CLAIM FOR VB ACCIDENT INSURANCE
Provident Life and Accident Insurance Company
The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-635-5597   Fax: 1-800-447-2498

For use with policies issued by Provident Life and Accident Insurance Company

Please mail or fax this form to:
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-635-5597   Fax: 1-800-447-2498

This form must be completed by the Attending Physician and the Employee, and be returned promptly for consideration of benefits. When instructed below to complete Section E, it is important to note that Section E is optional. The employee may decide whether to ask the Employer to complete and submit Section E. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

The employee is responsible for completion of all portions of this form without expense to the Provident Life and Accident Insurance Company.

INSTRUCTIONS:

Accidental Injury – Complete Sections A & B, which request specific information from you about the circumstances of your injury, and send copies of your bills. Also complete Sections C, D and E if applicable to your accident.
~~**Hospital Confinement, Intensive Care** – (Accident/Sickness) Complete Sections A & C and send copies of your hospital bills.~~
~~**Total Disability** – (Accident/Sickness) Complete Section A and ask your Doctor to complete Section D and your Employer to complete Section E.~~

Authorization: Sign and date this form. Provide a copy of the signed and dated form to your Attending Physician.

Please enclose any additional information that you feel will assist us in evaluating this claim.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

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Please check the type of claim you are filing below:

☐ Accidental Injury – Complete Sections A & B, which requests specific information from you about the circumstances of your injury.
☐ Hospital Confinement, Intensive Care – Complete Section A and have your doctor complete Section C and send copies of your hospital bills.
☐ Total Disability – (Accident/Sickness) Complete Section A and ask your Doctor to complete Section D and your Employer to complete Section E.

This claim is for: ☐ Self ☐ Spouse ☐ Dependent | Policy #

SECTION A. GENERAL INFORMATION

EMPLOYEE/POLICYHOLDER INFORMATION

Name of Employee/Policyholder

Social Security Number	Date of Birth

Address (Street, Apt. #, City, State, Zip)

Home Phone Number	Work Phone Number
Fax Number	Email Address

Employer Name and Address

PATIENT INFORMATION

Name of Patient (if not self) | ☐ Male ☐ Female

Social Security Number	Date of Birth

Address (Street, Apt. #, City, State, Zip)

Home Phone Number	Work Phone Number
Fax Number	Email Address

Employer Name and Address

INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL (please print)

Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).

Full name of Treating Doctor	Speciality

Mailing Address (Street, City, State, Zip)

Phone Number	Fax Number

Full Name of Primary Doctor	Speciality

Mailing Address (Street, City, State, Zip)

Phone Number	Fax Number

Full name of Referring Doctor/Hospital	Speciality

Mailing Address (Street, City, State, Zip)

Phone Number	Fax Number

CERTIFICATION

Policyholder/Employee's Name	Social Security Number

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form

Date	Patient Signature	Policyholder/Employee Signature

VB-614 (06/08)

Your claim must be filed within 90 days of your date of loss.

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PATIENT NAME	SOCIAL SECURITY NUMBER

SECTION B. ACCIDENTAL INJURY

Please complete and attach itemized copies of any related bills including doctor, emergency room, hospital, and motor vehicle incident/accident report. Bills should include diagnosis information (from your medical provider). Additional medical information may be requested by Provident Life and Accident Insurance Company to process your claim.

Date of Accident	Time of Accident ☐ a.m. ☐ p.m. (choose one)

Tell us how your accident happened: (If you need more space, you may attach on a separate piece of paper.)

Were you at work (working for wage or profit) at the time of your accident? ☐ Yes ☐ No

~~SECTION C. HOSPITAL CONFINEMENT, INTENSIVE CARE BENEFIT~~

~~Please send an itemized copy of your hospital bill which includes the diagnosis, admission and discharge dates.~~
~~Have your doctor complete this section if your bills do not include the diagnosis information.~~

~~Diagnosis/ICD-9 Code~~

~~Dates of Inpatient Hospital Confinement: From~~ ~~To~~

~~Dates of Confinement in Intensive Care, including Coronary Care Unit: From~~ ~~To~~

~~Hospital~~	~~Phone Number~~

~~Hospital Address~~

~~Date of Surgery~~ ☐ ~~Inpatient~~ ☐ ~~Outpatient (choose one)~~

~~Procedure/Procedure Code~~

~~Date of office visit following confinement or outpatient surgery~~

~~Signature of doctor~~	~~Date~~
~~Name of doctor~~	~~Phone Number~~
~~Specialty~~	~~Fax Number~~
~~Address~~	~~Tax ID or SSN~~

~~NOTE: Please make a copy of the patient's signed authorization to release information for your records.~~

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PATIENT NAME	SOCIAL SECURITY NUMBER

SECTION D. DISABILITY BENEFITS – ATTENDING PHYSICIAN STATEMENT

To be completed and signed by the DOCTOR treating you for this disability.

