PROVIDENT | CLAIMS SERVICES SM

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 California***: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ***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 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 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.
- ***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.

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- ***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 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 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.

DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)

Provident Claims Services, Inc. - PO Box 38295 Pittsburgh, PA 15238-8295
Toll Free: 800.447.0360 Fax: 412.963.0148
claims@providentclaims.com

Please mail or fax this form to:

Provident Claims Services, Inc.
P.O. Box 38295
Pittsburgh, PA 15238
Phone: 800.447.0360 Fax: 412.963.0148

Email: claims@providentclaims.com

Business Hours: 8:30 AM to 5 PM

This form must be completed by the Claimant's Employer and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please be sure to keep a copy of this form and any attachments for your records.

INSTRUCTIONS:

Employers Statement - This section must be completed by your employer. Please make sure the employer signs and dates the bottom section of the form.

Please enclose any additional information that you feel will assist us in evaluating this claim.

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Toll Free: 800.447.0360 Fax: 412.963.0148
claims@providentclaims.com

EMPLOYMENT STATEMENT (PLEASE PRINT)

Organization Name: | Policy Number:

1. Employer Name | Employer's Phone Number ( )

Employer Address (Street, City, State, Zip)

Policy Numbers | Division Number / Class Number | Division / Class Description

2. Claimant's Name

Claimant's Address (Street, City, State, Zip)

Claimant's Home Phone | Date of Birth | Social Security Number | Date of Hire | Effective Date of Insurance | Date Last Worked

Claimant's Work Status: ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-exempt ☐ Bargaining ☐ Non-Bargaining

Has the claimant's employment been terminated? ☐ Yes ☐ No If yes, please provide termination date:

General Information About the Claimant's Job

3. Job Title | Minimum education or training required

Does the claimant perform supervisory function? ☐ Yes ☐ No | If yes, how many people are supervised?

4. Describe job duties:

Duty	# of Weekly Hours Spent at Duty
Duty	# of Weekly Hours Spent at Duty
Duty	# of Weekly Hours Spent at Duty
Duty	# of Weekly Hours Spent at Duty

Name of Direct Supervisor | Telephone Number of Direct Supervisor ( )

Please attach a copy of the claimant's job description.

5. How was claimant paid? (please check one)

☐ Hourly ☐ Commissions ☐ Salaried ☐ Salary and Bonus ☐ Commissions Only ☐ Salary and Commissions

What is the earnings figure you use to compute premium payments for this claimant? $

Salary/Wage prior to date last worked ***(refer to Earnings definition in your contract).***

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	Bonuses (per week)	Overtime (prior year)	Commissions (per week)	W-2 Earnings
$	$	$	$	$

6. Does the claimant contribute toward the premiums? (Complete all that apply)

STD:	☐ Yes ☐ No:	If yes: ☐ Pre-Tax	☐ Post-Tax	If Post Tax:	% paid by employer	% paid by claimant
State Plans:	☐ Yes ☐ No:	If yes: ☐ Pre-Tax	☐ Post-Tax	If Post Tax:	% paid by employer	% paid by claimant
LTD:	☐ Yes ☐ No:	If yes: ☐ Pre-Tax	☐ Post-Tax	If Post Tax:	% paid by employer	% paid by claimant
IDI:	☐ Yes ☐ No:	If yes: ☐ Pre-Tax	☐ Post-Tax	If Post Tax:	% paid by employer	% paid by claimant
Life:	☐ Yes ☐ No:	If yes: ☐ Pre-Tax	☐ Post-Tax	If Post Tax:	% paid by employer	% paid by claimant

7. Year to Date Earnings as of Date of Disability (For FICA % Deductions) $

8. Financial Documentation (please refer to your contract for your Earnings definition and attach the appropriate documentation).
Salary Only/Current Earnings definition: Attach copy of payroll records or paystubs for 2 periods just prior to disability.
Bonus/Commissions Included: Attach copy of payroll records for the 12 or 24 months (see definition) just prior to disability.
Other Earnings definitions: Attach referenced document per Earnings definition (W-2, K-1's, Schedule C's, teacher's contract, etc.).

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Toll Free: 800.447.0360 Fax: 412.963.0148
claims@providentclaims.com

EMPLOYMENT STATEMENT (continued)

9. Date of last Salary/Wage Increase | Work Schedule at time last worked: Days/Week Hours/Day Hours/Week

Check off regular work days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat. | Number of hours on date last worked:

Date paid through: For: ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick Pay ☐ Other

10. Has claimant returned to work? ☐ Yes ☐ No If yes, date: ☐ Full Time ☐ Part Time Hours Per Week

11. Does the claimant have an ownership interest in this business? ☐ Yes ☐ No If yes, what is the % of ownership? %
Type of business entity? ☐ Regular Corporation ☐ S corporation ☐ Partnership ☐ Sole Proprietorship

12. If this is a Flexible Benefits Plan, indicate which option of coverage this claimant has chosen.
Previous Plan Year - Date of Open Enrollment: Option Current Plan Year - Date of Open Enrollment: Option

13. Prior LTD Carrier Name	Effective Date
Address (Street, City, State, Zip)	Termination Date

14. Is claimant eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	When do benefits begin?	When do benefits end?
Salary Continuation	☐	☐	$	☐	☐		
State Disability	☐	☐	$	☐	☐		
Other Disability Benefits	☐	☐	$	☐	☐		
Social Security	☐	☐	$	☐	☐		
Worker's Compensation	☐	☐	$	☐	☐		

Is the claim the result of a work related injury or sickness? ☐ Yes ☐ No

If so has Workers' Compensation claim been filed?	☐	☐	If yes, Name and Address of Carrier
Health Insurance	☐	☐	If yes, Name and Address of Carrier
Life Insurance	☐	☐	If yes, please provide the amount of coverage: $

If Workers' Compensation claim has been denied, please submit a copy of denial with this claim.

15. If New York DBL or New Jersey TDB applies, complete this question.

Earnings 8 weeks prior to disability

	Week Ending						Week Ending					
	Mo.	Day	Yr.	No. Days Worked	Amount		Mo.	Day	Yr.	No. Days Worked	Amount
1						5					
2						6					
3						7					
4						8					

16. Information about your pension plan (Please send copy of Plan Summary) (Do not complete for maternity claim)

Do you have a pension plan? ☐ Yes ☐ No | If yes, what type? ☐ Defined benefit ☐ Defined contribution ☐ 401(k)/403(b) ☐ Profit Sharing ☐ Other: (specify)

Is claimant eligible for your pension plan? ☐ Yes ☐ No | If eligible, does the claimant participate? ☐ Yes ☐ No | What % does claimant contribute?

If the claimant is participating, when is he or she eligible for benefits under the plan?

FRAUD NOTICE:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim.

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form	Telephone Number ( )
Title of Person Completing Form	Fax Number ( )
Signature	Date Signed