BILLY H. FORD, MD, PC

BILLY H. FORD, MD
Medical Director
bhfordmdpc@gmail.com

Name: txt_name|patientfullname _____ **Date:** txt_date|ToDay _____

DOB: txt_dob|DOB _____

REQUIRED PHARMACY INFORMATION

PREFERRED PHARMACY:

Billy H. Ford, MD, PC -prescribes all medications as mandated by federal laws. In order to comply, we need accurate pharmacy information. All controlled substances must be obtained at the same pharmacy, when possible, and **must** be filled in **The State of NY.**

Should the need to change pharmacies arise, our office must be informed ahead of time. Please provide your pharmacy's information where you expect to fill prescriptions written by the practitioners at the Billy H. Ford, MD, PC.

1. **Pharmacy Name: _____**
2. **Phone: (_____) _____-_____**

   Address: _____City : _____

   State:_____Zip _____

BILLY H. FORD, MD, PC

BILLY H. FORD, MD
Medical Director
bhfordmdpc@gmail.com

GENERAL CONSENT FOR TREATMENT

I understand by signing this consent, I allow Billy H. Ford, MD, PC and their staff to treat me. This includes but not limited to, injections, aspirations, wound care, physical examinations, and receiving prescription medication. **Please be advised that Billy Ford, M.D does not prescribe narcotics and does not routinely complete disability forms.**

Patient Social Security Number: txt_ssn|SSN

Patient Signature: _____

Print Name: txt_name|patientfullname Date: txt_date|ToDay

Guardian (if under 18 years of age):
Signature: _____

Print Name: txt_name|patientfullname

Initial: _____ Date: txt_date|ToDay

For Female Patients Only

I am not pregnant or possibly pregnant. I understand if I become pregnant, it is my full responsibility to notify Billy H. Ford, MD, PC or Billy Ford, M.D. or the x-ray technician of such.

Patients Social Security Number: txt_ssn|SSN Date: txt_date|ToDay

Patient Signature: _____ Print Name: _____

Guardian (if under 18 years of age): _____

Signature: _____ Print Name: _____

Date: txt_date|ToDay

Initial _____ Date _____ Initial _____ Date _____

BILLY H. FORD, MD, PC

BILLY H. FORD, MD
Medical Director
bhfordmdpc@gmail.com

MEMBER CONSENT FORM

Patient Name: txt_name|patientfullname
Member DOB: txt_dob|DOB
Insurance Carrier: txt_InsCo|InsCo
Subscriber ID#:

Dear Provider Claims Processing Department:

This correspondence serves as my official consent for my provider, Dr. Billy Ford, of Billy H. Ford, MD, PC, to appeal any type of denial made and/or request additional payment, on my behalf, to my above referenced medical insurance carrier.

I also authorize complete disclosure of my individually identifiable health information, including my plan, policy, and or contract be released by my insurance carrier, and its affiliates, to my named provider, Billy H. Ford, MD, PC in the event it is deemed necessary during any appeals process.

Additionally, I understand and agree that:

- This authorization is voluntary;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- . I may revoke this authorization at any time by notifying either my provider or my healthcare provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

_____ txt_date|ToDay

Signature of Member Date

Please note: If you are a guardian or court appointed representative, you must attach a *copy of your legal* ***authorization to represent the member and complete the following:***

_____ _____ _____

Guardian or Representative Name Guardian or Representative Signature Date

_____ _____

Guardian or Representative Full Address Guardian or Representative Phone Number

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)
Claim Number: txt_ClaimNumber

I, txt_name|patientfullname, ("Assignor") hereby assign to Billy H Ford, MD, PC, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on txt_doa|DOA, not withstanding any other agreement to the contrary. (Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

txt_name|patientfullname
(Print name of Patient)

(Signature of Patient)

(Date of signature)

txt_addressCityStateZip|fullAddress
(Address of Patient)

Billy Ford, M.D.
(Print name of Provider)

(Signature of Provider)

PO Box 21968

(Date of signature)

New York, NY 10087-1968
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

BILLY H. FORD, MD, PC

BILLY H. FORD, MD
Medical Director
103 Pierson Ave,
Hempstead, NY 11550
bhfordmdpc@gmail.com

Financial Agreement Contract

Thank you for trusting **Billy H. Ford, MD, PC,** to partner in your health care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Office/ Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

Please note that we do not participate with Medicare, Medicaid or any Managed/ Commercial medical insurance plans. We will not be billing any of these insurance plans for services rendered to you unless your plan offers *out-of network benefits.*

We would like to advise you that you will be fully responsible for the services rendered if your plan does not offer out of network benefits *unless other arrangements have been made in advance.*

Should you have out-of network benefits we will submit a claim for payment, the insurance will make the payment directly to you. You should endorse the check and forward it to our office as soon as possible. You should be aware that there may be a responsibility (coinsurance/deductible) on your part that is not covered by your insurance. The member services department at your insurance carrier may be reached for verification of patient contract details.

