

Instructions: A Claim Report MUST be fully completed by the Attending Physician, Employer and the Insured at the end of each 30 day Period of Disability, or when the Insured resumes work, whichever occurs first. Return this FULLY completed, dated and signed report to: Provident American Insurance Company, 10501 North Central Expressway, Suite 200, Dallas, TX 75231.

TO BE COMPLETED BY THE INSURED:

Insured's full name: _____ Phone: _____

Address: _____

Date of Birth: _____ Height: _____ Weight: _____

1. Business or Occupation: _____

a. Describe duties fully: _____

b. Name of firm or employer: _____

c. Average weekly or monthly earnings: _____

2. Have you other Accident, Health or Disability Insurance paying weekly or monthly indemnity? _____

Names of Company or Companies and amount in each: _____

HISTORY OF PRESENT DISABILITY (Complete one column)

Table with 2 columns: SICKNESS and ACCIDENT. Rows include 3S, 4S, 5S, 3A, 4A, 5A, 6A.

7. Were you confined to a Hospital? _____ If "yes", name & address: _____

8. Date of 1st medical treatment: _____ Name of Physician: _____

Physician's Address: _____

9. Names & addresses of any other treating physicians: _____

10. How long were you disabled from performing the duties of your occupation? _____

a. TOTALLY disabled? _____ From: _____ through _____

b. On what dates were you first able to do any part of your work, supervisory or otherwise? _____

c. If still TOTALLY disabled, when do you expect to be able to resume some work? _____

EMPLOYER'S STATEMENT

Employee's Name: _____

Occupation at the time last worked? _____

On what date did Employee first cease work entirely from disability? _____

On what date did employee resume any part of his/her work, supervisory or otherwise? _____

Has employee ever missed work as a result of this condition, previously? Yes _____ No _____ If "yes", when? _____

Was Injury or disease covered under Workmen's Compensation? Yes _____ No _____

If "yes", give name, address and phone of your compensation carrier: _____

(If Workmen's Compensation claim has been denied, please submit a copy of the denial with this claim.)

Are you as the employer able to accommodate the employee's restrictions and limitations, if appropriate, for an early return to work? (i.e. job modification, part-time, etc.) Please elaborate: _____

Person completing this form (please print or type name and title): _____

Signature of Employer: _____ Date: _____

Phone Number () _____ Address _____

IMPORTANT INSURED: PLEASE DATE AND SIGN AUTHORIZATION ON OTHER SIDE!

ATTENDING PHYSICIAN'S STATEMENT

Please Answer All Questions—Give Dates Where Called For

Patient's Name: _____

Nature of sickness or injury (Describe complications, if any)

When did symptoms first appear or accident happen? _____, 20_____

Is condition due to injury or sickness arising out of patient's employment? If "yes" explain. Yes _____ No _____

When did patient first consult you for this condition? _____, 20_____

Has patient ever had same or similar condition? (If "Yes" state when and describe) Yes _____ No _____

Was patient referred to you by another physician? (If "Yes", please give referring physician(s) full name and address)

Nature of surgical or obstetrical procedure, if any. (Describe fully) Charge for this procedure and date performed:

Where performed: _____

Give dates of treatment: _____

Is patient still under your care for this condition? If discharged, give date: _____

If patient hospitalized, give name and address of hospital: _____

How long was/ will patient be continuously totally disabled (unable to perform any portion of his work)? _____

How long was or will patient be partially disabled? _____

Describe any specific limitations and restrictions:

Under what conditions can this patient return to work? _____

Please print Physician name: _____

Signature of Physician: _____ Date: _____

Address: _____

Telephone: _____ Fax: _____

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records of knowledge of me or my health to give Provident American Insurance Company of it's re-insures, any such information. A photocopy of this authorization is to be considered as valid as the original.

PATIENT'S SIGNATURE:

(Name) (Date)