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.

Important Notice Regarding Fraud

- ***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.

GROUP CRITICAL ILLNESS CLAIM FORM

IMPORTANT INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

To expedite claim processing, the attached claim forms need to be fully completed and the following instructions must be adhered to. Each claim will be evaluated based on the terms and conditions of the insurance policy. The Insurance Company reserves the right to request additional information and/or documents to help us make this evaluation. The acceptance of these forms by the Insurance Company is not an admission of coverage under an insurance policy.

Section 1
This section must be completed in its entirety, specifying the applicable illness.

Section 2
This section is to be completed, in its entirety, by an authorized officer, member of the Fire Department, Rescue or Ambulance Squad or an official of the Named Insured.
.
Section 3 – Attending Physician's Dismemberment Form
This section is to be completed, in it's entirety by the attending physician treating the Critical Illness for which benefits are being requested.

Section 4 – Authorizations
This section requires the signature of the applicant or legal Guardian, Power of Attorney Designee, Conservator, Beneficiary, or personal representative, if the applicant is unable to sign. If someone other than the applicant signs, the legal documents permitting this should be included.

GROUP CRITICAL ILLNESS CLAIM FORM

Provident Claims Services, Inc. - PO Box 38295, Pittsburgh, PA 15238-8295
Business Hours: 8:30 AM to 5 PM
Toll-Free: 800.478.1752
Fax: 412.963.0148
claims@providentclaims.com
www.providentclaims.com

BOTH SECTIONS 1 & 2 MUST BE COMPLETED

SECTION 1

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 rostered active member with the Policyholder? ☐ Yes ☐ No

What is your illness? ☐ Heart Attack ☐ Invasive Cancer ☐ In Situ Cancer ☐ Kidney/Renal Failure ☐ Stroke

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

_____

_____

Date when illness was diagnosed: _____ Date when physician was first consulted for this illness: _____

Is this the first diagnosis for this illness? ☐ Yes ☐ No

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

_____

Provide names, addresses and phone numbers for all attending physicians: _____

_____

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Claimant Signature _____ **Date** _____

SECTION 2

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 rostered member of your organization on the date of diagnosis?				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

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.

PROVIDENT | CLAIMS SERVICES

GROUP CRITICAL ILLNESS CLAIM FORM

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Business Hours: 8:30 AM to 5 PM
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Fax: 412.963.0148
claims@providentclaims.com
www.providentclaims.com

SECTION 3 - ATTENDING PHYSICIAN'S STATEMENT

Patient's Name (first, middle initial, last name)	Patient's Date of Birth	Patient's Address (street, city, state, ZIP code)
Patient's sex ☐ Male ☐ Female	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child	
Date of Diagnosis:	Date first consulted you for this condition:	Has this patient previously had same or similar! condition: ☐ Yes ☐ No If yes, show first treatment date(s) 1. 2.
Name of referring or other treating physicians	For services related to hospitalization, provide hospitalization dates Admit: Discharge:	
Name and address of facility where services rendered (if other than home or office)		
Diagnosis or nature of illness:		
Physician Signature:	**Date:**	

Please check the condition that applies to this patient and provide a complete copy of the patient's medical records.

☐ Heart Attack	☐ Invasive Cancer	☐ In-Situ Cancer
☐ Kidney/Renal Failure	☐ Stroke	

BOTH SECTIONS 3 & 4 MUST BE COMPLETED

SECTION 4 - AUTHORIZATIONS

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to ***AXIS Insurance Company*** or its designated administrator**.** A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse ***AXIS Insurance Company*** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud (See Fraud Warning Important Notice sheet attached).

SIGNATURE _____ **DATE** _____

If applicable, I signed on behalf of the insured as_____(indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

SIGNATURE _____ **DATE** _____