Diagnosis/primary disability condition/ICD9 Code(s)

Is this condition the result of an accidental injury? ☐ Yes ☐ No If yes, please provide us with the date and description.

If related to a fracture or dislocation, please indicate: ☐ Open ☐ Closed ☐ Unknown

If related to a laceration, please indicate the length:

Is the patient's condition due to injury involving the patient's employment? ☐ Yes ☐ No ☐ Unknown

Has this patient been treated for same/similar condition prior to this occurrence? ☐ Yes ☐ No

If so, list related diagnosis & dates of treatment.

Date of Inpatient Hospital Confinement: From: To:

Hospital Name

Hospital Address

List date of any surgeries performed and submit a copy of the operative report.

How soon do you expect significant improvement in the patient's medical condition? # ☐ Weeks ☐ Months (choose one)

If due to complications of pregnancy prior to delivery, what is EDC?

Dates unable to work: Full Duty: From: To:

Dates unable to work: Partial Duty: From: To:

Anticipated return to work/release date: If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

Dates of treatment:

Is this patient considered to be house confined (unable to perform normal daily activities) or unable to perform two or more activities of daily living? (If not working at time of accident or when disability begins.) ☐ Yes ☐ No

If so, date: From: To:

(This information will be used in accordance with state regulations and policy provisions.)

Restrictions/Limitations

Is this patient permanently disabled? ☐ Yes ☐ No If yes, what is recommended frequency of treatment?

Does this patient have permanent restrictions/limitations? ☐ Yes ☐ No If so, please list.

Name of Referring Doctor	Phone Number
Address	

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Signature of Doctor	Date	Patient #
Name of Doctor	Phone Number	Fax Number
Specialty		
Address		
Email Address		Tax ID or SSN

Note: Please make a copy of the patient's signed authorization to release information for your records.

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PATIENT NAME	SOCIAL SECURITY NUMBER

~~SECTION E. DISABILITY BENEFITS – EMPLOYER STATEMENT~~

~~To be completed and signed by your EMPLOYER.~~

~~Name of Employer~~	~~Phone Number~~	~~Fax Number~~

~~Employee's Job Title~~

~~Employee's Job Title Duties include:~~

~~Lifting~~	☐ ~~less than 15 lbs.~~	☐ ~~15-44 lbs.~~	☐ ~~over 45 lbs.~~
~~Stooping/Bending~~	☐ ~~none~~	☐ ~~seldom~~	☐ ~~frequent~~
~~Crawling/Climbing/Kneeling~~	☐ ~~none~~	☐ ~~seldom~~	☐ ~~frequent~~
~~Reaching/Pulling/Pushing~~	☐ ~~none~~	☐ ~~seldom~~	☐ ~~frequent~~
~~Repetitive~~	☐ ~~none~~	☐ ~~seldom~~	☐ ~~frequent~~
~~Management Duties~~	☐ ~~none~~	☐ ~~seldom~~	☐ ~~frequent~~

~~Sitting (Number of hours each day)~~	~~Standing (Number of hours each day)~~

~~Dates this employee has been unable to work: From~~ ☐ ~~am~~ ☐ ~~pm~~ ~~to~~ ☐ ~~am~~ ☐ ~~pm~~

Date employee returned to light duty work:

Date employee returned to full duty work:

~~Has the employee's employment been terminated?~~ ☐ ~~Yes~~ ☐ ~~No~~ ~~If yes, please provide termination date:~~

~~Did the accident occur while working for wage/profit?~~ ☐ ~~Yes~~ ☐ ~~No~~

~~Name and Address of Worker's Compensation Carrier, if applicable:~~

~~**FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.**~~

~~Name of Person Completing Form~~

~~Title of Person Completing Form~~

~~Signed (to be signed by your employer)~~	~~Title~~	~~Date~~

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CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Fraud Warning for California Residents

For your protection, California law requires the following to appear:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning for Colorado Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning for District of Columbia, Maine, Tennessee and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Fraud Statement for New York Residents

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Statement for Puerto Rico Residents

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

CLAIM FOR VB ACCIDENT INSURANCE
EMPLOYEE'S AUTHORIZATION

Provident Life and Accident Insurance Company
The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; professional licensing body; and employer that has information about my health, financial or credit history, professional license, earnings, employment history, or other insurance claims and benefits, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum, its insurance subsidiaries* and duly authorized representatives ("Unum"), and, where applicable, to persons or entities that may assist me with or provide services related to my claim(s) for Social Security or other government-sponsored benefits. Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

______________________________	______________________________
(Claimant Signature)	(Date Signed)
______________________________	______________________________
(Print Name)	(Social Security Number)

I signed on behalf of the claimant as __________________(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.

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