

FRAUD STATEMENTS

Please read the following before completing the attached form.

- + **If you live in the states of Arkansas or Louisiana the following statement applies to you:**
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.
- + **If you live in the state of California, the following statement applies to you:**
For your protection California law requires the following to appear on the 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.
- + **If you live in the state of Colorado, the following statement applies to you:**
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.
- + **If you live in the District of Columbia, the following statement applies to you:**
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.
- + **If you live in the state of Florida, the following statement applies to you:**
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.
- + **If you live in the state of Kansas, Maryland or Oregon, the following statement applies to you:**
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 may be guilty of insurance fraud.
- + **If you live in the state of New Jersey, the following statement applies to you:**
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- + **If you live in the state of Virginia, the following statement applies to you:**
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 may have violated state law.
- + **If you live in a state other than mentioned above, the following statement applies to you:**
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.

Group Insurance Enrollment Card



Check one – Employer Use
 Initial Employee:
 Transfer from Prior Dental
 Non-Transfer
 New Employee
Date of Hire _____
 Change
 Open Enrollment

(Please print clearly.)

Employer: NC Dept. of Administration		Effective Date	Location/Division 609557	
Employee first name		MI	Last Name	
Address		City	State	Zip
Social Security No.	Birthdate	Phone	Sex <input type="checkbox"/> M <input type="checkbox"/> F	

DENTAL COVERAGE

I APPLY FOR: **Freedom Basic** (Lo Plan)
 Freedom Advance(Hi Plan)
 Employee only
 Employee and eligible dependents

I DECLINE COVERAGE FOR:
 Employee
 Spouse
 Child(ren)

Do you have eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete below to enroll them.	Relation	Sex	Birthdate			For children age 19 or older, indicate if a full-time student.	
			Mo	Day	Year	Yes	No
Spouse							
Child(ren)							

- List additional Children on reverse side and check box.
- If the address of any child is different than the employee's address, please show that **child's name and address** below.

 - Name of the custodial parent or organization requesting coverage for such dependent child _____
 - Name of the custodial parent or organization responsible for payment of premium for such dependent child _____
 - If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.
 I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Fortis Benefits Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the employer named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an active full-time employee of that employer. When necessary, I may be asked to execute a HIPAA authorization form, allowing Fortis Benefits Insurance Company to use and disclose protected health information.

Date _____ Signature _____

Deleted: 12/2001