Prudential

**Group Insurance**

Please send the completed form and all attachments to:

**The Prudential Insurance Company of America**
**Group Life Claim Division**
**P.O. Box 8517**
**Philadelphia, PA 19176**

# Group Life Insurance Claim Form – Arkansas and North Dakota

(Use for employee/member and dependent death claims)

**How to complete and submit a Group Life Insurance Claim Form**

1. **Complete Sections 1, 2, 3, 4, and 5 of the Group Contract Holder Statement portion of the Group Life Insurance Claim Form. Section 1 must be completed if the claim is for an employee/member, or for a dependent of an employee. Please be sure to complete the "Relationship to Employee" block.**
   For Dependent Term Life coverage on children, the employee is always the beneficiary. For Dependent Term Life coverage on a spouse, the employee is usually the beneficiary, except for certain Group Universal Life and Group Variable Universal Life coverage, in which the employee may be able to specify other beneficiaries.

2. **Detach the Beneficiary Statement* and give a copy to each beneficiary. Ask each beneficiary to complete it and return it to you.**
   If there are multiple beneficiaries, each beneficiary should complete a beneficiary statement. It is only necessary for you to submit one Group Contract Holder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you have.

   *If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator, or guardian). If no legal representative has been or will be court-appointed, this section should be completed by the person who assumed responsibility for the estate or beneficiary.

3. **Return both the Group Insurance Contract Holder Statement and the Beneficiary Statement(s) with the required documents noted below to:**
   The Prudential Insurance Company of America
   Group Life Claim Division
   P.O. Box 8517
   Philadelphia, PA 19176

   If you have any questions, please call Group Life Claim Customer Service at 800-524-0542 and a customer service representative will assist you.

**Documents to submit to Prudential**

Submit the Group Contract Holder Statement, Beneficiary Statement(s), and the following attachments:

1. A certified copy of the death certificate.

2. A copy of the employee's enrollment card, if available.

3. A copy of the most recent beneficiary designation and any beneficiary changes, if applicable.

4. The certificate of insurance, if available.

5. Legal documentation of the beneficiary for the following situations:

   If the beneficiary is
   (a) an estate, minor, or not competent to handle financial affairs: attach a certified copy of the court order appointing the legal representative.
   (b) a trust: attach a letter verifying that the trust is still in effect. If the trust is a testamentary, attach a certified copy of the will and a certified copy of the testamentary.
   (c) no longer living: attach a copy of the death certificate.

6. If the insurance was assigned, attach a copy of the assignment and all related papers. If it is a collateral assignment, attach the assignee's statement of indebtedness.

7. If an accidental death claim is being filed, attach supporting information, such as a police report or newspaper clippings.

8. If a Business Travel Accident (BTA) claim is being filed, attach information requested in (7) together with documentation further substantiating the loss, such as a trip itinerary, travel tickets, etc.

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# Group Insurance

Please send the completed form and all attachments to:

**The Prudential Insurance Company of America**
**Group Life Claim Division**
**P.O. Box 8517**
**Philadelphia, PA 19176**

## Group Insurance Contract Holder Statement (Use for employee/member and dependent death claims)

To be completed by Employer/Plan Administrator. Please complete all five sections.

### 1 Deceased's Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Date of Death (MM DD YYYY)

Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Employee ☐ Spouse ☐ Child ☐ Other

State of Residence

Did decedent have accidental death coverage? ☐ Yes ☐ No

Date of Accident (MM DD YYYY) | State of Accident

AKA: First Name | Last Name

### 2 Employee/ Member Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Date Last Worked (MM DD YYYY)

Date of Employment (MM DD YYYY)

☐ Hourly ☐ Salary ☐ Union ☐ Non–union ☐ Part Time ☐ Full Time

**Did the Employee receive a certificate of coverage and/or originally enroll for coverage while residing or working in NY?** *If yes, please provide beneficiary with the NY Beneficiary Statement.*

Occupation | Where Employed

☐ **Does any beneficiary reside in NY?** *If yes, please provide any beneficiary residing in NY with the NY Beneficiary Statement.*

If not actively at work immediately prior to death, what was the reason?

