PROVIDENT AMERICAN
INSURANCE

SICKNESS CLAIM FORM

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

FILING CLAIM FOR: ☐ Sickness ☐ Sickness With Total Disability

INSTRUCTIONS:

1. Complete Policyholder/Patient Information on this page.
2. Be sure to sign your claim form at the bottom of this page.
3. **Please review and sign the attached "Authorization to Obtain Information" form.** Two copies are attached: return one copy to Provident American Insurance Company and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.
4. **If you are filing for disability**, have your doctor complete and sign the "Physician's Statement" and have your Employer complete and sign the "Employer's Statement of Disability".

ADDITIONAL NOTES:

1. Submit all bills related to this claim such as doctor, hospital (must include the number of days confined, if applicable), ambulance, follow-up visits, physical therapy, etc. All bills should be itemized and should include the diagnosis, services rendered, date of service and actual charges for the service.
2. **If filing for total disability benefits due to sickness only, do not file any medical bills.**
3. If filing for benefits due to cancer, a pathology report diagnosing cancer **must** accompany your claim. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made clinically instead of pathologically, please submit the clinical evidence that established the diagnosis of cancer.
4. Be sure to include your policy number on all documents.

POLICYHOLDER'S INFORMATION

POLICYHOLDER LAST NAME | FIRST NAME | MIDDLE INITAL

☐ CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS

ADDRESS | CITY | ST | ZIP

SOCIAL SECURITY NUMBER | BIRTHDATE | PHONE NUMBER | POLICY NUMBER

PATIENT'S INFORMATION

PATIENT LAST NAME | FIRST NAME | MIDDLE INITAL | SOCIAL SECURITY NUMBER | BIRTHDATE

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER **RELATIONSHIP:** ☐ SELF ☐ SPOUSE ☐ DEPENDENT - CHECK IF DEPENDENT IS FULL-TIME STUDENT ☐

Date Illness/Sickness began: ___/___/___ Date of first treatment: ___/___/___

Name and address of Physician: _____

Describe Illness/Sickness and any prior treatment for similar Illness/Sickness: _____

If you are filing for Total Disability Benefits, answer these additional questions.

1. What is your occupation? _____
2. What is your average monthly salary for the 12 months prior to becoming disabled? _____
3. Name and address of your Employer or if self employed, full business address _____
4. Describe in your own words your sickness or disability _____
5. What date were you first treated by a Physician for this sickness? ___/___/___
6. Name and address of any other treating Physicians: _____
7. Give the first date you did not work due to this sickness or disability: ___/___/___
8. What duties are you now unable to perform due to this sickness or disability? _____
9. What date were you first able to do any part of your work, supervisory or otherwise? ___/___/___
10. What date did your resume your regular job duties? ___/___/___

SIGNATURE (IF CLAIM IS FOR A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN) 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