PROVIDENT AMERICAN
INSURANCE

ACCIDENT INJURY - EMPLOYER'S STATEMENT OF DISABILITY

Failure to complete this form in its entirety may result in a delay in processing this claim.

EMPLOYEE'S NAME:_____ **POLICY NUMBER:** _____

EMPLOYER'S STATEMENT OF DISABILITY - Please have employer complete if filing for disability.

EMPLOYER'S NAME | PHONE NUMBER | FAX NUMBER

EMPLOYER'S ADDRESS | CITY | STATE | ZIP

1. Date of hire: _____
2. What was the first date the employee was unable to perform his/her normal job duties?_____
3. Date returned (or expected to return) to full-time duty:_____
4. Is the person still employeed? ☐ Yes ☐ No If no, last day of employment: _____
5. Prior to this disability, number of hours worked per week: _____ Average monthly salary for the 12 monts prior to disability: $_____
6. Was this disability caused by an incident that occurred at the workplace? ☐ Yes ☐ No
7. Has employee returned to work? ☐ Yes ☐ No If yes, is employee working: ☐ Full-time ☐ Part-time ☐ Light duty
8. Date employee began light duty: _____

AUTHORIZED SIGNATURE | **PRINT NAME** | **TITLE** | **DATE**

Any person who knowling presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

MAIL TO
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