Important Notice Regarding Fraud

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and 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 Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.

- ***For residents of 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.

- ***For residents of the 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.

- ***For residents of 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.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

- ***For residents of Maine, Tennessee and 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.

- ***For residents of Oregon:*** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland:*** 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.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For resident of Virginia:*** 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 false or deceptive statement may have violated state law.

CANCER FIRST NOTICE OF CLAIM FORM

Provident - Main Office: PO Box 11588 - 272 Alpha Drive Pittsburgh, PA 15238-0588
Business Hours: 8:30 a.m. to 5 p.m.
Toll-Free: 800.447.0360
Fax: 412.963.0148
claims@providentins.com
www.providentins.com

BOTH SECTIONS MUST BE COMPLETED

Name			Date of Birth / /	Social Security Number
Address	City	State Zip Code		Home Phone Number ( )
Email Address				Cell Phone Number ( )
What is your regular, full time occupation?			Employed By (Name of Company)	
Employer's Address	City	State Zip Code		Employer's Phone Number ( )

Are you a current active volunteer firefighter with the Policyholder? ☐ Yes ☐ No Occupation: ☐ Career ☐ Non-Career

Do you have 5 or more years of service as an interior volunteer firefighter? ☐ Yes ☐ No Start/Hire Date:

Have you passed 5 yearly Fit Tests? ☐ Yes ☐ No Exam Date: Physician's Name:

Did you have a physical prior to becoming an interior volunteer firefighter? ☐ Yes ☐ No

Are you a volunteer firefighter with another Fire Department? ☐ Yes ☐ No
If yes, where and start date? _____

Are you filing for benefits with another Fire Department? ☐ Yes ☐ No
If yes, which one? _____

Occupation and duties prior to disability: _____

Monthly Salary: _____ Disability caused by: ☐ Cancer ☐ Injury

Give full description of cancer from which you are now suffering: _____

Date when cancer was diagnosed: _____ Date when physician was consulted for this condition: _____

Date when you became totally disabled due to the cancer diagnosis (unable to work): _____

Date when you were able to perform part of occupational duties again: _____

Provide names, addresses and dates of confinement for all hospitals: _____

Provide names, address and telephone # for all attending physicians: _____

Provide name, address and telephone # for usual family physician: _____

Are you receiving "Other Income Benefits" from any other source other than insurance separately purchased by the insured? Example: workers comp, social security, unemployment, disability policy or group policy, etc.: _____

Attending Physician's Certification

Diagnosis and Applicable ICD 10 Codes: _____

When was the patient initially diagnosed with cancer?: _____ Is patient still under your care for cancer? ☐ Yes ☐ No

If no, give dates services terminated: _____

Name (Attending Physician - Please Print): _____ Phone Number: (_____) _____

Address: _____

Signature of Attending Physician: _____ Date: _____

Signature of Insured or Authorized Representative: _____ Date: _____

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I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Claimant Signature _____

Date _____

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

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

☐ Yes ☐ No – Claimant was a member of your organization at the time of injury or illness ☐ Yes ☐ No – Claimant was engaged in an authorized activity at the time of injury or illness	Policy Number
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 ☐ Volunteer ☐ Career ☐ PT employee ☐ Auxiliary ☐ Other	
Date the Member Joined the Organization:	

See Fraud Warning Important Notice sheet attached. Failure to complete this form in its entirety may result in a delay of processing your claim.

****THE POLICYHOLDER MUST INCLUDE A COMPLETE RUN REPORT FOR THE MEMBER****

DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)

Provident; 272 Alpha Drive; P.O. Box 11588
Pittsburgh, PA 15238
Phone: 800.447.0360 Fax: 412.963.0148
claims@providentins.com

NOTE: This authorization allows the _____ to release all information pertaining to a diagnosis that occurred on or about _____ to Provident.

You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to Provident Agency, Inc. 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; GENEX Services, Inc.; 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 including Social Security benefits, to disclose any and all of this information to persons who administer claims for Provident. 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 Provident obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return 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 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 Provident 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, Provident 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, Provident 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.

PROVIDENT®

DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)

Provident; 272 Alpha Drive; P.O. Box 11588
Pittsburgh, PA 15238
Phone: 800.447.0360 Fax: 412.963.0148
claims@providentins.com

Authorization for Release of Protected Health Information

You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

I authorize _____ to release infromation from the record of:
Name of Facility/Person

_____ / / _____ _____ to
Patient Name Birth Date SS # / MR #

_____ _____ _____
Name of Facility/Person Phone Fax

_____
Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION):_____

Parts 1 and 2 must be completed to properly identify the records to be released:

1. Type of records to be released and approximate date(s) of service (check all that apply):

☐ Inpatient ☐ Emergency Department Dates:_____ to _____
☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☑ Mental Health Information ☑ Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):

☑ Consults	☑ Medical History & Physical Exam	☐ Physican Orders
☑ Discharge Summary/Admissions History	☐ Medication Records	☐ Progress Notes
☐ Laboratory Reports/Tests	☑ Operative Report	☐ Psychiatric/Psychological Eval
☐ Mammography Reports Emergency	☐ Pathology Report	☑ Radiology Report
☑ Dept. Reports	☑ EKG Report (s)	

☐ Other:_____

HIV-related information contained in the parts of the records indicated above will be released through this authrorization unless otherwise indicated. ☐ Do not release

I understand that this Authorization is valid for a period of two (2) years from the date of the signature, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the orginal. I understand that I am entitled to receive a copy of this authorization. I understand that once this information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information.

Date of Signature

Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

Date of Signature

Signature of Authorized Representative ◯ N/A

◯ Parent or Legal Guardian ◯ Power of Attorney
◯ Next of Kin of Deceased ◯ Executor of Estate

Please provide supporting documentation

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date Witness # 1 Date Witness # 2