PROVIDENT AMERICAN
INSURANCE

SICKNESS - 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

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 date of employment: ____________________
5. Prior to this disability, number of hours worked per week: _____________ Average monthly salary for the 12 months prior to disability: $__________
6. Has employee returned to work? ☐ Yes ☐ No If yes, is employee working: ☐ Full-time ☐ Part-time ☐ Light duty
7. 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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