

FRAUD WARNINGS

- (CA) 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.
- (LA) 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.
- (NY) Please read statement located at bottom of application (reverse side) above signature section.
- (PA) 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.
- (WA) 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.
- (All Other States) 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/or civil penalties.

NOTE: These A; under Classes
5 thru 8 in KS or NY; and to adult groups (i.e., ages 20 or over) in NY. Travel agencies are not eligible. For these various groups, or other options,
please contact the Special Risks Health Department at our Home Office. ACTIVITIES AND/OR ACTIVITY DATES NOT REPORTED AND PAID WITH THIS
APPLICATION REQUIRE A SEPARATE POLICY.

<p style="font-size: 1.2em; margin: 0;">PREMIUM REPORT</p> <p style="margin: 10px 0 0 0;">Must be completed for Application to be accepted</p> <p style="margin: 10px 0 0 0;">Age range of participants (not staff): _____ to _____ years of age</p>	Covered Activity	Date(s) of Activities	Number of Eligible Persons Anticipated to be Insured			Daily Premium per Eligible Person	Premium per Day	Total Number of Days	Premium Due
				Participants	Staff	Total			
			_____	+ _____	= _____	× \$ _____	= \$ _____	× _____	= \$ _____
			_____	+ _____	= _____	× \$ _____	= \$ _____	× _____	= \$ _____
			_____	+ _____	= _____	× \$ _____	= \$ _____	× _____	= \$ _____
			_____	+ _____	= _____	× \$ _____	= \$ _____	× _____	= \$ _____
			_____	+ _____	= _____	× \$ _____	= \$ _____	× _____	= \$ _____
Total premium due (subject to policy minimum)..... \$ _____									
<p style="margin: 0;">The minimum premium per policy term is \$225 for primary medical coverage and \$175 for excess medical coverage.</p> <p style="margin: 0;">I certify that to the best of my knowledge and belief: (1) the preceding information is correct and complete; (2) premium is being paid for the total number of eligible persons who are anticipated to be insured during the policy term; and (3) the premium is being paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance.</p>									
Date _____				by _____ Applicant's Signature and Title					
Day Telephone Number _____				Fax Number _____					
E-mail Address _____									

Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House or "ACH") call 1-800-525-8669, option 5.

