USI AFFINITY

NEW YORK LIFE

Group Business Overhead Expense Insurance Plan

FOR NEW JERSEY SOCIETY OF CPAS MEMBERS, & THEIR FAMILIES

Why not join the millions of insureds who have chosen to help protect their business with

New York Life Insurance Company?

NJCPA • PREMIER PARTNER •

Without you, what would happen to your business? And without your business, what would happen to you? Would the bills stop coming in just because you became disabled? If you find these questions troubling, Business Overhead Expense Insurance can help provide a comforting answer.

As a member of the New Jersey Society of CPAs, you have an opportunity others don't. The NJCPA Insurance Program has put together best-in-class features on Group Business Overhead Expense Insurance that helps protect your employees' salaries, your business, and your obligations if you are unable to work.

Affordability

The NJCPA Insurance Program gives you access to group buying power. Unlike plans you might find in the general market, you get the benefit of your group association. Plus, as part of a group plan, you can never be singled out for a rate increase.

Advocacy

For decades, the NJCPA has been sponsoring customized plans to meet the needs of New Jersey's accounting professionals. Our plan administrator, USI Affinity, employs a team to answer questions and help you understand your options. We're your advocate, and we work hard to understand and anticipate your needs as an accounting professional.

Stability

NJCPA and USI Affinity have gone through the paces of due diligence to ensure that you're getting coverage from a respected insurance carrier. This plan is underwritten by New York Life, a leading insurance provider who is rated A++ (Superior) by A.M. Best for financial strength and is a recognized leader in service and claims experience[1].

Eligibility

Members of the New Jersey Society of CPAs who are under age 55, residents of the U.S., at FULL-TIME WORK[2] and you operate a BUSINESS OFFICE FACILITY[3].

1: Third Party Ratings Report as of 10/15/2020.
2: FULL-TIME WORK means the active performance for pay or profit of the regular duties of our normal occupation on a basis of at least 30 hours each week at the place where such duties are normally performed.
3: BUSINESS OFFICE FACILITY means a room, set of rooms, or building where the business of a commercial or industrial organization or of a professional person is conducted.

How the Plan Works

This coverage is designed to pay monthly benefits up to 24 months for covered overhead expenses if you suffer a Total Disability while insured under the policy. "Totally Disabled" means that, as the result of a covered illness or accident, you are continuously and completely unable to perform the substantial and material duties of your regular occupation. You must be under the care of a licensed physician for your covered disability. Benefits are paid regardless of other insurance coverage you may have, and this coverage automatically renews, as long as applicable terms and conditions are met. Coverage is available whether you're in private practice or in a partnership.

You will also be considered Totally Disabled if a covered illness or injury results in at least one of the following for you:

- permanent loss of sight both eyes
- permanent loss of hearing in both ears
- the inability to speak
- severance above the wrist or ankle of: (a) both hands; (b) both feet; or (c) one hand and one foot.

Covered Overhead Expenses

There are many expenses that this plan will cover to help keep your business running. Eligible expenses include: rent and leased equipment, salaries for existing employees, utilities and phone, taxes, insurance premiums, and depreciation and other fixed overhead expenses as are normal and customary in the operation of your business. You must actually incur the overhead expense in the course of operation of your office.

If you're incorporated, a partner or joint tenant, Eligible Overhead Expenses include only your share of overhead expenses.

Eligible Overhead Expenses do not include: the salary, fees, drawing accounts, profits, or any compensation for you, your partner or any member of your profession employed by or working for you; any individual hired after the date your disability begins (except your temporary replacement); income taxes; personal expenses; charitable contributions; the cost of the purchase of office equipment, goods or merchandise; or the payment of principal on any indebtedness.

Your Choice of Monthly Benefit Amount

Apply for monthly benefit amounts between $1,000 and $10,000 in $100 increments.

Your Choice of Payment Options

You can choose to pay your premiums annually, semi-annually or by credit card. There is a $1.00 administrative fee if you choose semi-annual billing. To avoid this fee, choose to pay your premiums annually or by credit card.

Plan Features & Benefits

Waiting Period
The Waiting Period is the number of consecutive days you must be Totally Disabled before benefits begin. This plan gives you the flexibility to choose a Waiting Period that's most comfortable for you—either 15 or 30 days.

Worldwide Coverage
Once your coverage is effective, you are protected wherever you travel—whether for business or personal—as long as you remain a US resident[4].

Tax-Deductible Premiums
Premiums are typically tax-deductible as a business expense. Any benefit payments are generally taxable. You should consult with your personal tax advisor for further information.

