

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.

How to File a Medical Claim
(For Special Risks and Participant Accident Insurance Policies)
Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

Provident Claims Services, Inc.
P.O. Box 38295, Pittsburgh, PA 15238
Phone: 412.909.4991 | Fax: 412.963.0148
Email: claims@providentclaims.com
www.providentclaims.com

Step 1: The Participating Organization (NOT the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Statement.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

Step 2: The Parent/Guardian or Adult Claimant Should:

- Fully answer each item in Part II, including the claimant's personal information, parent's information, along with other insurance information.
- In order to ensure we receive complete claim information, we require providers to submit standardized itemized bills (called "UB04" for hospital charges and/or a "CMS-1500" for physician charges).
- Providers may bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs). **We are Primary over State provided Insurance (i.e. all Medicaid programs) and Non-active Duty TRICARE.**
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment, or zero balance information) claim payment is sent directly to the medical providers.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Helpful information for submitting claims

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will be sent back to injured party, to complete missing information.
- The acceptance of a claim form by an insurance company is not an admission of coverage.
- Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss or as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Step 3: Submit the Completed Notice of Claim (Claim Form) via email, mail, or fax.

PART I - PARTICIPATING ORGANIZATION STATEMENT

Policy Number:		Organization Name:		Event, Activity, or Sport:	
Claimant's Name (Injured Person)		The Injured Person Was A: Participant Staff Member Other		Date and Time Of Accident:	
Place Where Accident Occurred:		Type of Injury: (Indicate Part Of Body Injured - e.g. broken arm, etc.)			
Describe How Accident Occurred - Provide All Possible Details:					
Dental Claims	Indicate Which Teeth Were Involved:	Describe Condition of Injured Teeth Prior To Accident: Whole, Sound & Natural Filled Capped Artificial			
Did Accident (Check Yes or No for Each of The Following):					
A. During A Participating Organization Sponsored & Supervised, or Sanctioned Activity?		YES	No		
B. On Activity Premises:		YES	No		
C. While Traveling Directly and Uninterruptedly to Or from the Activity?		YES	No		
D. During A Participating Organization Practice or Competition?		YES	No		
E. Did Injury Result in Death:		YES	No		
Signature of Participating Organization Representative:		Name & Title of Participating Organization Representative:		Date:	

PART II - PARENT, RESPONSIBLE PARTY, OR GUARDIAN STATEMENT

Parent/Guardian Full Name:		Email Address:			
Address (in which information should be mailed to):					
Best Contact Phone Number:		Social Security Number (Of Injured):		Date of Birth (Of Injured):	
		M F			
Do you/spouse/parent have medical/health care, or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer, or other source? YES No					
If yes, name of insurance company:				Policy #:	
Are you eligible to receive benefits under any governmental plan or program, including Medicare?				YES No	
If yes, please explain:					

PART III - AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements. If not signed, provide proof of payment.

SIGNATURE: _____ **DATE:** _____

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 subjected to prosecution for insurance fraud.

SIGNATURE: _____ **DATE:** _____

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)

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.