

- 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: <u>WARNING</u>: 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.



- 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: <u>WARNING</u>: 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: 800.478.1752 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: 800.478.1752 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.



## DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO) Provident Claims Services, Inc. - PO Box 38295 Pittsburgh, PA 15238-8295 Toll Free: 800.478.1752 Fax: 412.963.0148 claims@providentclaims.com

# EMPLOYMENT STATEMENT (PLEASE PRINT)

Organization Name:					Policy Numbe	er:			
1. Employer Name						Employ (	Employer's Phone Number		
Employer Address (Street, C	City, State, Zip)								
Policy Numbers			Division Nun	nber / Class N	umber	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	E	Effective Date of Insurance Date Last Work			
Claimant's Work Status:	Full Time 🗌 Part Time	Exempt	Non-exempt	Bargaining	g 🗆 Non-Bar	gaining		·	
Has the claimant's employm	nent been terminated? 🗌 Y	es 🗌 No If ye	s, please prov	/ide terminatio	on date:				
<b>General Information Al</b>	bout the Claimant's Jo	b							
3. Job Title						Minimum ed	ucation or	training required	
Does the claimant perform s	supervisory function? $\Box$ Y	es 🗆 No If ye	s, how many	people are su	pervised?	·			
4. Describe job duties:									
# of Weekly Hours Spent at Duty								t 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	I	Telephone Number of Direct Supervisor							
Please attach a copy of th	e claimant's job description	on.							
5. How was claimant paid? □ Hourly □ Commissions	(please check one) s □ Salaried □ Salary a	nd Bonus 🛛 Co	ommissions C	Only 🗌 Salar	y and Commis	sions			
What is the earnings figure	you use to compute premiu	m payments for tl	nis claimant?	\$					
Salary/Wage prior to date la	st worked (refer to Earning	gs definition in y	our contract	<sup>•</sup> ).					
□ Weekly □ Bi-Weekly □ \$	Semi-Monthly Bonuse \$	s (per week)	Overtime \$	e (prior year)	Commis \$	sions (per week)	W-2 \$	Earnings	
<b>6.</b> Does the claimant contrib STD:	bute toward the premiums? b: If yes: $\Box$ Pre-Tax $\Box$ Pre-Tax			% paid	by employer		% paid	d by claimant	
State Plans: State						by employer % paid by clain			
LTD: 🗌 Yes 🗌 No	% paid	by employer		% paid by claimant					
IDI: 🗌 Yes 🗌 No	o: If yes: 🗌 Pre-Tax 🗌 P	ost-Tax If Post	Tax:	% paid	by employer	r % paid by claimant			
Life: Yes No: If yes: Pre-Tax Post-Tax If Post Tax: % paid by em						oyer % paid by claimant			
7. Year to Date Earnings as	of Date of Disability (For F	ICA % Deduction	s) \$						
8. Financial Documentation	on (please refer to your con	tract for your Ear	nings definitio	n and attach t	he appropriate	documentation	ı).		

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.).



## DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO) Provident Claims Services, Inc. - PO Box 38295 Pittsburgh, PA 15238-8295 Toll Free: 800.478.1752 Fax: 412.963.0148 claims@providentclaims.com