Waiver of Premium
It's good to know that your insurance will continue should you become totally disabled. Premium payments for your coverage will be waived if you become totally disabled prior to turning age 60 and said disability lasts at least six months. Please refer to your Certificate of Insurance for applicable conditions.

Summary of Terms & Conditions

When Coverage Begins
Coverage becomes effective on the first day of the month following the date the application is approved, provided the initial premium is paid within 31 days after billing and any person proposed for insurance is at FULL-TIME WORK and maintaining a BUSINESS OFFICE FACILITY for at least 12 months. If you are not at FULL-TIME WORK on the date your application is approved, coverage will not go into effect until the date you return to FULL-TIME WORK, provided you are still eligible and the date is within three months of the date the insurance would have otherwise taken effect. Payment of a premium contribution does not mean coverage is in force. Pregnancy will be treated as any other illness if the pregnancy begins after the first 30 days following the effective date of the policy and such pregnancy or childbirth results in continuous total disability.

When Benefits End
Benefits will cease at the earlier of the following: a) your covered disability ends; b) the maximum benefit period ends; or c) if required proof of continuing disability is not provided. You will remain insured after your benefits end, except as described in the "Exhaustion of Benefits" section.

30-Day Free Look
Once your coverage is approved, you will be sent a Certificate of Insurance summarizing your benefits under the Plan. If you are not completely satisfied with the terms of the Certificate, you may return it, without claim, within 30 days. We will refund your entire premium contribution and invalidate your coverage.

Exhaustion of Benefits
When you have reached the maximum benefit period, as determined by your plan and age when the covered disability began, coverage will be suspended and no premiums will be due. Your coverage will resume without evidence of insurability provided the following a) you advise the administrator that you have returned to FULL-TIME WORK; and b) do not meet the criteria described in the "When Coverage Ends" section.

When Coverage Ends
Coverage will remain in force until the earlier of: a) you reach age 70; b) failure to pay premiums when due; c) the Group Policy is terminated by New York Life or the Policyholder; d) the Group Policy is modified to exclude the class of insured in which you belong; e) you no longer incur Eligible Overhead Expenses due to the dissolution of your association with the BUSINESS OFFICE FACILITY; f) you receive benefits for the 24 month Benefit Period, or; g) you elect to end coverage.

Exclusions
Disabilities that are due or related to the following are excluded from coverage: air travel (except when a fare-paying passenger on a licensed commercial, non-military aircraft); military service; self-inflicted injury while sane or insane; pregnancy, except complications thereof; your incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime; declared or undeclared war or act of war; and any disability which does not require a doctor's regular care (regular care of doctor does not include yourself, a close relative, or a household member).

Current 2022 Annual Premiums per $100 in Monthly Benefits

Cost is based on the Waiting Period, Monthly Benefit and your age when coverage becomes effective. Cost increases on the premium due date on or immediately after you reach a higher age bracket.

Waiting Period	*15 Days*	*30 Days*
< Age 30	$ 5.50	$ 4.00
Ages 30 - 39	$ 11.00	$ 8.00
Ages 40 - 49	$ 15.50	$ 12.00
Ages 50 - 59	$ 27.00	$ 22.50
Ages 60 - 69	$ 42.00	$ 38.50

Note: A $1.00 administrative fee applies if you select semi-annual premium payments. To avoid this fee, choose to pay your premiums annual or by credit card.

The premium contributions shown reflect the current rates and benefit structure. Premium contributions may be changed by New York Life on any premium due date and any date on which premiums are changed. However, your rates may change only if they are changed for all others in the same class of insureds under this group policy. A class is a group of people with the same age.

4: Subject to U.S. government regulations on restricted countries.

How New York Life Obtains Information and Underwrites Your Request for Group Business Overhead Expense Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance , we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing, however, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: PROTECTED PERSONS[1] have a right of access to certain CONFIDENTIAL ABUSE INFORMATION[2] we maintain in our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSON by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.

1-PROTECTED PERSON means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.

2-CONFIDENTIAL ABUSE INFORMATION means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company **8.12 ed**

This Summary contains a brief description of some of the principal provisions of the proposed insurance coverage. Complete terms and conditions are set forth in the group policy issued by New York Life to the New Jersey Society of CPAs, and each insured will receive a Certificate of Insurance summarizing the benefits and coverage provisions provided under Group Policy G-29466-0 on policy form GMR-FACE/G-29466-0. This group life policy is available only in the U.S.

NJCPA is compensated in connection with this sponsored group plan to provide and maintain this valuable membership benefit.

