



PROVIDENT AMERICAN
I N S U R A N C E

SICKNESS - 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

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 employed? Yes No If no, last date of employment: _____
5. Prior to this disability, number of hours worked per week: _____ Average monthly salary for the 12 months prior to disability: \$ _____
6. Has employee returned to work? Yes No If yes, is employee working: Full-time Part-time Light duty
7. Date employee began light duty: _____

AUTHORIZED SIGNATURE

PRINT NAME

TITLE

DATE

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

MAIL TO
PROVIDENT AMERICAN INSURANCE COMPANY
10501 NORTH CENTRAL EXPRESSWAY, SUITE 200
Dallas, TX 75231
PHONE: 800.933.9456 OR 214.696.9091 FAX: 214.237.8664