



VOLUNTARY WORKPLACE BENEFITS
SUPPLEMENTAL STATEMENT OF CLAIM FORM

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

SECTION 1 TO BE COMPLETED BY POLICYHOLDER

1. Policyholder name [Male/Female] If the address you are providing is new, please mark box with an "X."
2. Patient name
Address (Street) Claim Number (see payment letter) or Policy Number
City State Zip Code Social Security Number Birthdate (MM/DD/YYYY)
3. Home Telephone () Alternate Telephone ()
4. Have you worked for payment, profit, or other compensation during your claimed period of disability?
5. Estimated or Actual Return to Work Dates? Part Time Full Time
6. How does your injury or sickness prevent you from working?
7. Are you being treated by any other medical providers?
8. Describe your present activities:
9. Other than as described above, have there been any other changes in your daily activities or your condition since your last report?

POLICYHOLDER 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 (MM/DD/YYYY) PATIENT SIGNATURE POLICYHOLDER/EMPLOYEE SIGNATURE

SECTION 2 TO BE COMPLETED BY THE ATTENDING PHYSICIAN

10. What is this patient's current primary diagnosis? ICD9:
Symptoms:
Objective Findings:
11. Are there secondary conditions contributing to the disability? If yes, what are they and would the patient be disabled without regards to these secondary conditions?
12. List any tests or surgeries performed and submit a copy of the results and/or the operative reports..
13. Please list names of all medications that patient is currently taking.
14. Restrictions (What the patient SHOULD NOT do)
15. Limitations (What the patient CANNOT do)
16. How soon do you expect significant improvement in the patient's medical condition?
17. Estimated or Actual Return to Work Date (MM/DD/YYYY) Released with restrictions and limitations?
19. Frequency of treatment Date of Last Visit (MM/DD/YYYY) Dates (MM/DD/YYYY) of Hospitalization (Last 3 months)

PHYSICIAN CERTIFICATION

21. Signature of Physician or Supplier Date (MM/DD/YYYY) Address
Telephone Number () Fax Number ()