Do you have questions about this coverage? Or do you need to file a claim?
Call our customer care center for more information or for the necessary forms:
1.855.874.0278 • Monday - Friday, 9 a.m. to 5 p.m. (ET)

USI AFFINITY

Administered By:
USI AFFINITY
14 Cliffwood Avenue, Suite 310
Matawan, NJ 07747 | 1.855.874.0278
AR Insurance License # 325944
CA Insurance License # 0G11911

Underwritten By:
NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue | New York, NY 10010
Under Group Policy G-29466-0
on Policy Form G-29466-0/GMR-FACE

Group Business Overhead Expense Application for Members of the New Jersey Society of CPAs

Request for Group BOE Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

TO APPLY: Complete this form and return it to USI AFFINITY, 14 Cliffwood Avenue, Suite 310, Matawan, NJ 07747
Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.

NJXKEAACH

1. MEMBER INFORMATION:

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ ( ) _____

Home Phone Number Office Phone Number Fax Number

Home E-mail Address _____ Office E-mail Address _____

Social Security #: ____ - ____ - _____ Date of Birth: ____ /____ / ____ Height: ____ ft. ____ in. Weight: _____ lbs. ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* ☐ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union is determined by state law.

Are you now a member of the New Jersey Society of Certified Public Accountants?

☐ Yes ☐ No If yes, Member ID#: _____

Are you presently insured by any other NJCPA-sponsored plan? ☐ Yes ☐ No
If yes, provide details: _____

Do you plan to reside outside the U.S. or Canada within the next 12 months?
Member: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. OCCUPATIONAL STATUS:

a) Occupation: _____ Main Duties: _____

b) "FULL TIME WORK" means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed. Are you at FULL TIME WORK? ☐ Yes ☐ No

c) What was the average monthly total of Eligible Overhead Expenses you incurred in the preceding 12 months? (Complete the worksheet to determine.): $_____

d) Type of Business: ☐ Sole Proprietor ☐ Corporation ☐ Partnership
If Corporation or Partnership, what percentage of the monthly Eligible Overhead Expenses are you responsible for? _____%

3. PAYMENT OPTION (Choose only one):

☐ Bill Me Annually ☐ Bill Me Semi-Annually* ☐ Charge My Credit Card (see below):

I request and authorize NJCPA Insurance Program, administered by USI Affinity, to make ☐ annual ☐ semi-annual ☐ monthly charges against the credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan.

☐ Visa ☐ MasterCard Account #: _____ Exp. Date _____ 3-Digit Code:_____

Cardholder's Name: _____ Signature: _____

*There is a $1.00 administrative fee for semi-annual billing. You can select annual billing to avoid this fee.

4. INSURANCE REQUESTED: (Refer to brochure for eligibility, options and coverage descriptions.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE, based upon all my statements made in this Request Form:

a) **Monthly Benefit Amount* Desired:** $_____

*NOTE: If you are increasing or altering present coverage in any way, do NOT indicate just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting. Choose an amount between $1,000 and $10,000 in $100 increments.)

b) **Benefit Period:** ☑ 24 Months

c) **Waiting Period:** ☐ 15 Days ☐ 30 Days

d) Do you now have or are you applying for other insurance that provides overhead expense benefits if you are unable to work because of a disability? ☐ Yes ☐ No If yes, provide details (insurance company, plan, monthly benefit, benefit period):

_____

5. STATEMENT OF HEALTH (Please initial any changes you make on this form.)

To the best of your knowledge and belief, please answer these questions as they apply to you:	Yes	No
1) Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐	☐
2) During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:		
a) Heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?	☐	☐
b) Other health or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?		
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?		
(iii) Any other impairment?	☐	☐
3) During the past have five years you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	☐	☐
4) Are you now pregnant?	☐	☐
5) Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	☐	☐
6) During the past two years, have you participated in, or plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang-gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	☐	☐
7) Driver's License No.: _____ State in which issued: _____		
8) During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations?	☐	☐
9) Except for residents of CT and MN, in the last seven years, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	☐	☐
For residents of CT and MN only, in the last seven years, have you been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	☐	☐

If you have answered 'yes' to any questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it.)

Name of Proposed Insured	Details

6. AUTHORIZATIONS AND SIGNATURES:

I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, the applicant **requests** the insurance indicated; and the applicant and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE enclosed and Fraud Notices indicated below including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

Agent Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

FRAUD NOTICE – *For Residents of all states except those listed below:* 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 may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO, *the following also applies:*** Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AL/AR/LA/RI: 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.

RESIDENTS OF CA: 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 may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

FOR RESIDENTS OF D.C.: 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 member.

RESIDENTS OF FL: 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.

RESIDENTS OF KS: 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 may be guilty of insurance fraud as determined by a court of law.

RESIDENTS OF MD: 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.

RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF OK: 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.

RESIDENTS OF TN/WA: 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.

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.