC/STC) INSURANCE CLAIM WITH BANKERS LIFE AND CASUALTY COMPANY**

To provide clarity in filing a claim, this claim information packet is designed to provide you with straightforward instructions on how to file a claim under your Long-Term Care/Short-Term Care policy.

### **CLAIM FILING INSTRUCTIONS**

Follow the four steps outlined below to file your claim.

#### **Step 1: Contact our Intake Team at 1 (800) 621-3724**

Working with an Intake Specialist will provide our claims team with valuable information to personalize your claim experience. Intake Specialist work with you one-on-one to answer your questions, walk you through your policy benefits, and assist you with the claim filing process.

The Intake Team is available between the hours of 8:00 AM – 4:30 PM Central Time, Monday through Friday. Intake Specialists can help answer questions such as:

- What types of services and expenses does my policy cover?
- Can you help me find qualified providers in my area?
- How would I qualify for benefits under my policy?
- What information/documents do I need to submit to receive reimbursement?
- How quickly can I expect a decision on my claim?
- What is an Elimination Period? Deductible? Waiver of Premium?

#### **Step 2: Fill out claim form**

The claim form begins your claims process. It is your opportunity to provide our claims team the necessary information to move your claim forward. Keep the following items in mind:

- Please note that care must begin before a claim can be submitted.
- Answer the questions as completely as possible. The more complete the information provided to us, the more efficiently we can process your claim. Feel free to attach additional pages if you need more room to respond.

#### **Step 3: Provide authorization forms**

These completed and signed forms will allow our claims team to request information on your behalf and provide updates to your authorized parties.

- The Claims Authorization for Medical Information form allows us to request information from your healthcare providers.
- The Voluntary Authorization to Disclose information to Third Party form allows us to provide information to your designated parties.
- Include a complete copy of your Power of Attorney document, if applicable.

#### **Step 4: Submit documentation**

You have three options for submitting claims documentation:

<b>Submit Electronically</b>	<b>Submit by Fax</b>	<b>Submit by Mail</b>
<a href="https://www.bankerslife.com/service-support/document-upload/">https://www.bankerslife.com/service-support/document-upload/</a>	(312) 396-5952	Bankers Life and Casualty Company PO Box 1902 Carmel, IN 46082-1902

**Step 5: What to expect after submitting your claim**

Below is a list of items we will request directly from your care provider. If there are questions regarding your claims submission, or if additional information is required, you and/or your provider will be contacted within three weeks.

**Nursing Home**

- Minimum Data Set (MDS):** A standardized assessment completed by Nursing Home staff.
- Facility's Service Plan:** A written plan of services to be provided.
- Itemized Bill(s):** Please include the Medicare, Medicare Replacement or any Government Insurance explanation of benefits when applicable. Please submit the attached Proof of Residence form along with all bills.
- Facility License:** A document showing that the Facility is licensed or certified.

**Assisted Living Facility**

- Facility's Service Plan:** A written plan of services to be provided.
- Medication Administration Record (MAR):** A daily record of medications administered.
- Itemized Bill(s):** Please include any Government Insurance explanation of benefits when applicable. Please submit the attached Proof of Residence form along with all bills.
- Facility License:** A document showing that the Facility is licensed or certified.

**Home Health Care Provider**

- Plan of Care:** A written plan of services to be provided.
- Initial Patient Assessment:** A written summary of medical conditions and history.
- Daily Visit Notes:** Daily documentation of care provided.
- Itemized Bill(s):** Please include the Medicare, Medicare Replacement or any Government Insurance explanation of benefits when applicable.
- Agency License:** A document showing that the Agency is licensed or certified.

*\*Please use Independent Caregiver Packet for private/non-agency caregivers. This can be found on our website at Bankerslife.com or by calling our Customer Service Department at 1(800) 621-3724*

**Adult Day Care Provider**

- Plan of Care:** A written plan of services to be provided.
- Itemized Bill(s):** Please include any Government Insurance explanation of benefits when applicable.
- Facility License:** A document showing that the Facility is licensed or certified.

