



PROVIDENT AMERICAN
I N S U R A N C E

PROOF OF DEATH PHYSICIAN'S STATEMENT

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

INSURED/DECEASED NAME: _____ **POLICY NUMBER:** _____

Residence at time of death: _____

Date of Death: _____ Place of Death: _____

What was the immediate cause of death? _____

How long did the deceased suffer from this condition? _____

Was the death due to suicide, homicide or an accident? YES NO

If death was due to an accident, please describe the accident: _____

What were the contributory causes of death?

Disease	Duration

How long did you know the deceased? _____ Date of last visit _____

Give particulars of each condition for which you treated or advised the deceased:

Nature of Condition	Date	Duration	Results

To your knowledge, was the insured hospitalized during the last year of life? YES NO

If yes:	Hospital's Name and Address	Reason	Dates

Please list the names and addresses of other physicians who attended the deceased during the past five years:

Name	Address	Condition

PHYSICIAN'S SIGNATURE

PRINT PHYSICIAN'S NAME

DATE

TAX ID NUMBER

PHYSICIAN'S ADDRESS

PHYSICIAN'S TELEPHONE NUMBER

PHYSICIAN'S FAX NUMBER

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
PHONE: 800.933.9456 OR 214.696.9091 FAX: 214.237.8664