



PROVIDENT

Insuring America's Heroes Since 1928

FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
272 ALPHA DRIVE - P.O. BOX 11588
PITTSBURGH, PA 15238
TOLL-FREE: 800-447-0360
PHONE: 412-963-1200
CLAIMS DEPT FAX: 412-963-0148
www.providentbenefits.com

BOTH SECTIONS MUST BE COMPLETED

Name		Date of Birth / /		Social Security Number	
Address		City		State Zip Code	
Home Phone Number ()				Cell Phone Number ()	
Email Address			Employed By (Name of Company)		
What is your regular, full time occupation?			Employed By (Name of Company)		
Employer's Address		City		State Zip Code	
Employer's Phone Number ()				Date of Hire (Full Time Occupation) / /	
Please enclose pre-injury pay stub or the prior years W2 or Schedule C (if self-employed).		Wages/Earnings Hourly: Weekly:		Date of Hire (Full Time Occupation) / /	
Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	Date of Accident / /	Place of Accident		Date Last Worked / /	
What is your injury or illness?			How did it happen?		
Name and Address of Treating Physician			Name and Address of Hospital		
Did you lose any Time from Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown at this time			Did you file with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I was totally disabled from / / to / /					
I was partially disabled from / / to / /					
Date you have or are expected to return to work / /					

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Casualty Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant Signature _____

THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY.

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

To be complete by an official of the Named Insured (must be someone other than the claimant or claimant's family member).

<input type="checkbox"/> Yes <input type="checkbox"/> No – Claimant was a member of your organization at the time of injury or illness		Policy Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No – Claimant was engaged in an authorized activity at the time of injury or illness			
Name of Fire/Rescue/Ambulance Company/District or Relief Association		Your Municipality	
Print Name and Title		Signed	
		Date / /	
Address		City	
State		Zip Code	
Telephone Number ()			
Is the claimant a <input type="checkbox"/> Volunteer <input type="checkbox"/> Career <input type="checkbox"/> PT employee <input type="checkbox"/> Auxiliary <input type="checkbox"/> Other			

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.



NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for Unum Group, its insurance subsidiaries* and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

(Claimant Signature)

(Date Signed)

(Print Name)

(Social Security Number)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following Unum insurance subsidiaries: First Unum Life Insurance Company and Provident Life and Casualty Insurance Company.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.