☐ Disability ☐ Leave of Absence ☐ Vacation ☐ Discharge
☐ Resigned ☐ Retired ☐ Temporary Layoff ☐ Other

Street Address (where employed) | Suite.

City | State | ZIP Code

### 3 Employer/ Association Information

Employer's Name

Street | Suite

City | State | ZIP Code

Telephone Number

Prudential

Deceased's Social Security Number

## 4 Insurance Coverages

Complete only the coverage(s) that apply to this claim.

| Group Coverage | Control Number | Amount | Effective Date of Coverage (MM DD YYYY) | Branch |
|---|---|---|---|---|
| ☐ Basic Term Life | | $ . | | |
| ☐ Optional Term Life | | . | | |
| ☐ Dependent Term Life | | . | | |
| ☐ Dependent Optional Term Life | | . | | |
| ☐ Group Universal Life | | . | | |
| ☐ Group Variable Universal Life | | . | | |
| ☐ Dependent Group Universal Life | | . | | |
| ☐ Dependent Group Variable Universal Life | | . | | |
| ☐ Accidental Death | | . | | |
| ☐ Group Universal Accidental Death | | . | | |
| ☐ Dependent Accidental Death | | . | | |
| ☐ Optional Accidental Death | | . | | |
| ☐ Dependent Optional Accidental Death | | . | | |
| ☐ Dependent Group Universal Accidental Death | | . | | |
| ☐ Business Travel Accidental Death | | . | | |
| ☐ Dependent Business Travel Accidental Death | | . | | |

Salary Amount on Last Day Worked

$ . per

☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned? ☐ Yes ☐ No

If yes, please attach a copy of assignment and all related papers. For collateral assignment, please attach assignee's statement of indebtedness.

Has insurance percentage increased in last two years? ☐ Yes ☐ No If yes, provide date (MM DD YYYY):

Was evidence of insurability required to secure current coverage? ☐ Yes ☐ No

Is there contributory insurance? ☐ Yes ☐ No

Date Last Premium Paid (MM DD YYYY)

Was insurance in force on date of death? ☐ Yes ☐ No

If no, provide date (MM DD YYYY):

Insurance Terminated

Conversion Privilege Offered (if available)

Did the employee or the covered dependent suffer a loss as defined by the BTA contract? ☐ Yes ☐ No

If yes, an officer of the company must provide a written statement validating the circumstances of the accidental death.

Prudential

Deceased's Social Security Number

## 5 Payment Information

Mail payment to: ☐ Employer at address listed on page 2 ☐ Beneficiary(ies) at address(es) listed below ☐ Other (please specify in cover letter)

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

**Name of Beneficiary**

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

**Name of Beneficiary**

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

**Name of Beneficiary**

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Completed by (name of representative of the employer or benefit administrator)

Please print or type name

Date (MM DD YYYY)

Signature X

Prudential

Deceased's Social Security Number

## 5 Payment Information Continued

Mail payment to: ☐ Employer at address listed on page 2 ☐ Beneficiary(ies) at address(es) listed below ☐ Other (please specify in cover letter)

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

**Name of Beneficiary**

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

**Name of Beneficiary**

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

**Name of Beneficiary**

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Completed by (name of representative of the employer or benefit administrator)

Please print or type name

Date (MM DD YYYY)

Signature X

# Group Life Insurance Beneficiary Statement

**NOTE TO EMPLOYERS**

1. If the Employee received a certificate of coverage and/or originally enrolled for coverage while residing or working in the state of New York, then please provide the beneficiary with the NY Beneficiary Statement.
2. Please provide any beneficiary residing in the state of New York with the New York Beneficiary Statement.

**Instructions for Beneficiaries to Complete Beneficiary Statement**

To receive your settlement, please complete the 'Group Life Insurance Beneficiary Statement' using the instructions below.

