

AIG Life Insurance Company*

Wilmington, Delaware

Delaware American Life Insurance Company*

Wilmington, Delaware

Member companies of American International Group, Inc.

Administrative Office: 3600 Route 66, Neptune, NJ 07753

*This company does not solicit business in New York.

DISABILITY BENEFITS

This packet contains the forms necessary to apply for Disability benefits. For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator.

EMPLOYEE INSTRUCTIONS:

1. Complete and sign your portion of the claim form.
2. Your treating physician should complete the Attending Physician's Statement. If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefit administrator.
3. Sign and date the Authorization for Release of Information, and send it, along with the Employee's Statement, to AIG Employee Benefits Disability Claims Center at the address listed below.
4. Maintain a copy of all documents for your records.

EMPLOYER INSTRUCTIONS: *

1. Complete and sign your portion of the claim form.
2. Attach a copy of job description and payroll records for the 3 months preceding disability.
3. Submit all forms along with required documents to the AIG Employee Benefits Disability Claims Center at the address listed below.
4. Notify AIG Employee Benefits Disability Claims Center of the employee's return to work date.

* If your Policy Number begins with a "V", attach a copy of the employee's Enrollment/Application form.

MAIL CLAIM FOR PROCESSING TO:

Plan Administration LTD
580 Hazard Avenue
Enfield, CT. 06082
(860) 272-1135
(860) 272-1136 FAX

OTHER BENEFITS THAT MAY REDUCE YOUR DISABILITY BENEFITS

Other benefits you receive may reduce the amount of Disability benefits due you. Your group insurance certificate lists these benefits, which may include, but are not limited to, sick leave, Workers' Compensation, State Disability, Social Security, and Retirement.

To avoid a possible overpayment of your claim, please inform us if you receive these or other benefits.

WHEN YOU RETURN TO WORK

Your Disability benefits usually stop when you return to work. Be sure that you or your employer notify us immediately when you plan to, or have, returned to work to assure no overpayment occurs.

All portions of this form packet must be completed to avoid undue delay in processing the claimant's request for benefits.



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Disability Benefits: Employee's Statement

Mail To:
Plan Administration LTD
580 Hazard Avenue
Enfield, CT. 06082

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TO BE COMPLETED BY THE EMPLOYEE

PLEASE TYPE OR PRINT • BE SURE TO ANSWER ALL QUESTIONS • FAILURE TO DO SO MAY DELAY YOUR CLAIM

Last Name	First Name	MI	Social Security Number
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Address	City	State	Zip Code
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Home Phone Number ()	Additional Phone Number ()
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Employer Name	Human Resources Contact	Phone Number ()
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Occupation/Job Title Before Disability	Job Location
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Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	If Married, Spouse's Name: Spouse's Date of Birth: Spouse's Social Security Number:
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Dependents you are responsible for:
 ___ Children under 18 ___ Children 18-25 attending elementary or Secondary school full time ___ Handicapped Children of any age
 If any of the above was checked, please list the names and dates of birth:

Name	Date of Birth
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1.
2.

Last day worked:	First day absent from work for this disability:	Medical condition preventing you from working:
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Please advise of the signs and symptoms preventing you from working at any job:

Do you expect to return to work? <input type="checkbox"/> Yes Date <input type="checkbox"/> No	Returned to work full time at a different job or your same job with some modifications: Date	Returned to work part time: Date	Returned to work full time to your original job: Date
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Is the condition work related? Yes No
 If yes, please state the name and phone number of your Workers' Compensation carrier:

Have you applied for or are you receiving benefits from:	Applied		Receiving		Date Applied For	Amount Received		Effective Date/ End Date
	Yes	No	Yes	No		Weekly	Monthly	
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Please specify type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other _____ (e.g. unemployment or union benefits, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Were you hospitalized? Yes No If yes,
 Name of Hospital: Phone Number: ()
 Admission Date: Date Released:

If this disability is the result of pregnancy or childbirth, provide the following:
 Expected date of delivery:
 Actual delivery date: Type of delivery: Normal C-Section

Attending Physician's Name: Address:	Specialty: Phone Number: ()) Fax Number: ())
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List Additional Providers: Name:	Specialty:	Phone Number:	Fax Number:	Last Office Visit:
1.				
2.				
3.				

Current Medications:

Additional Information

LEVEL OF EDUCATION

High School Graduate	Yes	No	If no, last grade completed:	
College Graduate	Yes	No	Degree	Major
Post Graduate	Yes	No	Degree	Major

Other Certificates/Technical Training

Have you attended, or are you currently attending any trade schools or received other special training? Yes No If yes, please describe:

List prior or current employers including self employment: Employer	Job Title
1.	
2.	
3.	

Please list any interests or hobbies:

ACKNOWLEDGEMENT

With the exception of any source(s) of income reported on this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my AIG American General Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period AIG American General has approved my disability claim, I must report all details to AIG American General immediately.

If I receive disability income benefits greater than those which should have been paid, I understand that I will be responsible to provide repayment to AIG American General. AIG American General has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the Fraud Statement included with this form.