*Note: If the claim involves care due to a Cognitive Impairment (ie Dementia, Alzheimer's, Memory Loss), we may request cognitive testing, \*including but not limited to Mini Mental State Exam (MMSE), and relevant medical records along with the information listed above.*

**Step 6: Create your profile on My.BankersLife.com (Optional)**

Your profile is a great way to manage your payments, request documents, view recent claims, and much more!

**Questions**

If you have additional questions, please contact our Customer Service department Monday through Friday between 8:00 AM – 6:00 PM Central Time at 1(800) 621-3724, or visit our website at [www.bankerslife.com](http://www.bankerslife.com).

**1. CLAIMANT'S INFORMATION**

List ALL long-term care/short-term care policy numbers under which you want to file a claim:

Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claimant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Contact Number: \_\_\_\_\_ Secondary Contact Number: \_\_\_\_\_

*Disclaimer: If you wish to make a change to your address on file, you must fill out Section 2 below: "Address Change Request."*

**2. ADDRESS CHANGE REQUEST - Please complete only if you would like to change your mailing address.**

Check this box if you would like to change your address of record and send all future correspondence related to this policy which includes Explanations of Benefits, renewal notices, etc. to:

Street (and Apt. #) or P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**3. ALTERNATE CONTACT PERSON**

Contact Person's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you want this person to be the primary contact for your claim?  Yes  No

If yes, please complete and include a "Voluntary Authorization to Disclose Information to Third Party" form, so we can share information about your claim with this individual.

Is this person a:  Power of Attorney  Conservator  Guardian  Other legal representative?

If so, please submit the documentation.

**4. CLAIM INFORMATION**

Reason for care: \_\_\_\_\_

Primary diagnosis(es) (for this claim): \_\_\_\_\_

Were you in the hospital within 30 days prior to receiving long-term care services?  Yes  No

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Hospital Name: \_\_\_\_\_ Hospital Phone Number: \_\_\_\_\_

What type of services are you requesting benefits for at this time? *Note: Care must have already started.*

- Home Health Care       Adult Day Care       Hospice       Respite       Nursing Home
- Assisted Living Facility       Other: \_\_\_\_\_

Name of Facility/Agency: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_ Is care on-going:  Yes  No

Date(s) you are filing from, if different than admit date: \_\_\_\_\_

What type of services are you requesting benefits for at this time? *Note: Care must have already started.*

- Home Health Care       Adult Day Care       Hospice       Respite       Nursing Home
- Assisted Living Facility       Other: \_\_\_\_\_

Name of Facility/Agency: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_ Is care on-going:  Yes  No

Date(s) you are filing from, if different than admit date: \_\_\_\_\_

**5. PHYSICIAN INFORMATION (Please include neurologist, gerontologist, etc. if applicable)**

Name of Primary Care Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Condition(s) treated: \_\_\_\_\_

Date of first visit: \_\_\_\_\_ Date of most recent visit: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Condition(s) treated: \_\_\_\_\_

Date of first visit: \_\_\_\_\_ Date of most recent visit: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Condition(s) treated: \_\_\_\_\_

Date of first visit: \_\_\_\_\_ Date of most recent visit: \_\_\_\_\_

**6. GOVERNMENT INSURANCE INFORMATION**

Do you currently have medical care under:

<b>Medicare</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Tricare</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Veteran Affairs</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicaid</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Is Medicare providing payment for any of the services you are filing for? <input type="checkbox"/> Yes <input type="checkbox"/> No  Do you have: <input type="checkbox"/> Part A only <input type="checkbox"/> Part B only <input type="checkbox"/> Parts A & B <input type="checkbox"/> Part C (Advantage)	Is Tricare providing payment for any of the services you are filing for? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Veterans Affairs providing payment for any of the services you are filing for? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Medicaid providing payment for any of the services you are filing for? <input type="checkbox"/> Yes <input type="checkbox"/> No

*\*Please submit any applicable Explanation of Benefits for any of the above.*

For your protection some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. If we determine that benefits have been paid under this coverage as a result of your fraudulent action(s), we have the right to recover those benefit amounts. We may recover those benefit amounts directly from you or by reducing any subsequent benefit payments under this coverage. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

I declare that all of the above answers are complete and true to the best of my knowledge and belief. I understand that the company reserves the right to require further proof.

