DISABILITY CLAIM – SUPPLEMENTAL SICKNESS BENEFIT PLAN
– IMPORTANT INSTRUCTIONS –

FOLLOW THESE DIRECTIONS FOR PROPER PROCESSING OF YOUR CLAIM.

1. **If you become disabled, immediately complete a "NOTICE OF DISABILITY" and mail to the address shown on the bottom of this form.**
2. **Fully complete PART A of this form.**
3. **Have your physician fully complete PART B of this form at the end of your disability, or at the end of each 30 day period of your disability, whichever comes first, and mail it to the address shown on the bottom of this form.**

PART A — EMPLOYEE'S STATEMENT

Name of Employee (Please Print)	Social Security No.	Employee Number	Birthdate (Mo. Da. Yr.)

Employee's Address (Number and Street)	Name of Employer	Occupation

(City) (State) (Zip)	List the dates for which you received vacation pay since your disability began. FROM TO

Have you returned to work?	If so, please provide the date

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 which is a crime, in Florida, a felony of the third degree.

The undersigned certifies that the information disclosed above is a correct declaration of facts upon which claim is based for benefits and further hereby acknowledges the limitations and provisions of the plan.

AUTHORIZATION

Solely to assist Provident Life and Accident Insurance Company in administering an insurance claim, I hereby authorize any provider of health care including but not limited to any institution, or person possessing information concerning:

_____

to permit the above named insurance company and its representative, insurance support organization, reinsurance companies or other persons performing business or legal services in connection with the claim, to view, copy, be furnished copies or be given details of all such physical or mental medical-record information including but not limited to drug, alcohol or psychiatric treatment or condition, as well as information regarding employment income, other insurance coverage, and/or any otherwise personal or privileged information, including but not limited to any other claim for insurance benefits, or any records concerning civil or criminal proceedings.

Any copy of the authorization shall have the same authority as the original.

I understand I, or my authorized representative, may receive a copy of this authorization upon request. This authorization is valid for the duration of the claim.

Signature _____ Date _____

PART B — ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent conditions
   (If diagnosis code other than ICDA* used, give name):

2. Dates of Treatment
   (If previous form submitted to this carrier, you need show only dates since last report)

3. Dates of Hospital Confinement
   Admitted Discharged

4. Frequency of Treatment

5. Is patient receiving physical therapy? ☐ Yes ☐ No If "Yes" indicate name and address of facility

6. Date symptoms first appeared or accident happened.

7. Date patient first consulted you for this condition.

8. Patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" when and describe

9. Patient still under your care for this condition? ☐ Yes ☐ No

10. Patient was continuously unable to perform the regular duties of his/her own occupation.
    From To

11. If still disabled, date patient should be able to return to work

Date Completed	Physician's Name (Print)	Signature	Degree	Taxpayer's Account No.
	X			

Street Address	City or Town	State or Province	Zip Code	Telephone No.

*ICDA – International Classification of Diseases

Approved by Council on Medical Service, AMA November 1964

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
Railroad Disability Claims
P. O. Box 180135
Chattanooga, TN 37401-7135
1-800-542-4231 • FAX (423) 755-7857

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