

DENTAL CLAIM STATEMENT

A	TYPE OF		1 STATEMENT									
Part	STATEMENT OF ACTUAL SERVICES PRE-TREATMENT ESTIMATE											
Part												
A STATE OF PRINTEN Print					11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP							
A Control and plane Part												
Part	l l											
Part Color	4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP											
1					15. PLAN/GROUP	15. PLAN/GROUP NUMBER 16. EMPLOYER NAME						
					PATIENT INFORMATION							
Maria Mari					17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)							
3. OTHER ROUNGE CONTAINE THE PROPERTY CONTAINE AND APPROPERTY CONTAINE AND APP	8. PLAN/GROUP NUMBER	I		OTHER								
Property 1	10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN N/				21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS							
Manyangaria				DENTA								
1				1		27. DESCRIP	PTION	28. FEE				
1		<u> </u>		<u> </u>		<u> </u>						
A	2											
1				<u> </u>		<u> </u>						
Control Cont			!	<u> </u>		<u> </u>						
1		 		 		 			-+			
1		<u> </u>	 -	 		├			-+			
1		-		├──		-						
1			-	 		 						
38. PLACE K ON MISSING 19. 2 3 3 4 5 5 6 7 8 8 9 10 10 11 12 13 14 15 16 16 8 8 10 10 10 10 10 10 10 10 10 10 10 10 10		 	+	 		 		no.	-+			
18	MISSING TEETH		PERMANENT				PRIMARY		29.	. TOTAL FEE CHARGED		
31. AUTHORIZATIONS 32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM. PATENT/GUARDIAN SIGNATURE DATE 33. INFRET MERITING DENTIST. 34. PLACE OF TREATMENT DIGITAL IMAGES 35. NUMBER OF ENCOSURES. RADIOGRAPHS 36. IS TREATMENT RELATED TO ORTHODONTICS? NO YES DATE APPULANCE PLACED. 37. TREATMENT RELATED TO ORTHODONTICS? NO YES DATE APPULANCE PLACED. 38. REPLACEMENT OF PROSTHESSS? YES DATE PROOF PLACEMENT. 39. REPLACEMENT OF PROSTHESSS? YES DATE PROOF PLACEMENT. 30. STREATMENT PLACEMENT. 31. TREATMENT RELATED TO ORTHODONTICS? NO YES DATE APPULANCE PLACED. 32. REPLACEMENT OF PROSTHESSS? YES DATE PROOF PLACEMENT. 33. REPLACEMENT OF PROSTHESSS? YES DATE PROOF PLACEMENT. 34. HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES SENDICATED BY DATE AND/OR WISH TO DETAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE RECESSARY IN MY PROFESSIONAL JUDGMENT. 35. NAME, ADDRESS, CITY, STATE, ZIP 46. HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES WERE/ARE RECESSARY IN MY PROFESSIONAL JUDGMENT. 36. STREATMENT OF THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE RECESSARY IN MY PROFESSIONAL JUDGMENT. 37. STREATMENT OF THE PROCEDURES WERE/ARE RECESSARY IN MY PROFESSIONAL JUDGMENT. 38. REPLACEMENT OF PROSTHESS? YES DATE PROOF PLACEMENT. 39. NAME, ADDRESS, CITY, STATE, ZIP 46. HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES WERE/ARE RECESSARY IN MY PROFESSIONAL JUDGMENT. 36. STREATMENT REAL RECESSARY IN MY PROFESSIONAL JUDGMENT. 37. TREATMENT REAL RECESSARY IN MY PROFESSIONAL JUDGMENT. 38. STREATMENT REAL RECESSARY IN MY PROFESSIONAL JUDGMENT. 39. NAME, ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN 899)	30. PLACE A ON MISSING		+ + + + + + + + + + + + + + + + + + + +	+ + -	+ + + -	 	+ + + +	+ + +	_			
AUTHORIZATIONS 32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PRYMENT OF THIS CLAIM. 33. NUMBER OF ENCLOSURES RADIOGRAPHS DIGITAL IMAGES MODELS RODIES RADIOGRAPHS DIGITAL IMAGES MODELS RADIOGRAPHS NO YES DIST APPLIANCE PLACED MODELS REPLIANCE PLACE												
32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM. 33. NUMBER OF ENCLOSURES RADIOGRAPHS DIGITAL IMAGES MODELS PATIENT/GUARDIAN SIGNATURE DATE 34. PLACE OF TREATMENT DENTAL OFFICE HOSPITAL ECF OTHER 35. NUMBER OF ENCLOSURES RADIOGRAPHS DIGITAL IMAGES MODELS ***ON YES DATE APPLIANCE PLACED MONTHS OF TREATMENT REMAINING ***OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT OTHER ACCIDENT OTHER ACCIDENT OTHER ACCIDENT OF PROSTHESISS? YES DATE PRIOR PLACEMENT OF PROSTHESISS? YES DATE PRIOR PLACEMENT MOT HAVE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. **X**SIGNED (TREATMENT GENTIST)***DATE 45. NPI 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN 839)	31.											
32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM. 33. NUMBER OF ENCLOSURES RADIOGRAPHS DIGITAL IMAGES MODELS 34. PLACE OF TREATMENT DENTAL SERIES DIGITAL IMAGES MODELS 35. NUMBER OF ENCLOSURES RADIOGRAPHS DIGITAL IMAGES MODELS 36. IS TREATMENT RELATED TO ORTHODONTICS? NO YES DATE APPLIANCE PLACED MONTHS OF TREATMENT REMAINING 37. TREATMENT RESULTING FROM: OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT 38. REPLACEMENT OF PROSTHESIS? YES DATE PRIOR PLACEMENT OF PROSTHESIS? YES DATE PRIOR PLACEMENT THAT I HAVE PERFORMENT BY PROCEDURES WERE ARD/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE JARREN RECESSARY IN MY PROFESSIONAL JUDGMENT. **X** SIGNED (TREATMENT BY THAT I HAVE PERFORMENT THAN 1849) 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN 899)	AUTHORIZATIONS ADDITIONAL CLAIM INFORMATION											
233. IF PREMITTED, I HEREBY ASSIGN AND AUTHORIZE PRYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE REATING DENTIST. 376. TREATMENT RELATED TO ORTHODONTICS? NO YES DATE APPLIANCE PLACED	32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND		OTECTED HEALTH INFORMATION	N FOR 34	34. PLACE OF TREATMENT							
RADIOGRAPHS DIGITAL IMAGES MODELS 33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TERATING DENTIST. 34. IS TREATMENT RELUTED TO ORTHODONTICS? THE TREATING DENTIST. 35. IS TREATMENT RESULTING FROM: OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT TO THE TREATING DENTIST. 36. IS TREATMENT RESULTING FROM: OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT THE TREATING DENTIST AND LOCATIONS TREATMENT RESULTING FROM: OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT TO THE ACCIDENT NO TREATING DENTIST AND LOCATION 46. ILICENSE NUMBER SIGNATURE 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)	PURPOSES OF PAYMENT OF THIS CLAIM.			35								
33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST. 37. TREATMENT RESULTING FROM: OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT 38. REPLACEMENT OF PROSTHESIS? YES DATE PRIOR PLACEMENT NO TREATING DENTIST AND LOCATION 39. NAME, ADDRESS, CITY, STATE, ZIP 44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. X SIGNED (TREATING DENTIST) DATE 45. NPI 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)	PATIENT/GUARDIAN SIGNATURE											
38. REPLACEMENT OF PROSTHESIS? SUBSCRIBER SIGNATURE DATE DATE TREATING DENTIST AND LOCATION 39. NAME, ADDRESS, CITY, STATE, ZIP 44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. X SIGNED (TREATING DENTIST) DATE 45. NPI 46. LICENSE NUMBER 47. TIN	33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO				NO YES DATE APPLIANCE PLACED MONTHS OF TREATMENT REMAINING							
SUBSCRIBER SIGNATURE BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS) 39. NAME, ADDRESS, CITY, STATE, ZIP 44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. X SIGNED (TREATING DENTIST) 45. NPI 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)	THE TREATING DENTIST.				OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT							
39. NAME, ADDRESS, CITY, STATE, ZIP 44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. **X** SIGNED (TREATING DENTIST)* DATE 45. NPI 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)							·	NO				
ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. X SIGNED (TREATING DENTIST) DATE 45. NPI 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)	BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)						TREATING DENTIST	AND LOCATI	ION			
45. NPI 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)	39. NAME, ADDRESS, CITY, STATE, ZIP											
45. NPI 46. LICENSE NUMBER 47. TIN 48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)												
48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)		-										
		ļ <u></u>										
					S. COURSES, S. C., SINIS, ET. (II STILLER TIME 1923)							
43. PHONE NUMBER 50. ADDITIONAL DENTIST ID 51. SPECIALTY CODE	43. PHONE NUMBER			49	9. PHONE NUMBER	PHONE NUMBER 50. ADDITIONAL DENTIST ID 51. SPECIALTY CODE				CODE		