Signature* _____
Date

***Please sign and date the Authorization for Release of Information and include it with this form.**

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Wilmington, Delaware

Delaware American Life Insurance Company*

Wilmington, Delaware

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Administrative Office: 3600 Route 66, Neptune, NJ 07753

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Claimant's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, AIG Life Insurance Company of Puerto Rico, American General Life Insurance Company, American Home Assurance Company, Delaware American Life Insurance Company, Pacific Union Assurance Company, and the American General Life Companies LLC, (an affiliated service company), (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG American General Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: AIG Employee Benefits Disability Claims Center, P.O. Box 387, Farmington, CT 06034-0387. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

 Name

 Date

 Signature of Claimant/Guardian/Representative



AIG Life Insurance Company*
 Wilmington, Delaware
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 Wilmington, Delaware

Disability Benefits: Employer's Statement

Mail To:
Plan Administration LTD
580 Hazard Avenue
Enfield, CT. 06082

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WARNING: 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 FACTS MATERIALLY THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

TO BE COMPLETED BY THE EMPLOYER

Employer	Policy Number	Class/Plan
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Employee Name	Social Security Number
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Occupation/Job Title prior to disability (attach copy of job description)

Date of hire:	Employee's plan effective date:	Did the employee have prior plan coverage?	Work status prior to disability: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time (____) hours
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Last day employee worked:	Reason employee stopped working:	Returned to work full time to original job: Date	Returned to work part time: Date
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Employee's earnings:\$ _____ (check one) <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annual <input type="checkbox"/> commission <input type="checkbox"/> other	Was salary continued? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last paid:
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Has the employee applied for or is he/she receiving benefits from:	Applied		Receiving		Date Applied For	Amount Received		Effective Date/ End Date
	Yes	No	Yes	No		Weekly	Monthly	
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Please specify type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
FMLA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other _____ (e.g. unemployment or union benefits, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Name and address of Workers' Compensation carrier:	Workers' Compensation claim number:
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List any other source of income to which the employee is entitled as a result of this disability:

Percentage of employee contribution towards disability premium: <small>(see Internal Revenue Code Section 105(a) and Regulations thereunder)</small>	Employee's contributions were made on a: <input type="checkbox"/> Pre tax basis <input type="checkbox"/> Post tax basis	Premium paid through date:
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Is employee eligible for Group Pension? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, monthly amount:
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Percentage of employee contribution to Group Pension:	Effective date:
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Employee's job is primarily: sedentary light medium heavy very heavy

In a work day given two breaks and a meal break, the employee must:					Total hours								With positional change			
Lift (in pounds)	<input type="checkbox"/> 1-10	<input type="checkbox"/> 11-20	<input type="checkbox"/> 21-50	<input type="checkbox"/> 51-75	<input type="checkbox"/> 76+	Sit	8	7	6	5	4	3	2	1	(hrs)	_____
Carry (in pounds)	<input type="checkbox"/> 1-10	<input type="checkbox"/> 11-20	<input type="checkbox"/> 21-50	<input type="checkbox"/> 51-75	<input type="checkbox"/> 76+	Stand	8	7	6	5	4	3	2	1	(hrs)	_____
						Walk	8	7	6	5	4	3	2	1	(hrs)	_____
Reach above shoulder	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	Alternately sit/stand		8	7	6	5	4	3	2	1	(hrs)	_____	
Climb	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently													
Crawl	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently													
Bend/stoop	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently													

ACKNOWLEDGEMENT
 I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included on this form.

Employer Signature	Title	Date
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Phone Number ()	Fax Number ()	Email Address
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TO BE COMPLETED BY THE EMPLOYEE

First Name	Last Name	Date of Birth	Policy Number
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TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Diagnosis	ICD-9 Classification		
Symptoms	Height	Weight	B/P

PREGNANCY (if applicable)

Expected date of delivery	Actual date of delivery	Type of delivery	<input type="checkbox"/> Normal	<input type="checkbox"/> C-section
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Significant complications, if any

HISTORY

Date the patient ceased working	When did symptoms first appear or injury happen?
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Has the patient ever had the same or similar condition? Yes No If yes, when?

Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date of first visit	Date(s) of subsequent visits	Date of most recent visit
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Planned course and duration of treatment (include surgery and medications, if any)

HOSPITALIZATION (if applicable)

Date admitted	Reason	Date discharged
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Name and address of hospital

PHYSICAL IMPAIRMENT (*As defined in Federal Dictionary of Occupational Titles)

- Class 1 No limitation of functional capacity; capable of heavy work* no restrictions (0-10%)
- Class 2 Medium manual activity* (15-30%)
- Class 3 Slight limitation of functional capacity; capable of light work* (35-55%)
- Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity* (60-70%)
- Class 5 Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)
- Remarks

In a work day given two breaks and a meal break, the patient is able to:		Total hours										With positional change
Lift (in pounds)	<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+	Sit	8	7	6	5	4	3	2	1	(hrs)	_____
Carry (in pounds)	<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+	Stand	8	7	6	5	4	3	2	1	(hrs)	_____
		Walk	8	7	6	5	4	3	2	1	(hrs)	_____
Reach above shoulder	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently	Alternately sit/stand	8	7	6	5	4	3	2	1	(hrs)	_____
Climb	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently											
Crawl	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently											
Bend/stoop	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently											

FOR RESIDENTS OF:

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: 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.

ARKANSAS: 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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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 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.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim 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.

HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

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: 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.

MAINE: 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.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEVADA: Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 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.

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.

OHIO: 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 is guilty of insurance fraud.

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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: 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.

TENNESSEE: 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.

TEXAS: 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.

VIRGINIA: 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.

WASHINGTON: It is unlawful for any person, knowing it to be such, to: (a) present, or cause to be presented, a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under a contract of insurance; or (b) prepare, make, or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with intent that it be presented or used in support of such a claim.

WEST VIRGINIA: 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.

FOR RESIDENTS OF ALL OTHER STATES NOT LISTED ABOVE:

Warning: 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 facts materially thereto, commits a fraudulent insurance act, which may be a crime and subject such person to criminal and civil penalties.