



# 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.



## **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 its 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

**SECTION 1**

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		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 MUST BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE OF THE FIRE DEPARTMENT OR MUNICIPALITY. The individual completing this section must be an official of the Named Insured and may not be the claimant or a member of the claimant's immediate family.**

<input type="checkbox"/> Yes <input type="checkbox"/> 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		Telephone Number
Is the claimant a <input type="checkbox"/> Volunteer <input type="checkbox"/> Career <input type="checkbox"/> 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.

\*\*\*BOTH SECTIONS 1 & 2 MUST BE COMPLETED\*\*\*





## ACH Direct Deposit Authorization Form

**Authorization Agreement (ACH Direct Deposit Only).** By signing below, I (the "Receiver") authorize Provident Claims Services, Inc. (PCS) (the "Originator") to initiate Automated Clearing House (ACH) credit entries (direct deposits) to the deposit account identified below (the "Account"). This authorization is limited to the direct deposit of claim payment proceeds and any permissible correcting entries related to those deposits.

**ACH CREDITS ONLY ACKNOWLEDGMENT.** By checking this box, I acknowledge and agree that this authorization permits PCS to initiate ACH credit entries (direct deposits) ONLY. No ACH debit entries will be initiated to my account under this authorization.

This form is to be used for PCS direct deposit of funds only.

Request Type:	<input type="checkbox"/> New Authorization	<input type="checkbox"/> Change Existing	<input type="checkbox"/> Discontinue Service
Receiver SS# or FEIN #:	Receiver Name:		
Start Date:	Receiver Phone Number:		
On behalf of (claimant, minor, etc.)	Receiver Email Address:		

**No Liability for Bank Delays/Incorrect Information.** I understand the Originator is not responsible for delays or losses caused by incorrect or incomplete information I provide, actions or errors by my financial institution, or events outside the Originator's reasonable control.

**Compliance and Dispute Cooperation.** Entries initiated under this authorization will comply with the Nacha Operating Rules and applicable U.S. law. I certify that I am an authorized signer or owner of the Account and authorize my financial institution to provide information needed to resolve any entry, return, or notice of change related to this authorization.

**Revocation/Changes.** This authorization will remain in effect until the Originator receives my written notice to change or revoke it. Any change or revocation request must be received at least five (5) banking days before the next scheduled deposit date to allow a reasonable opportunity to act.

**Notice of Issues.** I will promptly review my Account activity and notify PCS if a direct deposit has not been received or if an amount is incorrect. To the extent permitted by law and the Nacha Rules, claims relating to an unauthorized or erroneous entry are subject to applicable reporting timeframes.

**Correction, Reversal, and Adjustments for Errors.** If an entry is made in error (including an incorrect amount, duplicate entry, wrong account, or wrong effective date), I authorize the Originator to initiate a correcting entry or reversal as permitted by the Nacha Operating Rules and applicable law. The Originator will make reasonable efforts to notify me of any reversal and the reason for it as required by the Nacha Rules.

**Account Verification and Receipt of Entries.** I authorize the Originator and its financial institution to verify my Account information, including by initiating one or more prenotification (zero-dollar)



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**entries or other commercially reasonable verification methods, and to deposit funds to the Account in accordance with this authorization.**

ACH Direct Deposit Authorization Instructions:

1. Please complete and submit this form to the Provident Claims Services, Inc.: PO Box 38295, Pittsburgh, PA 15238 | Email: claims@providentclaims.com | Phone: (412) 909-4991 | Fax: (412) 963-0148

2. Please attach a voided check for the account into which funds will be deposited or obtain the account and routing numbers directly from your financial institution.

3. Select New Authorization, Change Existing, or Discontinue Service, as applicable.

### Primary Account Information

Name of Financial Institution:		
	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account Category: <input type="checkbox"/> Personal <input type="checkbox"/> Commercial
Routing Number:		
Account Number:		

**Privacy and Data Use Notice.** PCS will use the banking and personal information provided on this form solely for the purpose of initiating and administering ACH direct deposit transactions and for related operational, legal, and compliance purposes. Such information will be maintained and safeguarded in accordance with applicable federal and state privacy and data security laws, including the Gramm-Leach-Bliley Act (GLBA), and will not be disclosed to third parties except as necessary to process ACH transactions, comply with law, or as otherwise permitted by applicable regulations.

### Signature

Authorized Signature (Primary):	Date:
Authorized Signature (Joint):	Date:

Please attach a voided check and return this completed form in its entirety to the PCS.