



Welcome to Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Your coverage options



Dental insurance

Taking care of teeth and overall health

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1 Read through this information.

2 Find out more about your benefits.

3 Talk to your employer if you need help or have any questions.

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Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.



Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and strokes may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Worsening oral health is seen as Alzheimer's disease progresses.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2021.

You will receive these benefits if you meet the conditions listed in the policy.



Your dental coverage

Option 1 or 2: Core or Buy Up plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: Core		Option 2: Buy Up	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	90%	90%	90%	90%
Major Care	60%	60%	60%	60%
Orthodontia	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit	\$1750		\$2500	
Maximum Rollover	Yes		Yes	
Rollover Threshold	\$700		\$900	
Rollover Amount	\$350		\$450	
Rollover In-network Amount	\$500		\$700	
Rollover Account Limit	\$1250		\$1500	
Lifetime Orthodontia Maximum	Not Applicable		\$2500	
Dependent Age Limits	26		26	



Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: Core <i>Plan pays (on average)</i>		Option 2: Buy Up <i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 in 12 Months		2 in 12 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	90%	90%	90%	90%
	Fillings‡	90%	90%	90%	90%
	Perio Surgery	90%	90%	90%	90%
	Periodontal Maintenance	90%	90%	90%	90%
	Frequency:	2 in 12 months		2 in 12 months	
	Root Canal	90%	90%	90%	90%
	Scaling & Root Planing (per quadrant)	90%	90%	90%	90%
	Simple Extractions	90%	90%	90%	90%
	Surgical Extractions	90%	90%	90%	90%
Major Care	Bridges and Dentures	60%	60%	60%	60%
	Dental Implants	60%	60%	60%	60%
	Inlays, Onlays, Veneers**	60%	60%	60%	60%
	Repair & Maintenance of Crowns, Bridges & Dentures	60%	60%	60%	60%
	Single Crowns	60%	60%	60%	60%
Orthodontia	Orthodontia	Not Covered		50%	50%
	Limits:			Adults & Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



Your dental coverage

Manage Your Benefits:

Go to www.Guardianlife.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Find A Dentist:

Visit www.Guardianlife.com
Click on “Find A Provider”; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which

no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-I-DG2000 et al.

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only.
Policy Form # GP-1-DG2000, et al, GP-1-DEN-16

Your Guardian Vision Access Program

If you're eligible, you can receive discounts on vision care services or supplies from vision providers within the Vision Service Plan (VSP) Preferred Provider Organization (PPO) network.

You must pay the entire discounted fee directly to your VSP Network doctor. Discounts are not available from providers outside the VSP network.

You'll save on exams, materials, and more

Average discounts:

Eye exams	20% off the usual charge
Frames, standard lenses, and lens options	20% off the usual charge when a complete pair of prescription glasses is purchased
Contact lens professional services	15% off the usual charge for professional services (contact lenses are not discounted)
Laser surgery	An average of 15% off the laser surgeon's usual charge, or 5% off of any promotional price if it's less than the usual discounted price



It's easy to save

Find a participating doctor near you by visiting guardiananytime.com/fpapp/FPWeb/vision or calling **1 800 877 7195**.

You don't need to bring your ID card, but you do need to let your doctor know that you have the Guardian VSP Access Plan at the time of service to receive your discount.

This is not insurance. If you qualify, you must pay the entire discounted fee directly to the VSP network doctor. There is no charge for the Discount Vision Access program. You must be enrolled in a Guardian dental plan in order to be eligible for the Discount Vision Access program. When you are no longer enrolled for dental coverage, your access to the network discounts ends.

The Guardian Life Insurance Company of America New York, NY 10004-4025, guardiananytime.com. Guardian's Vision Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage. Policy Form No. No. GP-1-VSN-96-1 et al.

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2020-105022 (07/22)

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
\$1,750 Maximum claims reimbursement	\$700 Claims amount that determines rollover eligibility	\$350 Additional dollars added to a plan's annual maximum for future years	\$500 Additional dollars added if only in-network providers were used during the benefit year	\$1,250 The limit that cannot be exceeded within the maximum rollover account



Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

* This example has been created for illustrative purposes only.

