



CLAIM FOR VWB ACCIDENT INSURANCE

Provident Life and Accident Insurance Company
The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158
Pacific Time Zone Toll-free: 1.877.851.7637 Fax: 1.877.851.7624
All Other Time Zones Toll-free: 1.800.858.6843 Fax: 1.800.447.2498

For use with policies issued by Provident Life and Accident Insurance Company

Please mail or fax this form to:

Chattanooga Benefits Center
P.O. Box 12030
Chattanooga, TN 37401-3030

Toll free: 800.633.7479 Fax: 423.755.3009 or 800.494.4516

This form must be completed by the Attending Physician, the Employee, and the Employer (if applicable), and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

The employee is responsible for completion of all portions of this form without expense to the Provident Life and Accident Insurance Company.

INSTRUCTIONS:

Accidental Injury – Complete Sections A & B, which request specific information from you about the circumstances of your injury, and send copies of your bills. Also complete Sections C & D if applicable to your accident.

Hospital Confinement, Intensive Care – (Accident/Sickness) Complete Sections A & C and send copies of your hospital bills.

Total Disability – (Accident/Sickness) Complete Section A and ask your Employer and Doctor to complete Section D.

Authorization: Sign and date this form. Provide a copy of the signed and dated form to your Attending Physician.

Please enclose any additional information that you feel will assist us in evaluating this claim.



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Please check the type of claim you are filing below:

- Accidental Injury – Complete Sections A & B, which requests specific information from you about the circumstances of your injury.
- Hospital Confinement, Intensive Care – Complete Section A and have your doctor complete Section C and send copies of your hospital bills.
- Total Disability – (Accident/Sickness) Complete Section A and ask your Employer and Doctor to complete Section D.

This claim is for: Self Spouse Dependent | Policy #

SECTION A. GENERAL INFORMATION

EMPLOYEE/POLICYHOLDER INFORMATION

Name of Employee/Policyholder

Social Security Number

Date of Birth

Address (Street, Apt. #, City, State, Zip)

Home Phone Number

Work Phone Number

Fax Number

Email Address

Employer Name and Address:

PATIENT INFORMATION

Name of Patient (if not self)

Male
 Female

Social Security Number

Date of Birth

Address (Street, Apt. #, City, State, Zip)

Home Phone Number

Work Phone Number

Fax Number

Email Address

Employer Name and Address:

INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL (please print)

Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).

Full name of Treating Doctor

Speciality

Mailing Address (Street, City, State, Zip)

Phone Number

Fax Number

Full Name of Primary Doctor

Speciality

Mailing Address (Street, City, State, Zip)

Phone Number

Fax Number

Full name of Referring Doctor/Hospital

Speciality

Mailing Address (Street, City, State, Zip)

Phone Number

Fax Number

CERTIFICATION

Policyholder/Employee's Name

Social Security Number

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct Social Security Number is shown on this form

Date

Patient Signature

Policyholder/Employee Signature



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PATIENT NAME	SOCIAL SECURITY NUMBER
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SECTION B. ACCIDENTAL INJURY

Please complete and attach itemized copies of any related bills including doctor, emergency room, hospital, and motor vehicle incident/accident report. Bills should include diagnosis information (from your medical provider). Additional medical information may be requested by Provident Life and Accident Insurance Company to process your claim.

Date of Accident	Time of Accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (choose one)
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Tell us how your accident happened: (If you need more space, you may attach on a separate piece of paper.)

Were you at work (working for wage or profit) at the time of your accident? Yes No

SECTION C. HOSPITAL CONFINEMENT, INTENSIVE CARE BENEFIT

Please send an itemized copy of your hospital bill which includes the diagnosis, admission and discharge dates. Have your doctor complete this section if your bills do not include the diagnosis information.

Diagnosis/ICD-9 Code

Dates of Inpatient Hospital Confinement: From _____ To _____

Dates of Confinement in Intensive Care, including Coronary Care Unit: From _____ To _____

Hospital	Phone Number
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Hospital Address

Date of Surgery Inpatient Outpatient (choose one)

Procedure/Procedure Code

Date of office visit following confinement or outpatient surgery

Signature of doctor	Date
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Name of doctor	Phone Number
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Specialty	Fax Number
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Address	Tax ID or SSN
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NOTE: Please make a copy of the patient's signed authorization to release information for your records.



