PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

FIRST NOTICE OF CLAIM

272 ALPHA DRIVE
P.O. BOX 11588
PITTSBURGH, PA 15238

(412) 963-1200
800-447-0360
FAX: (412) 963-0415

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 ( )
Wages: Hourly: or Weekly:	Date Last Worked / /	
Time of Accident AM ☐ PM ☐ / Date of Accident / /	Place of Accident	
Describe injury or sickness and how it began.		
Name and Address of Treating Physician	Name and Address of Hospital	
Did you lose 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 expect 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 photocopy 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 OR RESCUE SQUAD

☐ Yes ☐ No—Claimant was member of your organization at time of injury
☐ Yes ☐ No—Claimant was engaged in an authorized activity at time of injury

Name of Fire/Rescue Company/Relief Association or Auxiliary			Your Municipality	
Print Name	Signed		Title	Date
Address	State	Zip Code	Telephone Number	

White Copy—Provident *Yellow Copy—Municipality/Worker's Compensation* *Pink Copy—Fire Department*

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