GENERAL INSURANCE AGENCY, INC.

"Insurance for Volunteers"

www.GIA911.com

Toll Free: (800) 882-0801 | Fax: (888) 973-7891

Hello,

In an effort to help expedite the filing of your claim we ask that you also submit to us as quickly as possible the following items in addition to the completed Provident FNOC form:

- preinjury wage verification (either a W-2 from the prior year or the most recent paystub issued prior to their injury or illness date that includes a gross year to date earnings) for all jobs he or she had prior to the claim
- workers compensation determination related to payment responsibilities (we understand that this might take longer to receive)
- out of work slip from their treating doctor that includes objective restrictions and limitations that prevent him or her from returning to their pre-injury occupation

Also, depending on the duration of his or her disability, the claim staff will determine if the following forms are applicable and will present them to the claimant with the claim initiation letter. These include:

- Attending Physician Statement (APS)
- Claimant Statement (CS)
- Additional HIPAA-Compliant Authorizations
- Loss of Earnings Verification (LOE)

Please make sure the Provident FNOC claim form has been filled out as best as you can and make sure to complete the bottom of page 2 with an authorized fire company officer name and signature.

If you have any questions you can always contact Wes at 215-317-8414 or email: wes@generalinsuranceinc.com or Kevin at 484-239-5572 or email: kevin@gia911.com

Thank you

PROVIDENT
Insuring America's Heroes Since 1928

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 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, Virginia 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 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 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 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:*** 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 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.

Print Form Reset Form

FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
272 ALPHA DRIVE - P.O. BOX 11588
PITTSBURGH, PA 15238
TOLL-FREE: 800-447-0360
PHONE: 412-963-1200
CLAIMS DEPT FAX: 412-963-0148
www.providentbenefits.com

BOTH SECTIONS MUST BE COMPLETED

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 ( )
Please enclose pre-injury pay stub or the prior years W2 or Schedule C (if self-employed).		Wages/Earnings Hourly: Weekly:	Date of Hire (Full Time Occupation) / /
Time of Accident ☐ AM ☐ PM	Date of Accident / /	Place of Accident	Date Last Worked / /
What is your injury or illness?		How did it happen?	
Name and Address of Treating Physician		Name and Address of Hospital	
Did you lose any Time from Work? ☐ Yes ☐ No ☐ Unknown at this time		Did you file with Workers' Compensation? ☐ Yes ☐ No	
I was totally disabled from / / to / /			
I was partially disabled from / / to / /			
Date you have or are expected to return to work / /			

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Accident Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant Signature _____

THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY.

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

To be complete by an official of the Named Insured (must be someone other than the claimant or claimant's family member).

☐ Yes ☐ No – Claimant was a member of your organization at the time of injury or illness ☐ Yes ☐ No – Claimant was engaged in an authorized activity at the time of injury or illness		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 ☐ Auxiliary ☐ Other		

See Fraud Warning Important Notice sheet attached.

Print Form Reset Form

Print Form Reset Form

PROVIDENT
Insuring America's Heroes Since 1928

Provident Agency, Inc. - Main Office: PO Box 11588 - 272 Alpha Drive
Pittsburgh, PA 15238-0588
Toll-Free: 800-447-0360 Fax: 412-963-0148

NOTE: This authorization allows the _____ to release all information pertaining to an injury that occurred on or about _____ to Provident Agency, Inc. You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits including Social Security benefits, to disclose any and all of this information to persons who administer claims for Provident. Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Provident obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Provident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above. I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____
(Claimant Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I signed on behalf of the claimant as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Print Form Reset Form

PROVIDENT

DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)
Provident Agency, Inc.; 272 Alpha Drive; P.O. Box 11588
Pittsburgh, PA 15238
Phone: 800.447.0360 Fax: 412.963-0148

Authorization for Release of Protected Health Information

You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

I authorize _____ to release infromation from the record of:
Name of Facility/Person

_____ / / _____ _____ to
Patient Name | Birth Date | SS # / MR #

Provident Agency, Inc. | (412) 963-1200 | (412) 963-0148
Name of Facility/Person | Phone | Fax

272 Alpha Drive, PO Box 11588, Pittsburgh, PA 15238
Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION): Insurance Benefits

Parts 1 and 2 must be completed to properly identify the records to be released:

1. Type of records to be released and approximate date(s) of service (check all that apply):
☐ Inpatient ☐ Emergency Department Dates: _____ to _____
☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☑ Mental Health Information ☑ Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):

☑ Consults	☑ Medical History & Physical Exam	☐ Physican Orders
☑ Discharge Summary/Instructions	☐ Medication Records	☐ Progress Notes
☐ Laboratory Reports/Tests	☑ Operative Report	☐ Psychiatric/Psychological Eval
☐ Mammography Reports	☐ Pathology Report	☑ Radiology Report
☑ Emergency Dept. Reports	☑ EKG Report (s)	

☐ Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authrorization unless otherwise indicated. ☐ Do not release

I understand that this Authorization is valid for a period of two (2) years from the date of the signature, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the orginal. I understand that I am entitled to receive a copy of this authorization. I understand that once this information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information.

Date of Signature _____ Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

Date of Signature _____ Signature of Authorized Representative ☐ N/A

☐ Parent or Legal Guardian ☐ Power of Attorney
☐ Next of Kin of Deceased ☐ Executor of Estate

Please provide supporting documentation

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date _____ Witness # 1 _____ Date _____ Witness # 2 _____