** If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan. May not be available in all states.

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Oral Health Rewards Program

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How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
\$2,500 Maximum claims reimbursement	\$900 Claims amount that determines rollover eligibility	\$450 Additional dollars added to a plan's annual maximum for future years	\$700 Additional dollars added if only in-network providers were used during the benefit year	\$1,500 The limit that cannot be exceeded within the maximum rollover account



Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

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Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information



Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.

Visit <https://www.guardiananytime.com/notice48> to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.

Visit <https://www.guardiananytime.com/notice46> to read more.

Dental insurance



Guardian's HIPAA Notice of Privacy Practices

The notice describes how health information about you may be used and disclosed and how you can access this information.

Visit <https://www.guardiananytime.com/notice50> to read more.

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Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer/Planholder Name: EXELIXIS, INC.	Group Plan Number: 00026645	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Member Dependents/Family Members <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<p>In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term, and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.</p>		

Class: _____	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer/Planholder)
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About You: Full Legal Name-First, MI, Last Name: _____ What is the name you go by? (optional) _____	Employer/Planholder Provided Identification: _____	Social Security Number _____ - _____ - _____ Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address _____	City _____	State _____	Zip _____
Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth (mm-dd-yy): ____ - ____ - ____			
Phone (indicate primary): <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____ <input type="checkbox"/> Mobile (____) ____ - ____			
Email Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
Are you married or in a domestic partnership? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of marriage/domestic partnership: ____ - ____ - ____ Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No Placement date of adopted child: ____ - ____ - ____			

About Your Job:	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation Hours worked per week: _____	Date of full time hire: ____ - ____ - ____

About Your Family: Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.			
If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.			
Spouse	Gender Identity:	Social Security Number	
Address/City/State/Zip: _____	<input type="checkbox"/> M <input type="checkbox"/> F	____ - ____ - ____	
Phone: () - _____		Date of Birth (mm-dd-yyyy)	
		____ - ____ - ____	

Child/Dependent 1: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Drop Coverage: <input type="checkbox"/> Drop Employee/Member <input type="checkbox"/> Drop Dependents/Family Members The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	Coverage Being Dropped: <input type="checkbox"/> Dental <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Basic Term Life <input type="checkbox"/> Voluntary Term Life
Loss Of Other Coverage: I and/or my dependents were previously covered under Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: ____ - ____ - ____ <input type="checkbox"/> Divorce/Separation ____ - ____ - ____ <input type="checkbox"/> Death of Spouse or Partner ____ - ____ - ____ <input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost <input type="checkbox"/> Dental	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)

Dental Coverage: You must be enrolled to cover your dependents/family members. Check only one box.	
Employee/Member Only	Employee/Member, Spouse or Partner & Dependent/Child(ren)
Option 1: Core <input type="checkbox"/>	<input type="checkbox"/>
Option 2: Buy Up <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I do not want Dental Coverage because (Check as applicable): <input type="checkbox"/> I am covered under another Dental plan <input type="checkbox"/> My dependents/family members are covered under another Dental plan	

Signature <ul style="list-style-type: none"> • I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage. • If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request. • I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
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- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.
- "California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law requires that insurers offering Accident, Cancer, Critical Illness and Hospital Indemnity policies or certificates must require that the person to be insured is covered for essential health benefits or minimum essential coverage as defined in federal law. If you do not have such essential health benefits or minimum essential coverage as defined in federal law, you may not enroll for Accident, Cancer, Critical Illness or Hospital Indemnity Coverage. By your signature below, you affirmatively attest that you, and any dependents to be covered, are covered by essential health benefits or minimum essential coverage as defined in federal law.

SIGNATURE OF EMPLOYEE/MEMBER X _____

DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

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.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Delaware, Indiana and Oklahoma: 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.

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.

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.

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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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. (Does not apply to Life Insurance.)

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 CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she 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.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who with intent to defraud or knowing that he/she 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.