** I have read and understand that by signing this Financial Agreement Contract, I fully accept responsibility for payment of the services provided.

txt_name|patientfullname

Patient , Print Name

Patient Signature

txt_date|ToDay

Date

BILLY FORD, M.D.
Medical Director

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
txt_name|patientfullname	txt_dob|DOB	txt_ssn|SSN
Patient Address		
txt_addressCityStateZip|fullAddress		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
    - ❑ At request of individual
    - ❑ Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

BILLY H FORD, MD, PC

BILLY H FORD, MD**,**
Medical Director
bhfordmdpc@gmail.com

ASSIGNMENT AND LIEN

Date: txt_date|ToDay

Claimant's Name: txt_c_name|patientfullname

Date of Accident: txt_doa|DOA

I ("Claimant"), hereby authorize and direct my attorney ("Attorney") to pay directly and in full to **Billy H. Ford, MD, PC and/or Billy Ford, M.D.,** ("Provider") such sums as may be due and owing for medical services rendered by Provider to Claimant by reason of injuries incurred in the subject incident. **This agreement is acting as a valid assignment of Claimant's proceeds from any settlement, judgment, or verdict pertaining to the subject incident;** accordingly, this agreement is not acting as an attempted assignment of the cause of action itself. Such payment shall be drawn from any and all proceeds of any settlement, judgment or verdict that may be paid to Attorney on behalf of Claimant from the cause of action arising from the subject incident. Claimant agrees that this assignment is hereby made a lien against Claimant's claim, and such payment to Provider shall take priority over disbursement of any balance remaining to Claimant.

Provider relies upon the representation of Claimant, that Claimant has elected not to utilize Claimant's health care coverage because Claimant does not want to pay, or does not have the ability to pay, any copayments; and/or that Claimant does not want to meet and pay, or does not have the ability to meet and pay, any required deductible amounts due under the health care coverage; and/or that Claimant does not want to use health care providers within the network of providers available through Claimant health care coverage. Claimant acknowledges and understands that, regardless of whether Claimant proceeds under Claimant's health insurance coverage or through this lien, Claimant will be obligated upon recovery of expenses to pay some consideration for the medical services being provided to Claimant. Claimant affirmatively represents that no person has stated, recommended, counseled, advised or otherwise suggested to Claimant that should not utilize any health insurance coverage for treatment to be rendered to Claimant.

This lien encumbers all insurance coverages available to Claimant, of which insurer is responsible for actual coverage. Claimant authorizes Provider to disclose whatever information is necessary in order to protect and/or perfect the lien rights granted under this agreement.
In the event that other counsel is substituted for the undersigned present counsel, present counsel shall immediately notify the new/incoming counsel of this lien in writing, by certified mail, return receipt requested and shall immediately advise Provider of the name and address of new/incoming counsel in writing, by certified mail, return receipt requested. Claimant agrees and acknowledges that if Claimant changes attorneys, this agreement will remain in force and effect.
1Attorney agrees to withhold such sums from any settlement, judgment or verdict from the cause of action arising from the subject incident, and to pay directly and in full to Provider such sums as may be due and owing for medical and related services rendered by Provider to Claimant as a result of the subject incident; and Attorney shall tender payment in full to Provider before disbursing any payment to Claimant.

Claimant and Attorney agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Provider. However, should any provision of this Agreement be found to be invalid, illegal and unenforceable, or for any reason cease to be binding on any party hereto, all other provisions of this Agreement shall, nevertheless, remain in full force and effect.

Please contact **MDN Billing & Consulting,** 914-376-6100, melissa@mdnmedicalbilling.com or ncahall@mdnmedicalbilling.com, to arrange for satisfaction of this lien at the time of any resolution, specifically but not limited to any settlement or verdict.

txt_name|patientfullname

Claimant Name (print)

Claimant Signature

txt_date|ToDay

Date

Custodial Parent/Legal Guardian Name (print)

Parent/Guardian Signature

txt_date|ToDay

Date

txt_attorney|Attorney

Attorney Name (print)

Attorney Signature

txt_date|ToDay

Date

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

txt_InsCo|InsCo
txt_Insaddress|InsAddress1

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
txt_date|	txt_name|patientfullname	txt_policy_no|policy_no	txt_doa|DOA	txt_ClaimNumber|

Billy H Ford, MD, PC
PO Box 21968
New York, NY 10087-1968

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

txt_name|patientfullname txt_addressCityStateZip|fullAddress

2. DATE OF BIRTH txt_dob|DOB
3. SEX txt_sex|Sex
4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES [ ] NO IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES [X] NO [ ] IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES NO [X]

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [X]
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH:

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES [x] NO [ ] IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES [ ] NO [ ]

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. [ ] (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME txt_name|patientfullname (PATIENT) SIGNED Signature on file (PATIENT) txt_date|ToDay (DATE)

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME txt_name|patientfullname		SIGNED Signature on file		txt_date|ToD
PATIENT (Assignor)		PATIENT		DATE
PRINT NAME Billy Ford, MD,		SIGNED		txt_date|ToD
PROVIDER OF HEALTH CARE SERVICE (Assignee)		PROVIDER OF HEALTH CARE SERVICE		DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
txt_date|Tol		22-3623785	

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.