



FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
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 TOLL-FREE: 800-447-0360
 PHONE: 412-963-1200
 FAX: 412-963-0415
www.providentbenefits.com

Benefits for Emergency Service Organizations since 1928

Name		Date of Birth / /		Social Security Number	
Address				Home Phone Number ()	
What is your regular occupation?			Employed By (Name of Company)		
Employer's Address				Employer's Phone Number ()	
Please enclose pay stubs or prior year Schedule Cs (self-employed).		Wages/Earnings: Hourly: Weekly:		Date Last Worked / /	
Time of Accident AM PM	Date of Accident / /		Place of Accident		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown at this time		Did you file with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I was totally 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 _____ 20 _____ Signed _____
 (Claimant)

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No – Claimant was a member of your organization at the time of injury or illness	Policy Number
<input type="checkbox"/> Yes	<input type="checkbox"/> No – Claimant was engaged in an authorized activity at the time of injury or illness	
Name of Fire/Rescue/Ambulance Company/District or Relief Association		Your Municipality
Print Name and Title	Signed	Date / /
Address	State	Zip Code
		Telephone Number ()

A-31369 (2/02)

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.

White Copy-Provident Yellow Copy-Workers' Compensation Pink Copy-Department or Company

Underwritten by Provident Life and Accident Insurance Company
 1 Fountain Square, Chattanooga, TN 37402