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PATIENT NAME _____ SOCIAL SECURITY NUMBER _____

SECTION D. DISABILITY BENEFITS - EMPLOYER STATEMENT

To be completed and signed by your EMPLOYER.

Name of Employer _____ Phone Number _____ Fax Number _____

Employee's Job Title _____

Employee's Job Title Duties include:

Lifting	<input type="checkbox"/> less than 15 lbs.	<input type="checkbox"/> 15-44 lbs.	<input type="checkbox"/> over 45 lbs.
Stooping/Bending	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Crawling/Climbing/Kneeling	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Reaching/Pulling/Pushing	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Repetitive	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Management Duties	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent

Sitting (Number of hours each day) _____ Standing (Number of hours each day) _____

Dates this employee has been unable to work: From _____ am to _____ am
 pm pm

Date employee returned to light duty work _____

Date employee returned to full duty work _____

Has the employee's employment been terminated? Yes No If yes, please provide termination date: _____

Did the accident occur while working for wage/profit? Yes No

Name and Address of Worker's Compensation Carrier, if applicable: _____

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Name of Person Completing Form _____

Title of Person Completing Form _____

Signed (to be signed by your employer) _____ Title _____ Date _____



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PATIENT NAME _____ SOCIAL SECURITY NUMBER _____

SECTION D. DISABILITY BENEFITS - ATTENDING PHYSICIAN STATEMENT

To be completed and signed by the DOCTOR treating you for this disability.

Diagnosis/primary disability condition/ICD9 Code(s) _____

Is this condition the result of an accidental injury? Yes No If yes, please provide us with the date and description _____

Has this patient been treated for same/similar condition prior to this occurrence? Yes No

If so, list related diagnosis & dates of treatment _____

Date of Inpatient Hospital Confinement: From _____ To _____

Hospital Name _____

Hospital Address _____

List date of any surgeries performed and submit a copy of the operative report _____

How soon do you expect significant improvement in the patient's medical condition? # Weeks Months (choose one)

If due to complications of pregnancy prior to delivery, what is EDC? _____

Dates unable to work: Full Duty: From _____ To _____

Dates unable to work: Partial Duty: From _____ To _____

Anticipated return to work/release date _____ If undetermined, based on your medical knowledge,

what is a reasonable timeframe before you expect to be able to release this patient to return to work? _____

Dates of treatment _____

Is this patient considered to be house confined (unable to perform normal daily activities) or unable to perform two or more

activities of daily living? (If not working at time of accident or when disability begins.) Yes No

If so, date: From _____ To _____

(this information will be used in accordance with state regulations and policy provisions.)

Restrictions/Limitations _____

Is this patient permanent disabled? Yes No If yes, what is recommended frequency of treatment? _____

Does this patient have permanent restrictions/limitations? Yes No If so, please list _____

Name of Referring Doctor _____ Phone Number _____

Address _____

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Signature of Doctor _____ Date _____ Patient # _____

Name of Doctor _____ Phone Number _____ Fax Number _____

Specialty _____

Address _____

Email Address _____ Tax ID or SSN _____

Note: Please make a copy of the patient's signed authorization to release information for your records.



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CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, West Virginia, Wisconsin, Wyoming, and others require the following statement to appear:

Fraud Warning

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.

Fraud Warning for California Residents

For your protection California law requires the following to appear on this form. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.

Fraud Warning for Colorado Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning for District of Columbia Residents

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Fraud Warning for Florida Residents

Any Person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Warning for Georgia, Oregon, Texas and Virginia Residents

Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

Fraud Warning for Iowa Residents

Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.

Fraud Warning for Kentucky Residents

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, which is a crime.

Fraud Warning for Louisiana Residents

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning for Maine Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Minnesota Residents

A person who, submits an application, files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

Fraud Warning for New Mexico Residents

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Fraud Warning for New Jersey Residents

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning for New York Residents

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Fraud Warning for Pennsylvania Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, which is a crime and subjects such person to criminal and civil penalties.

Fraud Statement for Washington Residents

Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.



CLAIM FOR VWB ACCIDENT INSURANCE EMPLOYEE'S AUTHORIZATION

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FOR EMPLOYEE TO COMPLETE

NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

(Claimant Signature)

(Date Signed)

(Print Name)

(Social Security Number)

I signed on behalf of the claimant as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.