PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

PO Box 17323, Phoenix, AZ 85011-0323
Phone: (602) 255-5575 | **Fax**: (602) 296-2371
E-mail: cancerinsurance@psprs.com

INITIAL CLAIM FORM

PRINT Name of Member/Claimant	SSN	Date of Birth *(MM/DD/YYYY)*	☐ Male ☐ Female	☐ Single ☐ Married

Address: (City, State, Zip)		Phone:	
		Email:	

Have you previously claimed benefits for this condition?	☐ Yes OR ☐ No	If Yes, when:	

Name and address of Physicians who were consulted or are currently treating you for this condition:		
Name	**Address, City, State, & ZIP**	**Phone**
Name	**Address, City, State, & ZIP**	**Phone**
Name	**Address, City, State, & ZIP**	**Phone**

Beneficiary Designation		
Name	**Relationship**	**Address, City, State, & ZIP**
Name	**Relationship**	**Address, City, State, & ZIP**

WARNING AND NOTICE: Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines and/or imprisonment.
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 with the Department of Regulatory Agencies.
California: For your protection, California law requires the following to appear on this form: Any person who knowingly prevents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines or confinement in state prison.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
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 any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.
Authorization: I authorize my doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient, employee or deceased, including financial institutions, to give Public Safety Personnel Retirement System or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs. A photocopy of this form is as valid as the original. This form will be in force for one year from the date shown below. I may revoke it at any time for information not then obtained by writing to Public Safety Personnel Retirement System***. I certify that the foregoing statements and answers on this form are complete and true to the best of my knowledge***.

TO FILE A CLAIM, send ALL of the following REQUIRED documents to the PO Box stated above:

1. This **Initial Claim Form**
2. Submit an **Attending Physician Statement** for each Doctor/Physician that is currently treating you for your cancer, including medication list.
3. Attach **Pathology Report** confirming diagnosis.

REQUIRED Signature of Member	Date (MM/DD/YYYY)