9. Date flast Salary/Wage Increase       Work Schedule at time lat worked:       Daye/Week       Hours/Day       Hours/Day         10. date flast Salary/Wage Increase       Work Schedule at time lat worked:       Daye/Week       Hours/Daye         Date plat flinuogit:       Fri       Salary/Continuation       Vaccued Sick Pay       Hours/Daye         10. has claimant tretured to work?       Work Schedule at time last worked:       Path Entry       Path Entry       Hours/Daye         11. Does the claimant have an ownership interest in this business?       Schedule at time last worked:       Path Entry       Path Entry       Hours/Daye         12. If this is a Flexible Benefits Plan, indicate which option of coverage this claimant has chosen.       Previous Plan's Vac- Date of Open Enrollment:       Option         13. Prior LTD Carrier Name       If yes, woekly or monthly amount       Weekly Monthy       When do benefits begin?       When do benefits egin?       When do benefits egin?         State Disability       S       S       Image: Schedule at time task worked:       Image: Schedule at time task worked:       Image: Schedule at time task worked:         State Disability Benefits       S       Image: Schedule at time task worked:       Image: Schedule at time task worked:       Image: Schedule at time task worked:         State Disability Benefits       S       Image: Schedule at time task worked:       Image: Sc	EMPLO	DYI	MEN	T ST	ATE	ME	ENT	(continued	)									
Date paid through:       For:       Salary Continuation       Vacation Pay       Accrued Sick Pay       Other         10. has claimant returned to work?       VS       No       If yes, date:       Image: Salary Time       Hours Per Week         11. Does the claimant have an ownership interest in this business?       Yes       No.       If yes, what he % of ownership?       %         12. If this is a Flexible Benefits Plan, indicate which option of coverage this claimant has chosen.       Provious Plan Year - Date of Open Enrollment:       Option         13. Prior LTD Carrier Name       Effective Date       Effective Date       Address (Street, City, State, Zip)       Termination Date         14. Is claimant eligible for:       Yes       No       monthly amount       Weeky. Monthly       When do benefits begin?       When do benefits end?         Salary Continuation       \$       \$       Image: State Disability       \$       Image: State Disability       S       Image: State Disability       I	9. Date o	9. Date of last Salary/Wage Increase Work Schedule at time last worked: Days/Week Hours/Day Hours/Wee								Hours/Week								
10. Has claimant returned to work?       Yes       No       If yes, date:       Pull Time       Part Time       Hours Per Week         11. Does the claimant have an ownership interest in this busines?       Yes       No       If yes, what is the % of ownership?       %         Type of business entity?       Regular Corporation       Partnership       Sole Proprietorship       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         13. Frich TLD Carrier Name       Effective Date       Effective Date         Address (Street, City, State, Zip)       Termination Date       If yes, weekly or monthly amount       Weekly Monthly       When do benefits begin?       When do benefits end?         Salary Continuation       \$       If yes, weekly or monthly amount       Weekly Monthly       When do benefits begin?       When do benefits end?         Salary Continuation       \$       If yes, weekly or monthly amount       Weekly Monthly       When do benefits begin?       When do benefits end?         Salary Continuation       \$       If yes, weekly or monthly amount       Weekly       Weekly       Ferrotinuation       Sole Sole Sole Sole Sole Sole Sole Sole	Check off	regu	ılar wo	ork day	rs: 🗆 Su	In		Mon 🗌 Tu	es 🗆 Wed 🗆	Thurs	🗆 Fri 🛛	Sat.	Numb	oer of	hours on date	last worked:		
11. Does the claimant have an ownership interest in this busines?       Yes       No       If yes, what is the % of ownership?       %         Type of business entity?       Regular Corporation       Partnership       Sole Proprietorship         12. If this is a Rebib Benefits Plen, indicate which option of coverage this claimant has chosen.       Option       Current Plan Year - Date of Open Enrollment:       Option         13. Prior LTD Carrier Name       Effective Date       Effective Date       Address (Street, City, State, Zip)       Termination Date         14. Is claimant eligible for:       Yes No       Mo mothly amount       Weekly Monthly       When do benefits begin?       When do benefits end?         State Disability       \$	Date paid	thro	ugh:					F	or: 🗌 Salary C	Continuatio	on 🗆 V	acatior	n Pay	🗆 Ac	crued Sick Pay	/ 🗌 Other		
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. Effective Date   Previous Plan Vear - 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 monthly amount Weekly Monthly   When do benefits begin? When do benefits end?   Satar Disability Scottinuation   \$ \$	<b>10.</b> Has o	claim	ant re	turned	to work	?	ΠY	′es 🗌 No	If yes, date:					🗆 Fi	ull Time 🛛 P	art Time		Hours Per Week
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)     It yes, weekly or monthly amount     Weekly Monthly     Salary Continuation     \$     State Disability     \$     Other Disability Benefits     \$     Other Disability     \$     Social Security     \$     Other Disability Benefits     \$     Other Disability     \$     Other Disability     \$     Social Security     \$     Other Disability Benefits     \$     Other Disability Benefits     \$     Social Security     If ly es, Name and Address of Carrier        Health Insurance   If New York DBL or New denset of Lipease shortid a copy of d																%		
Address (Street, City, State, Zip)       Termination Date         14. Is claimant eligible for:       Yes No       monthly amount       Weekly Monthly       When do benefits begin?       When do benefits end?         State Disability       S       Image: State Disability Benefits       Image: State Disability Benefits       Image: State Disability State Disabilit														Date o	of Open Enrollr	nent:	C	Option
If yes, weekly or monthly amount       Weekly Monthly       When do benefits begin?       When do benefits end?         Salary Continuation       \$	<b>13.</b> Prior LTD Carrier Name     Effective Date																	
14. Is claimant eligible for:       Yes       No       monthly amount       Weekly       Wonthly       When do benefits begin?       When do benefits end?         Salary Continuation       S       S       S       S       S       S       S         State Disability       S	Address (Street, City, State, Zip)										Termination Date							