1. Review and complete Sections 1, 2, and 3.
2. If filing for an Accidental Death or Business Travel Accident (BTA) claim, please review and complete Section 4.
3. Review Sections 5 and 6, including the fraud warnings found at the back of this statement.
4. Once you have reviewed Sections 5 and 6, sign the bottom of Section 5.

Once all sections of this form have been completed, please return this form and all necessary documents according to the instructions that were provided to you with this form. Note: Each beneficiary should complete and return a separate statement.

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## Beneficiary Statement

Each beneficiary should complete Sections 1, 2, 3 and 5. If Accidental Death or Business Travel Accident benefits are being claimed, Section 4 should also be completed.

**1 Deceased's Information**

First Name | MI | Last Name

Social Security Number

**2 Beneficiary's Information**

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Telephone Number | Date of Birth (MM DD YYYY)

**3 Taxpayer Identification Number and Certification**

**Prudential requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:**

- are an individual, your Taxpayer Identification Number is the Social Security Number.
- represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number.
- represent a minor, please provide the minor's Social Security Number.
- are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.

**TAXPAYER IDENTIFICATION NUMBER/FORM W-9 CERTIFICATION:**
**Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (Social Security Number). I further certify that the citizen/residency status I have listed on this form is my correct citizen/residency status. I am not subject to backup withholding because (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding, (b) the IRS has told me that I am no longer subject to a backup withholding order, or (c) I am exempt from backup withholding.**

**Social Security Number or Taxpayer Identification Number of beneficiary**

**Check here only if you are subject to backup withholding:**

☐ **I have been notified by the Internal Revenue Service that I am subject to backup withholding due to underreporting of interest or dividends.**

☐ **I am not a U.S. person (including resident alien). I am a citizen of**
*(Attach completed IRS Form W-8BEN, if applicable)*

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Date (MM DD YYYY)

X
Signature

Prudential

Deceased's Social Security Number

## Beneficiary Statement

If filing for an Accidental Death or Business Travel Accident claim, please complete Section 4 below.

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### Authorization for Release of Information to Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Print Name of Deceased or Patient

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to the Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at: P.O. Box 8517, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of my Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release his/her complete medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

Date (MM DD YYYY)

X

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

**NOTICE TO MONTANA RESIDENTS:** You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.

## 5 Life Insurance Payment Options

We understand that this may be an emotionally challenging time in life and making financial decisions can seem overwhelming. To help make one decision easier for you, Prudential will establish an interest-bearing Alliance Account® in your name, where your money will be safe and secure until you're ready to make decisions about how to use the funds.

### How It Works

Prudential's Alliance Account is a supplemental contract offered to beneficiaries receiving group life insurance payments of $5,000 or more.[1] **Eligible life claim benefits will be settled as a lump sum into an Alliance Account unless you select an alternate settlement option below.** (For information about alternate settlement options, see section 6 of this form.)

| Prudential's Alliance Account | Your Money Continues to Grow | Access the Funds As You Wish |
|---|---|---|
| ▪ Upon receipt of the beneficiary claim, the full amount of the proceeds payable to you are settled in a single distribution via an interest-bearing Alliance Account established in your name. | ▪ The funds in your Alliance Account begin earning interest immediately and will continue to earn interest until they are withdrawn.<br>▪ See *"Interest On Your Funds" under "Additional Important Information" for more details.* | ▪ You can access the money immediately or whenever you are ready by using the draft[2] book you will receive.<br>▪ You can write drafts as often as you like.<br>▪ One draft can be written to withdraw the entire account balance at any time. |

### What You Need to Know

The Alliance Account can give you peace of mind and provide you with the precious gift of time, so you can focus on what matters most now and make decisions regarding your settlement when you're ready.

| | |
|---|---|
| **Access your funds at any time.** | ▪ Personalized drafts, which you use as you would use your bank checks, are provided with your account and can be used at any time to withdraw funds. (Certain businesses may have their own policies and procedures for handling "drafts.") |
| **No account or usage fees.** | ▪ The Alliance Account has no monthly service fees or per draft charges.<br>▪ Additional drafts can be ordered at no cost.<br>▪ Some special services, however, such as requests to stop a draft, will incur a charge. (See section 6 of this form for the schedule of fees for special services.) |
| **Your money is secure.** | ▪ The Alliance Account is a settlement option under the original life insurance policy and is backed by the financial strength of The Prudential Insurance Company of America (Prudential)—one of the largest insurance companies in the U.S. *See "Your Funds Are Secure" in "Additional Important Information" for more details.* |

