



PROVIDENT AMERICAN
I N S U R A N C E

ACCIDENT INJURY - EMPLOYER'S STATEMENT OF DISABILITY

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

EMPLOYEE'S NAME: _____ **POLICY NUMBER:** _____

EMPLOYER'S STATEMENT OF DISABILITY - Please have employer complete if filing for disability.

EMPLOYER'S NAME

PHONE NUMBER

FAX NUMBER

EMPLOYER'S ADDRESS

CITY

STATE

ZIP

1. Date of hire: _____
2. What was the first date the employee was unable to perform his/her normal job duties? _____
3. Date returned (or expected to return) to full-time duty: _____
4. Is the person still employed? Yes No If no, last day of employment: _____
5. Prior to this disability, number of hours worked per week: _____ Average monthly salary for the 12 months prior to disability: \$_____
6. Was this disability caused by an incident that occurred at the workplace? Yes No
7. Has employee returned to work? Yes No If yes, is employee working: Full-time Part-time
 Light duty
8. Date employee began light duty: _____

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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