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- Clearly type, hand write, or use a computer printer to enter information.
- Use all upper-case (capital) letters, if possible.
- Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.
- · Keep information within the correct field.
- Make sure the typewriter or printer ribbon is dark and the print can be easily read.
- Cover mistakes with line tape and print or type over—do not use liquid correction fluid.
- Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter \$0 unless the primary carrier's determination of payment was \$0. DO NOT ATTACH the primary carrier's voucher.
- Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- · Hand or machine print
- When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).
- Use current ADA CDT procedure codes.
- Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental
 requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary
 documentation delays processing.

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.
- Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.
- Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

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.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO			
Delta Dental	Delta Dental	800-524-0149 (GROUP)			
P.O. Box 9085	Attn: Customer Service	800-971-4108 (INDIVIDUAL)			
Farmington Hills, MI 48333-9085	P.O. Box 9089				
	Farmington Hills, MI 48333-9089				

Delta Dental of Michigan www.deltadentalmi.com

Delta Dental of Ohio www.deltadentaloh.com

Delta Dental of Indiana www.deltadentalin.com

Delta Dental of North Carolina www.deltadentalnc.com

FRAUD WARNINGS

Please read the warning statement for the state where you reside and for the state where your policy was issued.

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.

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 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.

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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim 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.

Kansas: NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

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 {Footnote 1} 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

Massachusetts: 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.

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

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 R.S.A. 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 \$5000 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 and 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 presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under 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.

Rhode Island: 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.

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.

Vermont: No person shall, with intent to defraud, present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact. Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

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 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.

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.