## 5 What You Need to Know (Continued)

| | |
|---|---|
| **Take the time you need to make a decision.** | ▪ Leave your money in the account for as long as you wish, access any or all of it, or transfer funds to an alternate settlement option at any time and at no cost. If the balance falls below $250, you will receive a check for the remaining balance plus interest at the end of the monthly cycle in which the balance fell below $250.<br>▪ Unlike other options, the account gives you immediate access to the funds while keeping *all* alternate options available for you to consider when you are ready.<br>▪ You should consult with a tax, investment or other financial advisor for tax information or other available investment options; we cannot provide tax advice. |
| **One Account for all Settlements.** | ▪ If you are the beneficiary on more than one life insurance policy or annuity contract, the proceeds will be paid into one Alliance Account.<br>▪ If you already have an Alliance Account, proceeds from this claim will be placed into that account and the transaction confirmation will appear on your next statement.<br>▪ The Alliance Account is a separate arrangement between you and Prudential. |
| **Get the answers you need, when you need them.** | ▪ You can speak directly with a dedicated customer service representative between 8 a.m. and 8 p.m. Eastern time, Monday through Friday.<br>▪ Or, call our automated voice-response system 24 hours a day to check your account balance, request additional drafts and more.<br>▪ Call toll free at 877-255-4262 or write to Prudential Alliance Account at P.O. BOX 41582, Philadelphia, PA 19176. |

### Additional Important Information

**Interest on Your Funds:** The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily and credited every month. The interest earned on your account may be taxable. The interest rate credited to your Alliance Account is adjusted by Prudential at its discretion based on variable economic factors (including, but not limited to, prevailing market rates for short term demand deposit accounts, bank money market rates and Federal Reserve Interest rates) and may be more or less than the rate Prudential earns on the funds in the account.

The current interest rate for Prudential's Alliance Account is 0.50%, subject to a current minimum of 0.25%. The current interest rate may change and will vary over time and may be more, but not less than any applicable minimum rate. The minimum rate will not change more than once every 90 days. You will be mailed statements at least quarterly and as frequent as monthly depending on activity in the Account. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support.

**Your Funds Are Secure:** All funds are held within Prudential's general account. It is not FDIC-insured because it is not a bank account or a bank product. Funds held in the Alliance Account are guaranteed by State Guaranty Associations. Please contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about coverage or limitations on your account. State Guaranty Fund coverages are not determined by Prudential. FOR FURTHER INFORMATION, YOU MAY ALSO CONTACT YOUR STATE DEPARTMENT OF INSURANCE.

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Check the appropriate box below:

I choose: ☐ Alliance Account settlement option ☐ Single Lump Sum Check
☐ Other (please specify)_____

**FLORIDA RESIDENTS**—Any person 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 is guilty of a felony of the third degree.

**NEW YORK 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.

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

**SIGN HERE** → **Signature** _____ **Date (MM DD YYYY)** ☐☐ ☐☐ ☐☐☐☐

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## Understanding Your Options

State law requires that if there is no account activity and we have had no contact with you regarding your Alliance Account after a number of years (which time period varies by state), your Alliance Account may be considered dormant. If your Alliance Account becomes dormant, you will be mailed a check for the remaining balance plus interest, at your last address shown on our records. If you do not timely cash that check, your funds will be transferred to the state as unclaimed property. If your funds are transferred to the state, you may claim those funds from the state but you may be charged a fee by the state. Once your funds are transferred to the state, we no longer have any liability or responsibility with respect to your Alliance Account.

