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LONG TERM DISABILITY CLAIM FORM

The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-858-6843 Fax: 1-800-447-2498 Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

For use with policies issued by the following Unum Group ["Unum"] subsidiaries:

Unum Life Insurance Company of America Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

When should you use this claim form?

Use this claim form to submit a disability claim to Unum. This form should be used for the following types of claims only:

Long Term Disability, or any combination of the following: Long Term Disability, Individual Disability and Life Insurance Waiver
of Premium. If you are covered for more than one of these products, this is the only form you need to complete.

Instructions

The information provided on this claim form will be used to evaluate your eligibility for disability benefits.

This form should be completed by you (the employee), your employer and attending physician.

- Employee/Individual Statement (pages 4-7): Please complete this section of the claim form and fax it to 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- **Direct Deposit Request (page 8):** Please complete this form if you wish to have your Long Term Disability benefits deposited directly into your bank account. You may also sign up via your online account at www.unum.com/cclaims.
- Authorization to Share Information with Third Parties (page 9): If you wish to give us permission to share the details of your claim with a third party (such as your spouse, child, sibling, friend, etc.), please sign and date this form and fax it to 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- Employee/Individual Authorization (last page): Please sign and date this form and provide a copy to your attending physician. Fax the completed form to 1-800-447-2498 or mail it to the address noted above.
- Employer Statement (pages 10-12): Please give this section of the claim form to your employer and ask him/her to complete, sign and date the form. Your employer should fax the completed form to 1-800-447-2498 or mail it to the address noted above.
- Attending Physician Statement (pages 13-15): Please give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to complete and fax the completed form to 1-800-447-2498. If s/he prefers, it may be mailed to the address noted above.

Unum Online Services

Unum has developed a secure and easy way for you to submit and manage your claim online via our secure website at www.unum.com/claims. Our secure web services allow you to access and make changes to your open claims, as well as view updates and available correspondence. Please contact your employer's human resource department to verify online filing is available to you.

Once you have submitted your claim, you may manage it with the Unum Customer App. The Unum Customer App is available for Apple and Android.

Questions?

If, at any time, you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center is staffed with experienced professionals who can be contacted from 8 a.m. to 8 p.m. Monday through Friday.



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Instructions (continued) / Claim Fraud Statements

Fraud Warning

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, New Mexico, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, Washington, and West Virginia require the following statement to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning for Alabama Residents

For your protection, Alabama law requires the following to appear on this claim form:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Fraud Warning for California Residents

For your protection, California law requires the following to appear on this claim form:

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

For your protection, Colorado law requires the following to appear on this claim form:

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 Residents

For your protection, the District of Columbia requires the following to appear on this claim form:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Fraud Warning for Florida Residents

For your protection, Florida law requires the following to appear on this claim form:

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

Fraud Warning for Kentucky Residents

For your protection, Kentucky law requires the following to appear on this claim form:

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.

Fraud Warning for Minnesota Residents

For your protection, Minnesota law requires the following to appear on this claim form:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Fraud Warning for New Hampshire Residents

For your protection, New Hampshire law requires the following to appear on this claim form:

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.



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Claim Fraud Statements

Fraud Warning for New Jersey Residents

For your protection, New Jersey law requires the following to appear on this claim form:

Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and civil penalties.

Fraud Warning for New York Residents

For your protection, New York law requires the following to appear on this claim form: 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 Warning for Pennsylvania Residents

For your protection, Pennsylvania law requires the following to appear on this claim form: 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 Warning for Puerto Rico Residents

For your protection, Puerto Rico law requires the following to appear on this claim form: 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 dollars (\$5,000) and not more than ten thousand dollars (\$10,000), 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.



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EMPLOYEE/INDIVIDUAL STATEMENT (PLEAS	E PRI	NT)																					
A. Information About You																							
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Language Preference ☐ English ☐ Spanish ☐ Other																		—	—				
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□ Voluntary Benefits Cancer/Critical Illness □ Voluntary Ber	nefits Ad	ccident	t 🗆 \	Volun	tary	Bene	efits	Med	dSup	port													
Are you currently self-employed? ☐ Yes ☐ No ☐ Do you wor	k for ar	other	emplo	yer?		Yes	□ N	No															
If yes, employer name:										Te	eleph	non	e Ni	umb	er								
B. Information About Your Disability																							
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C. Information About the Condition(s) Causing Your Disabi	lilty																						
1. For illness , answer the following questions then go to #4:																							
What is the name of your medical condition?		What	were	your	first	symp	otom	s?															
Describe when you first noticed the symptoms.											- 1		-			first	trea	ated	by a	a ph	ysic	ian	
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2. For an injury , answer the following questions then go to #4:																							
What is the name of your medical condition?																							
Describe where and how the injury occurred.																							
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Date the injury occurred (mm/dd/yy):	If relat	od to a	moto	r voh	iclo	accid	ont	wa	20		Тг)ata		11.\A/	aro i	firet	troc	ated	by :	nh	veic	ian	
Date the injury occurred (min/ud/yy).	accide						,		ali		- 1		-	yy):		iii St	ucc	iicu	Бу с	а рп	ysic	iaii	
3. For pregnancy , answer the following questions then go to #	4:																						
What is your expected delivery date?																							
Were there any complications causing you to		If yes,	pleas	e exp	olain	:					_									_			
stop work prior to your expected delivery date? ☐ Yes ☐ No)																						



