



# VWB ACCIDENT INSURANCE SUPPLEMENTAL QUESTIONNAIRE

Provident Life and Accident Insurance Company  
Chattanooga Benefits Center, P.O. Box 12030,  
Chattanooga, TN 37401-3030  
Phone: 800.633.7479 Fax: 423.755.3009 or 800.494.4516

Please check the type of claim you are filing below:

- Accidental Injury – Section A – requests specific information from you about the circumstances of your injury.
- Hospital Confinement, Intensive Care – Have your doctor complete Section B and send copies of your hospital bills.

This claim is for:  Self  Spouse  Dependent | Policy #

## 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



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PATIENT NAME	SOCIAL SECURITY NUMBER
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**A. 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (choose one)
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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

**B. 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
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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.**



**VWB ACCIDENT INSURANCE  
SUPPLEMENTAL QUESTIONNAIRE  
EMPLOYEE'S AUTHORIZATION**

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Phone: 800.633.7479 Fax: 423.755.3009 or 800.494.4516

**FOR EMPLOYEE TO COMPLETE**

**NOTE:** Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident 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; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries\* and duly authorized representatives ("UnumProvident"). 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 UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning 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 period 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 UnumProvident 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, UnumProvident 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, UnumProvident 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 UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.