There are fees for special services, which are subject to change, and include:

- Stop Payment Fee – $12 each; $25 maximum for 3 or more per day
- Statement Copy Fee – $2 per statement
- Draft Copy Fee – $2 per draft
- Insufficient Funds Draft Fee – $10 per draft
- Overnight Delivery – Variable fee schedule

You may choose one of the following settlement or payment options as an alternative to the Alliance Account:

- *Payments for a Fixed Period:* The Death Benefit plus interest may be paid over a fixed number of years (1 to 25) either monthly, quarterly, semi-annually, or annually.
- *Payments in Installments for Life:* The Death Benefit may provide monthly payments in installments for as long as you live.
- *Payment of a Fixed Amount:* You may choose a payment of a stated amount either monthly, quarterly, semi-annually, or annually.

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Under each of the previously-mentioned alternative options, each payment must generally be at least $20.

- *Interest Income:* All or part of the proceeds may be left with Prudential to earn interest, which can be paid annually, semi-annually, quarterly, or monthly. The minimum deposit is $1,000. This option allows you to choose another settlement option at a later time. Withdrawals of $100 or more (including the entire balance) can be made at any time.
- *Lump Sum:* Receive the full death benefit in a single lump sum check. Before electing this payment option, you may want to consider the Alliance Account option, which also provides you with a single lump sum settlement and allows you to:
  - Begin earning interest immediately. Choosing a lump sum check means you will not begin earning interest until the check has been received and deposited into an interest-bearing account.
  - Access the funds for urgent expenses while reviewing long-term options including writing a draft for the full balance or electing another settlement option.
  - Maintain some of the tax benefits of the original policy. Specifically, you can name your own beneficiary to receive any remaining balance at your death as insurance proceeds, which are generally income tax-free.

The tax treatment of the Death Benefit may be different depending on the settlement option you choose. Please consult your tax advisor for advice. Should you have any questions about these settlement options, please contact Prudential at 800-524-0542.

Open Solutions Inc. is the Service Provider of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street Newark, NJ 07102-3777. Draft clearing is provided by UMB Bank, N.A. and processing support is provided by First Data Payment Services (FDPS). Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). Open Solutions Inc., UMB Bank, N.A., and First Data Payment Services are not Prudential Financial Companies.

**For residents of all states except Arizona, California, the District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, Pennsylvania, Rhode Island, Utah, Vermont, Virginia and Washington; WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**ARIZONA 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.

**CALIFORNIA RESIDENTS —** For your protection, California law requires the following to appear on this form. 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.

**DISTRICT OF COLUMBIA AND RHODE ISLAND 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.

**FLORIDA 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.

**KENTUCKY RESIDENTS —** 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.

**MARYLAND 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.

**NEW JERSEY RESIDENTS —** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NEW YORK 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. This notice ONLY applies to accident and disability income coverage.

**PENNSYLVANIA and UTAH 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**VERMONT RESIDENTS —** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

**VIRGINIA RESIDENTS —** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**WASHINGTON RESIDENTS —** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

## IMPORTANT INFORMATION

**COLORADO RESIDENTS —** Funds held by insurance companies are guaranteed by the Colorado Life and Health Insurance Protection Association, but are not guaranteed by the Federal Deposit Insurance Corporation (FDIC). Please contact the Colorado Life and Health Insurance Protection Association, the National Organization of Life and Health Guaranty Associations, or the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about the coverage limitations to your account.

**ILLINOIS RESIDENTS —** Payment on accidental death and dismemberment claims made after 31 days from the day we receive proof of accidental death or dismemberment of the insured, under the policies issued in Illinois, will include interest at the rate of 10% per year. The interest will be payable from the date of accidental death or dismemberment to the date of payment.

**LOUISIANA RESIDENTS —** The Louisiana Department of Insurance is located at 1702 N. 3rd Street, Baton Rouge, LA 70802 and can be reached by calling 800-259-5300. Written inquiries can be sent to the Louisiana Department of Insurance, Post Office Box 94214, Baton Rouge, LA 70804.

[1] Alliance is not available for payments less than $5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These generally will be paid by check.

[2] Alliance Account drafts are considered checks under federal law for certain purposes.