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Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

Please provide the information requested below. Once completed, sign and date the form, <u>attach the appropriate documentation</u> <u>and mail or fax it to the address or fax number indicated above.</u> As a convenience, we also offer a secure website at www.unum. com/claimant where you can sign up for direct deposit.

, , ,
A. Information About You
Last Name First Name MI
Address
City State Zip
Social Security Number Home Telephone Number
B. Information About How to Set-up or Change Your Direct Deposit
□ Set-up Direct Deposit □ Change Direct Deposit Account
Bank/Financial Institution Information
Name
City State Zip
Choose Type of Account – Note: We are <u>only</u> able to deposit benefit payments into one account. Checking OR Savings REQUIRED FOR CHECKING: Please provide either 1.) a voided check imprinted with your name; or 2.) the top portion of a bank statement or a letter from your bank, on bank letterhead, signed and dated by a bank representative. One of these items must be received to process your request.
Please note: additional documentation is <u>not</u> required for direct deposit into a savings account.
Please verify the Transit Routing number with your bank. A Routing Number beginning with the number 5 is not valid. (Ex: 502000027)
Bank Transit/Routing Number Personal Account Number
C. Direct Deposit Cancellation Request
Please complete this section if you are canceling your direct deposit agreement.
□ Cancel my direct deposit agreement Effective Date □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
D. Signature of Individual
x
Signature of Individual Date

Frequently Asked Questions About Direct Deposit

- · What is Direct Deposit?
 - Unum will deposit your benefits directly into your checking or savings account on a weekly or monthly basis as per policy provisions.
- When can I expect the money to be in my account?

Because this can vary from person to person, please discuss the details with a Direct Deposit Specialist. Funds will be credited on the second business day after the date of release of funds with the exception of a Federal Reserve Bank Holiday.

· What if I have questions?

Please call our toll-free Direct Deposit Customer Service line at 1-800-413-7671. Knowledgeable and courteous representatives are available to answer your questions, Monday through Friday, 8 a.m. to 4 p.m. Eastern Standard Time.

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



The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-858-6843 Fax: 1-800-447-2498 Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) with the family members, friends, and/or other third parties listed below:

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My Spouse:	
(Name)	(Telephone Number)
Other Family Member:	
(Name / Relationship)	(Telephone Number)
Other person:	
(Name / Relationship)	(Telephone Number)
I understand that information about my claim(s) an health and that such information about my health n system including, but not limited to, HIV and AIDS; history, condition, advice or treatment, but does not do not wish the following information about my claim applicable):	nay be related to any disorder of the immune use of drugs and alcohol; and mental and physica t include psychotherapy notes.
I further understand that the information is subject certain federal regulations governing the privacy of I may revoke this authorization in writing at any time recipient of my information has relied on it prior to be	f health information. ne except to the extent Unum or the authorized
this Authorization by sending written notice to the a	
This authorization is valid for the shorter of two (2) leave(s). I may request a copy of the Authorization	
Claimant Signature	Date
Printed Name	Social Security Number
I signed on behalf of the claimant as	(indicate relationship). If tive, Guardian, or Conservator, please attach a