State Disability          \$         Other Disability Benefits          \$         Other Disability Benefits          \$         Other Disability Benefits          \$         Social Security          \$         Is the claim the result of a work related injury or sickness?         Yes         Is the deaim the result of a work related injury or sickness?       Yes         Is ohas Workers' Compensation          fl yes, Name and Address of Carrier         Health Insurance          fl yes, Name and Address of Carrier         Health Insurance          fl 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.         Is the Kending       Week Ending         Week Ending       Week Ending         Mo.       Day       Yr.         No.       Days Worked       Amount         1          4          4         2          6          1         3          1          7         4          1          1         3          1          1         4          1          1         4          1          1	14. Is cla	imar	nt eligit	ole for:	Ye	S	No				Monthly	,	When do benefits begin?			When do benefits end?		
Other Disability Benefits       \$	Salary Co	ontinu	uation			]		\$										
Social Security       \$	State Disa	ability	y			]		\$										
Worker's Compensation       \$	Other Dis	abilit	y Bene	efits		]		\$										
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, 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. 15. If New York DBL or New Jersey TDB applies, complete this question. 15. If New York DBL or New Jersey TDB applies, complete this question. 16. Information about your pension plan (Please send copy of Plan Summary) (Do not complete for maternity claim) Do you have a pension plan?   If yes, what type? Yes No	Social Se	curit	y			]		\$										
If so has Workers' Compensation       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         1       6           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?       If yes, what type?              Yes       No       Defined benefit       Defined contribution       401(k)/403(b)       Profit Sharing       Other: (specify)	Worker's	Com	pensa	tion		]		\$										
claim been filed?       If yes, Name and Address of Carrier         Health Insurance       If yes, Name and Address of Carrier         Life Insurance       If yes, Name and Address of Carrier         Life Insurance       If yes, please provide the amount of coverage: \$         ft 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.         Week Ending         Week Ending         Mo.       Day         Mo.       Day         Yr.       No. Days Worked         Amount       Mo.         Day       Yr.         No.       Day Worked         Amount       Mo.         Day       Yr.         No.       Days Worked         Amount       Mo.         Day       Yr.         No.       Days Worked         Amount       Mo.         Days       Yr.         No.       Days Worked         Amount       Mo.         Days       Yr.         No       Days Worked         Amount       Mo.         Days       Yr.         No       Days Worked	Is the clai	m th	e resu	lt of a v	work rela	ate	ed inj	ury or sickne	ess? 🗆 Yes 🛛	🗌 No								
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				npensa			_											
Life Insurance I f yes, please provide the amount of coverage: \$ If Workers' Compensation claim has been denied, please submit a copy of denial with this claim.  I5. If New York DBL or New Jersey TDB applies, complete this question.  Earnings 8 weeks prior to disability  Week Ending  Mo. Day Yr. No. Days Worked Amount Mo. Day Yr. No. Days Worked Amount  Mo. Day Yr. No. Days Worked Amount Mo. Day Yr. No. Days Worked Amount  Mo. Day Yr. No. Days Worked Amount Mo. Day Yr. No. Days Worked Amount  I																		
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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																		
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 <td></td> <td></td> <td>· ·</td> <td></td> <td></td> <td></td> <td></td> <td>,</td> <td>•</td> <td>.,</td> <td>f denial</td> <td>with th</td> <td>is claii</td> <td>m.</td> <td></td> <td></td> <td></td> <td></td>			· ·					,	•	.,	f denial	with th	is claii	m.				
Week Ending       Week Ending         Mo.       Day       Yr.       No. Days Worked       Amount       Mo.       Day       Yr.       No. Days Worked       Amount         1       5       5       5       5       5       5       5       5         2       6       7	15. If Ne	w Yo	rk DB	L or N	ew Jers	sey	עו /	B applies, c	· · ·									
Mo.       Day       Yr.       No. Days Worked       Amount       Mo.       Day       Yr.       No. Days Worked       Amount         1       5									Earni	ngs 8 wee	eks prior							
1       5       5         2       6       6         3       7       6         4       8       6         5       6         6       6         7       6         6       6         7       6         6       6         7       6         7       6         1       6         1       7         1       6         1       7         1       8         1       1      <			Na	No. Davia Warked			Arrent					,	No. Dave Worked			Arran		
2       6       6       6       6       6       6       6       6       6       6       6       6       6       6       6       7		10.	Day	۲ſ.	INO	о. D	Jays	worked	Amou	uni	5	IVIO.	Day	ŤĨ.	NO. Day	s worked		Amount
3       7       7       1       1         4       8       8       1       1         16. Information about your pension plan (Please send copy of Plan Summary) (Do not complete for maternity claim)       1         Do you have a pension plan?       If yes, what type?       1         Yes       No       Defined benefit       Defined contribution       401(k)/403(b)       Profit Sharing       Other: (specify)         Is claimant eligible for your pension plan?       If eligible, does the claimant participate?       What % does claimant contribute?         Yes       No       Yes       No       No       Yes       No																		
4       8       8       10         16. Information about your pension plan (Please send copy of Plan Summary) (Do not complete for maternity claim)         Do you have a pension plan?       If yes, what type?         Yes       No         Is claimant eligible for your pension plan?       If eligible, does the claimant participate?         Yes       No											-							
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Is claimant eligible for your pension plan?       If eligible, does the claimant participate?       What % does claimant contribute?         Yes       No       Yes       No	Do you ha	ave a	a pensi	-	n?	lf y	/es, v	what type?								her: (specifv)		
	Is claimant eligible for your pension plan? If eligible, does the claimant participate? What % does claimant contribute?																	
				ticipati	ng, whe	n is	s he			inder the j	olan?							

#### 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