CLAIM FOR DISABILITY BENEFITS
P.O. Box 100158
Columbia, SC 29202-3158
Telephone: (800) 858-6843 Fax: (800) 447-2498

INSURED'S STATEMENT

1. Insured's full name ______ Social Security No. ______
   Street and No. ______ City ______ State ______ Zip Code ______
   Birthdate ______ Male o Female o Telephone Number ______
2. Date sickness began or injury occurred ______ Date last worked ______
3. Date of first treatment by a physician for present disability ______
4. State nature of sickness or injury ______
5. If injured, state how and where the injury occurred ______
   ______ Did injury occur on duty? Yes o No o
6. From and to what dates were you continuously totally disabled and prevented from performing any work?
   From ______ to ______
7. Date you were first able to do any work? ______
8. Has claim been filed or will claim be filed under any Worker's Compensation Act or similar law? Yes o No o
   Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, in Florida, a felony of the third degree.

   I hereby authorize any hospital, physician, or surgeon to furnish the Provident Life and Accident Insurance Company any information desired.

Date ______ (Signed) ______
(Insured)

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name ______ Age ______
1. Nature of sickness or injury (Describe complications if any) ______
   ______ ICD 9 CODE NO. ______
2. Did this sickness or injury arise out of patient's employment? Yes o No o
   If "yes", explain ______
3. Is disability due to pregnancy? Yes o No o What is the expected delivery date or actual delivery date? ______
   Type of delivery o cesarean o vaginal Please describe any complications ______
4. Nature of surgical or obstetrical procedure, if any, (describe fully). ______
   ______
   ______
   Date performed ______
5. Give dates of treatments:
   Date of first office visit: ______ Date of last office visit: ______ Frequency of treatment: ______
   Home ______
   Hospital: Admission date: ______ time: ______ Discharge date: ______ time: ______
6. The patient has been continuously disabled (unable to work) from ______ through ______
7. Remarks: ______

Date	Attending Physician's Signature	Telephone Number SSN or Employers ID No.

Street Address	City or Town	State	Zip Code

EMPLOYER'S STATEMENT

1. Insured's full name ______ Date of Birth ______
2. Policy No. 498035 Claims Division 003 Date Insured ______ Date Employed ______ SS No. ______
3. Was Insured's premium paid when disability began or loss occurred? ______ To what date have premiums been paid? ______
4. Has claim been filed or is it possible that claim will be filed under any Worker's Compensation Act or similar law? Yes o No o
5. Date insured ______ Occupation ______
6. Date Insured last worked ______ A.M. P.M.
   Weekly Earnings $ ______
   Date ______
   REMARKS: ______

Date resumed work ______ A.M. P.M.
Name of Company Northern Arizona University
Address P.O. Box 4113
City Flagstaff State AZ Zip Code 86011-4113
Department ______
(Signed) ______
My position is ______

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