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C. In	form	atio	n Ab	out t	he E	mplo	oyee	's Oc	cup	ation																								
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										No II												Full	Tin	ne		Part	Time	e F	lours	Per	Wee	k:		
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EMPLOYER STATE	MEN	IT (C	onti	inue	d)																								
Employee's Name (Last N	ame, S	Suffix,	First	Name	, MI)																_	Date	e of	Birt	h (m	nm/do	d/yy	')	
							Ш																			\perp			
D. Information About the					1,040 F	Nonna	ob o ok	all the	t ann	dy o	nd inc	lioo	to the			t noi	۵						_	_	_		_		
How was the employee pa ☐ Hourly \$				St WOI			ni-Mon				na inc				ouri	t pai	a.												
□ Weekly \$			_			□ Bon			\$_																				
☐ Bi-Weekly \$ Date paid through for (mm							nmissio Paid Ti		ff hals	ance	2 25 0	f lac	et da		ker	1.							—	—	—	—	—		
☐ Salary Continuation _					_									,															
☐ Vacation Pay ☐ Accrued Sick pay					-		Sick Le	eave b	oaland	ce a	s of la	ist c	day w	orke	d:														
□ Other _					-																								
Does the employee have a	an own	ershi	p inte	rest in	this bu	usines	s? □	Yes	□ No	0 1	f yes,	wh	at is	the %	of	own	ers	ship?	? .			%	6						
Type of business: ☐ Reg	gular C	orpor	ation		Corpo	oration	ı 🗆 Р	Partne	rship		Sole	Pro	opriet	orshi	р														
Other than payments under tion, PTO? ☐ Yes ☐ N		policy	, will t	the em	ployee	e be re	ceiving	g any (other	inco	ome fr	om	you,	such	as	K-1	ea	rninç	gs,	bonı	use	s, co	mm	iissio	ons,	sala	ry co	ontin	iua-
Financial Documentation your policy and provide us				_				e can a	accura	ately	y calcı	ulat	e you	ır em	plo	yee'	s b	enef	fit. F	Pleas	se r	efer t	to th	ne de	efini	tion (of ea	arnin	igs in
If your earnings definitio	n is:		The	n we	need:																								
Salary Only/Current Earnir	ngs		Pay	roll re	cords o	or pays	stubs fo	or the	3 moi	nths	s just p	orio	r to d	isabil	ity														
Bonus/Commissions Include	ded		Pay	roll re	cords f	or eith	ner 12 c	or 24 r	nonth	ıs (p	er you	ur d	efinit	ion o	f ea	arnin	gs)	just	pri	or to	dis	sabilit	iy						
Other			Pay	roll do	cumer	ntation	refere	nced i	n you	ır de	efinitio	n of	f earr	nings	(e.	g. W	-2,	K-1	, So	ched	ule	C, te	ach	ner c	ontr	act,	etc.))	
E. Information Needed fo	or Calc	ulatio	on of	FICA																			_	_	_		_		
What percent of the Long	Term E	Disabi	lity be	enefit i	s taxab	ole?			%																				
[See IRS Publication 15-A calculating the taxable per Note: We will assume the	cent.]	-	-								•	₹ер	ortin	g and	d/o	r IRS	S R	evei	nue	Rul	ling	g 200	4-5	5 for	· mo	re in	form	natio	n on
What percent of the Individ										Jeu.															—		—		
[See IRS Publication 15-A calculating the taxable per Note: We will assume the	<i>Empl</i> cent.]	oyer':	s Sup	pplem	ental 1	- Γax Gι	uide, S	ectio	n 6, S			Rep	ortin	g and	d/o	r IRS	S R	evei	nue	e Rul	ling	g 200	4-5	5 for	· mo	re in	form	natio	n on
Year to Date Earnings (from																								_	_		_		
F. Information About Oth	er Dis	abilit	v Inco	ome																									
			,																										
Is employee eligible for:	Yes	No			es, we nthly a			W	eekly	/ M	onthly	,		Da	te I	bene	fits	beg	gin					Da	te be	enefi	its e	nd	
Salary Continuation			\$				_																						
Short Term Disability			\$				_																						
State Disability			\$																										
Other Disability Benefits			\$																										
Social Security Disability Insurance			\$																										
Workers' Compensation			\$									Ţ											_						



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EMPLOYER STATEMENT (Continued)														
Employee's Name (Last Name, Suffix, First Name, MI)				I	Dat	e of E	Birth	ո (m	m/dd	/yy))			
				J						_				
Is the claim the result of a work related injury or illness? Yes No If yes, has a Workers' Compensa	tion c	laim be	en f	iled?	, [∃ Ye	s	□ 1	No					
If yes, name of Workers' Compensation carrier		elephor												
Address of Carrier	F	ax Nun	nber											
City	_ e	Zip												
		'												
If a Workers' Compensation claim has been denied, please submit a copy of denial with this claim.														
□ Cash Balance □ 401(k)/403(b) □ Profit Sharing □ Money Purchase Plan/401A □ Other: (specify)														
\square Cash Balance \square 401(k)/403(b) \square Profit Sharing \square Money Purchase Plan/401A \square Other: (specify	')													
Is the employee eligible for your pension plan? ☐ Yes ☐ No	What	percer	itage	e do	es t	he er	nplo	oye	e con	trib	ute?			
If eligible, does the employee participate? ☐ Yes ☐ No			%											
s the employee eligible for your pension plan?														
H. Information About Your Rehire or Return-to-Work Program														
If the employee is released to return to work in restricted duty, are you willing to discuss accommodations?	□ Ye	es 🗆	No											
If yes, whom should we contact to discuss a return-to-work plan?														
Name														
Title			Tele	epho	ne l	Numb	er							
FRAUD NOTICE: Any person who knowingly files a statement of claim of	onta	aining	j fa	alse	9 0	r m	isl	ea	din	g				
information is subject to criminal and civil penalties. This includes the Em											m.			
I. Signature of Benefit Administrator (Please Print)														
The above statements are true and complete to the best of my knowledge and belief.														
Name of Person Completing Form														
Title of Person Completing Form														
Telephone Number Fax Number	Er	mployer	Tax	(ID I	Nun	nber								
E-mail Address	1													
Signature	Date	9												
X														



