



**CLAIM FOR DISABILITY BENEFITS**  
**P.O. Box 100158**  
**Columbia, SC 29202-3158**  
**Telephone: (800) 858-6843 Fax: (800) 447-2498**

**INSURED'S STATEMENT**

- Insured's full name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Street and No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Male  Female  Telephone Number \_\_\_\_\_
- Date sickness began or injury occurred \_\_\_\_\_ Date last worked \_\_\_\_\_
- Date of first treatment by a physician for present disability \_\_\_\_\_
- State nature of sickness or injury \_\_\_\_\_
- If injured, state how and where the injury occurred \_\_\_\_\_  
 \_\_\_\_\_ Did injury occur on duty? Yes  No
- From and to what dates were you continuously totally disabled and prevented from performing any work?  
 From \_\_\_\_\_ to \_\_\_\_\_
- Date you were first able to do any work? \_\_\_\_\_
- Has claim been filed or will claim be filed under any Worker's Compensation Act or similar law? Yes  No   
 Any person who knowingly and with intent to defraud any insurance company or other person files a 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, in Florida, a felony of the third degree.

I hereby authorize any hospital, physician, or surgeon to furnish the Provident Life and Accident Insurance Company any information desired.

Date \_\_\_\_\_ (Signed) \_\_\_\_\_ (Insured)

**ATTENDING PHYSICIAN'S STATEMENT**

- Patient's Name \_\_\_\_\_ Age \_\_\_\_\_
- Nature of sickness or injury (Describe complications if any) \_\_\_\_\_  
 \_\_\_\_\_ ICD 9 CODE NO. \_\_\_\_\_
  - Did this sickness or injury arise out of patient's employment? Yes  No   
 If "yes", explain \_\_\_\_\_
  - Is disability due to pregnancy? Yes  No  What is the expected delivery date or actual delivery date? \_\_\_\_\_  
 Type of delivery  cesarean  vaginal Please describe any complications \_\_\_\_\_
  - Nature of surgical or obstetrical procedure, if any, (describe fully). \_\_\_\_\_  
 \_\_\_\_\_  
 Date performed \_\_\_\_\_
  - Give dates of treatments:  
 Date of first office visit: \_\_\_\_\_ Date of last office visit: \_\_\_\_\_ Frequency of treatment: \_\_\_\_\_  
 Home \_\_\_\_\_  
 Hospital: Admission date: \_\_\_\_\_ time: \_\_\_\_\_ Discharge date: \_\_\_\_\_ time: \_\_\_\_\_
  - The patient has been continuously disabled (unable to work) from \_\_\_\_\_ through \_\_\_\_\_
  - Remarks: \_\_\_\_\_  
 \_\_\_\_\_

Date	Attending Physician's Signature	Telephone Number
		SSN or Employers ID No.
Street Address	City or Town	State Zip Code

**EMPLOYER'S STATEMENT**

- Insured's full name \_\_\_\_\_ Date of Birth \_\_\_\_\_
- Policy No. \_\_\_\_\_ Date Insured \_\_\_\_\_ Date Employed \_\_\_\_\_ SS No. \_\_\_\_\_
- Was Insured's premium paid when disability began or loss occurred? \_\_\_\_\_ To what date have premiums been paid? \_\_\_\_\_
- Has claim been filed or is it possible that claim will be filed under any Worker's Compensation Act or similar law? Yes  No
- Date insured \_\_\_\_\_ Occupation \_\_\_\_\_
- Date Insured last worked \_\_\_\_\_ A.M. P.M. Date resumed work \_\_\_\_\_ A.M. P.M.  
 Weekly Earnings \$ \_\_\_\_\_ Name of Company **Northern Arizona University - Human Resources**  
 Date \_\_\_\_\_ Address **P.O. Box 4113**  
 REMARKS: \_\_\_\_\_ City **Flagstaff** State **AZ** Zip Code **86011**  
 \_\_\_\_\_ Department \_\_\_\_\_  
 \_\_\_\_\_ (Signed) \_\_\_\_\_  
 \_\_\_\_\_ My position is \_\_\_\_\_