Provident Agency, Inc.
PO Box 11588
Pittsburgh, PA 15238-0588
Toll-free: 1-800-447-0360 Fax: 412-963-0148
Call Monday through Friday, 8:30 a.m. to 5 p.m. (ET)

Facility of Payment Affidavit

Instructions: The information provided on this form will help us identify the correct beneficiary(ies).

This affidavit may be completed by any of _____ surviving relatives or by the representative of _____ estate. Please complete all applicable sections, sign and date the form and have it notarized. Mail or fax the completed and notarized form to the address or fax number indicated above.

The term "Employee" refers to employees, members, and/or retirees.

Employee Name: Claim Number:

A. Information About the Employee's Estate

Has an estate been established? ☐ Yes ☐ No

If yes, who is the executor of the estate? _____

If known, what is the tax identification number of the estate? _____

If no, will an estate be established? ☐ Yes ☐ No

B. Information About the Employee's Spouse/Civil Union Partner/Domestic Partner –

If the employee did not have a spouse/civil union partner/domestic partner, move ahead to section C.

Please check one: ■ Spouse □ Civil Union Partner □ Domestic Partner

Name & Address	Social Security Number	Date of Birth

C. Information About All the Employee's Natural Children and Legally Adopted Children –

If there are more than four children, please provide the following information on a separate sheet of paper and include it with this form. If the employee did not have children, move ahead to section D on page 2.

Name & Address	Social Security Number	Date of Birth

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Employee Name: Claim Number:

Name and Address	Social Security Number	Date of Birth

If this section is completed, move ahead to section F on page 3.

D. Information About the Employee's Parents – If the employee's parents were not living at the time of the employee's death, please skip to section E.

Name & Address	Social Security Number	Date of Birth

If this section is completed, move ahead to section F on page 3.

E. Information About All the Employee's Siblings (Brothers & Sisters) – If there are more than three siblings, please provide the following information on a separate sheet of paper and include it with this form.

Name & Address	Social Security Number	Date of Birth

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Employee Name: Claim Number:

F. Signature of the Person Completing this Form

The above statements are true and complete to the best of my knowledge and belief. I understand that the completion of this form does not guarantee payment under the policy. I understand that if the claim is payable, benefits will be paid according to the beneficiary provision in the policy based on the information I have provided on this form.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

_____ _____
Signature Date

_____ _____
Printed Name Date of Birth

_____
Street Address / City / State / Zip

_____ _____
Relationship to Insured Telephone Number

G. Signature of Notary

County: _____ State: _____

Sworn and subscribed before me on _____
Date

X_____ _____
Signature of Notary Public Date Commission Expires