\_\_\_\_\_  
Signature of Policyholder (or Legal Representative)

\_\_\_\_\_  
Date signed (Month/Day/Year)

\_\_\_\_\_  
Policyholder (or Legal Representative) Name (Please Print)

\_\_\_\_\_  
Signed at (City, County, State)

If Legal Representative, give relationship to Policyholder: \_\_\_\_\_

**CLAIMS AUTHORIZATION FOR MEDICAL INFORMATION  
CONFORMS TO HIPAA PRIVACY RULE**

**1. My Information – the individual who is the subject of the information**

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Soc. Sec. Number (Last 4 Digits): \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**2. Disclosing Party – the party or parties authorized to release information about me**

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration or governmental agency

**3. Description of my information authorized for release**

Any/all information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse

**4. Purpose of Authorization – how my information will be used**

To administer benefits under a policy or certificate of insurance

**5. Duration of Authorization**

Twenty-four (24) months from the date written below, unless I specify an earlier date here: \_\_\_\_\_

**6. Receiving Parties – the parties authorized to receive information about me**

- Bankers Life and Casualty Company, its agents, representatives and reinsurers
- Bankers Consec Life Insurance Company\*, its agents, representatives and reinsurers

\*domiciled and licensed in the State of New York

**7. Important information – review carefully before signing**

Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage. This Authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: LTC Claims Administration P.O. Box 1902, Carmel, IN 46082-1902. The Receiving Parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected. I understand that I have a right to a copy of this Authorization, and that a photocopy or facsimile is as valid as the original. California residents are entitled to a large print version of this form by calling 800-621-3724 to request form 18727-LARGE.

**8. Approval – must be signed and dated by me or my Legal Representative\* to be valid**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to the Insured

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed



**VOLUNTARY AUTHORIZATION TO DISCLOSE INFORMATION TO THIRD PARTY  
PURSUANT TO THE HIPAA PRIVACY RULE - FOR USE IN CONJUNCTION WITH LONG TERM CARE POLICIES ONLY**

**I. My Information – The individual whose information will be released**

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

**II. Disclosing Party – Organization authorized to release my information**

Bankers Life and Casualty Company\*, Bankers Consec Life Insurance Company\*\*, Washington National Insurance Company\*

\*not licensed in the State of New York

\*\*domiciled in and licensed in the State of New York

**III. Description of my information authorized for release**

- All information pertaining to my insurance transactions, claims and coverage including health and financial information
- Only information pertaining to: \_\_\_\_\_

**IV. Purpose of release – Describing how my information will be used by the Receiving Party after it is released**

At the request of the individual identified above.

**V. Duration of authorization**

This authorization will expire 12 months from the date written below, unless I specify an alternate expiration date here: \_\_\_\_\_

**VI. Receiving Party – Individual(s) or organization(s) authorized by me to receive my information**

Name: \_\_\_\_\_ Company Name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Company Name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**VII. Approval – Signed and dated by me or my legal representative**

- I understand that this authorization to release information to a third party is optional and I am not required under the terms of my policy to give such authorization.
- I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by sending a written revocation to the address below.
- I understand that my treatment, payment and eligibility for benefits may not be conditioned on this authorization.
- I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, it could be re-disclosed and no longer protected by federal health information privacy laws.
- I understand that I or my legal representative are entitled to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

\*Legal Representatives must provide documentation of legal authority

**PROOF OF RESIDENCE FORM**

**Instructions**

- The Proof of Residence (POR) form is a required part of the monthly claim submission and must be completed in its entirety by **facility staff**.
- Ensure copies of BLANK POR forms are maintained by the facility. Additional forms can be found at [www.BankersLife.com/Service-Support/](http://www.BankersLife.com/Service-Support/).
- Complete a form each month, on or after the last day of the month, after the services have been provided and submit with the corresponding bill. (Example: Facility charges from June 1st – June 30th should not be submitted prior to July 1st)
- Incomplete forms and photocopies of a prior month's completed POR form will be considered ineligible and may delay the reimbursement process.
- Please make sure to complete the form using the correct dates. Please verify Month, Day, and Year while completing the form.

