



PROVIDENT AMERICAN INSURANCE

POLICYOWNER'S CONTINUANCE OF DISABILITY REPORT

Failure to complete this form in it's entirety may result in a delay in processing this claim.

Filing claim for: Continuance of Disability due to Accident Continuance of Disability due to Sickness

INSTRUCTIONS:

- Complete Policyholder information
- Your Physician should complete and sign "PHYSICIAN'S SUPPLEMENTARY STATEMENT"
- Your Employer should complete and sign "EMPLOYER'S SUPPLEMENTARY STATEMENT OF DISABILITY"

POLICYHOLDER INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL
 ADDRESS CITY ST ZIP CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS

SOCIAL SECURITY NUMBER BIRTHDATE PHONE NUMBER POLICY NUMBER
 Give dates physician treated you since your last report: _____
 What are your activities and how do you spend your time? _____

Describe any change in your condition: _____
 Have you resumed any of your regular job duties: YES NO Date you resumed work: _____

CLAIMANT SIGNATURE DATE
PHYSICIAN'S SUPPLEMENTARY STATEMENT - Must be completed by physician or member of physician's staff

PHYSICIAN'S NAME PHONE NUMBER FAX NUMBER
 ADDRESS CITY ST ZIP

PATIENT'S NAME POLICY NUMBER
 Diagnosis/ICD-9-CM code: _____
 Give dates of treatments (since last report) Office: _____ Diagnostic test: _____ Hospital: _____
 Describe any other diseases or infirmities affecting present condition: _____

Is patient able to perform his/her regular job duties? YES NO If yes, the patient may return to work Part time Full time
 If yes, what date do you expect the patient to be able to return to work? _____
 What specific job duties is the patient able to perform? _____
 If no, what date do you expect the patient to be able to return to work? _____

PHYSICIAN'S SIGNATURE PRINT PHYSICIAN'S NAME DATE
EMPLOYER'S SUPPLEMENTARY STATEMENT OF DISABILITY - Must be completed by employer

EMPLOYER'S NAME PHONE NUMBER FAX NUMBER
 ADDRESS CITY STATE ZIP

Date of hire: _____ First date of total disability: _____
 Is this person still employed? YES NO If NO, last date of employment: _____
 What are the job duties, job title or position of this employee? _____
 Is this a Worker's Compensation Case? YES NO If yes, date Worker's Compensation Benefits began _____
 Name and address of Worker's Compensation Company _____

I hereby certify that _____ did not perform any part of his/her normal job duties from _____
 through _____
 EMPLOYEE'S NAME

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
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