**Please complete the form and submit monthly with the corresponding bill. Send via fax (preferred) to (312) 396-5952, upload to [www.BankersLife.com/Service-Support/Document-Upload](http://www.BankersLife.com/Service-Support/Document-Upload), or mail to: Bankers Life, P.O. Box 1902, Carmel, IN 46082**

Resident Name : \_\_\_\_\_ Facility Name: \_\_\_\_\_

Resident Policy #(s): \_\_\_\_\_ Facility Address: \_\_\_\_\_

Resident Move-In Date: \_\_\_\_\_ Facility Phone Number: \_\_\_\_\_  
(MM/DD/YYYY)

Month of Service: From: \_\_\_\_\_ To: \_\_\_\_\_ Facility Fax Number: \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

1. Is the resident deceased?  Yes  No If Yes, please provide date of death: \_\_\_\_\_  
(MM/DD/YYYY)  
 Was the resident charged for services on the date of death?  Yes  No

2. Select the level of care that describes the resident's current room, unit, or apartment:  
 Skilled Nursing Facility  Assisted Living Facility  Other: \_\_\_\_\_

3. At any time during this service period, was the resident away from the facility overnight for any reason?  Yes  No  
 If Yes, provide dates: Departure Date: \_\_\_\_\_ Return Date: \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

Provide reason for absence:  Hospitalization  Voluntary leave  Other: \_\_\_\_\_  
 Was the resident charged for the days out of the facility?:  Yes  No If Yes, daily amount \$: \_\_\_\_\_

4. Please explain any credits appearing on the bill: \_\_\_\_\_

5. Did Medicare, Medicaid/MediCal or any other insurance provide benefits during this service period?  
 No  Yes, Medicare  
 Yes, Medicaid  Other government insurance: \_\_\_\_\_

Please provide dates of 100% coverage/coinsurance/private pay below. Please include Explanation of Benefits or UB-04 form along with the bills and this form. \_\_\_\_\_

**By signing below, I declare that I have read the Fraud Notice on the reverse side of this form and that all of the answers given are complete and true to the best of my knowledge and belief.**

Print Name \_\_\_\_\_ Title \_\_\_\_\_ Phone Number \_\_\_\_\_

Signature \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

**Fraud Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, files a claim or materials in support of a claim containing false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties.**

Bankers Life is the marketing brand of various affiliated companies of CNO Financial Group including, Bankers Life and Casualty Company, Bankers Life Securities, Inc., and Bankers Life Advisory Services, Inc. Non-affiliated insurance products are offered through Bankers Life General Agency, Inc. (dba BL General Insurance Agency, Inc., AK, AL, CA, NV, PA).

Securities and variable annuity products and services are offered by Bankers Life Securities, Inc. Member FINRA/SIPC, (dba BL Securities, Inc., AL, GA, IA, IL, MI, NV, PA). Advisory products and services are offered by Bankers Life Advisory Services, Inc. SEC Registered Investment Adviser (dba BL Advisory Services, Inc., AL, GA, IA, MT, NV, PA).

**Investments are: Not Guaranteed—Involve Risk—May Lose Value.**

**AK residents:** 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.

**AZ residents:** 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.

**AL residents:** 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.

**AR / LA and RI residents:** 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.

**CA residents:** 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.

**CO residents:** 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.

**DC residents: 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.

**DE residents:** A 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.

**FL residents:** 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.

**ID residents:** 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.

**IN residents:** 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.

**KY residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claiming 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.

**MD residents:** 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.

**ME / TN / VA and WA residents:** 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.

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

**NH residents:** Any person who, with the 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 N.H. Rev. Stat. Ann. 638:20.

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

**NM residents:** 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.

**NY residents:** 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.

**OH residents:** 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.

**OK residents: 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.

**PA residents:** 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.

**PR residents:** 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 with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravated circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**TX residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**WV residents:** 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.

**All other states residents:** Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

Bankers Life is the marketing brand of Bankers Life and Casualty Company. Medicare Supplement insurance policies sold by Colonial Penn Life Insurance Company and select policies sold in New York by Bankers Conseco Life Insurance Company (BCLIC). BCLIC is authorized to sell insurance in New York.