LONG TERM DISABILITY CLAIM FORM The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

ATTENDING PHYSICIAN STATEMENT (P	LEASE PRINT)													
TO BE COMPLETED BY PHYSICIAN OR TREA Instructions: Please complete, sign and date thi plete all questions on this form and provide copie and/or testing. Be sure to sign and date this form	s form. The purpose of this form is to assist us in making a disability determination. Please com s of supporting reports, such as office notes, medical records, medication logs, consultations													
Name of Patient (Last Name, Suffix, First Name,	MI) Social Security Number													
Date of Birth (mm/dd/yy) Patient Teleph	one Number													
Employer Name														
A. Patient Information														
ate of first visit for this current condition(s) Date of last office visit (mm/dd/yy): Date of next office visit (mm/dd/yy): Date of next office visit (mm/dd/yy): Did you advise your patient to stop working? Yes No If yes, effective when? (mm/dd/yy): Yes, please provide treatment dates (mm/dd/yy): Through														
Has the patient been treated for the same/similar	condition in the past? ☐ Yes ☐ No ☐ Unknown													
If ves, please provide treatment dates (mm/dd/vv): From Through													
Is the patient's condition work related? Yes	,													
What is the primary diagnosis that may impact yo														
Please include primary ICD or DSM codes	ICD Code:													
	DSM:													
What are the other diagnoses that may impact yo	our patient's functional capacity? NA													
Secondary Diagnosis:	ICD Code:													
Secondary Diagnosis:	ICD Code:													
Has the patient been hospitalized? ☐ Yes ☐ N	No If yes, date hospitalized (mm/dd/yy): through (mm/dd/yy):													
Was surgery performed? ☐ Yes ☐ No If yes (mm/dd/yy):	, what procedure was performed? CPT Code: Date Surgery Performed													



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AT	TEI	NDII	NG I	РΗ	YSIC	CIA	N S	ST	ΑΤΙ	EM	ΕN	NT (Coi	ntin	ued)																						
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Phy	sica	ıl Re	stric	tic	ns a	nd/	or	Lir	mita	tio	ns																											_
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Beh	avio	oral	Heal	th	Rest	rict	ion	าร	and	/or	Li	mita	tior	าร																								
LIMI	TAT	ION	S (a	ctiv	ities	pati	ent	t ca	anno	ot d	0)	plea	se l	ist b	elov	ı. Pl	ease	be	spe	ctivitie ecific n us h	and	d ur	nder	sta	nd th	nat	a re	ply	of '	"nc	ow c	VIC	ORA or "I	L HE	EALT ly dis	H abl	ed" v	/ill
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Wha	t dia	agno	stic	or o	clinica	al fir	ndii	ng	s su	ppc	ort	your	pa	tient	's re	stric	ctions	s an	ıd/o	r limi	tatio	ons	as ı	not	ed a	bo	ve?											
Wha	t is	your	trea	tm	ent p	lan?	? P	lea	ase i	incli	ude	e all	me	dicat	ions	S.																						



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ATTENDING PHYSICIAN STATEMENT (Co	ontinued	d)																	
Patient's Name		-											Di	ate	of B	irth (ı	nm/d	d/yy	')
C. Other Treating Providers, Facilities or Hospi	itals																		
Please provide complete name, contact informatio		ecialty	of ar	ny othe	er tre	ating	phys	sicia	ans,	facili	ties	or h	ospita	ls.					
	ecialty				y, Sta								-						
FRAUD NOTICE: Any person who know is subject to criminal and civil penalties.	wingly f . This i	iles a nclud	sta es <i>l</i>	teme Atten	ent c ding	of cla g Ph	aim iysic	cor	ntai 1 po	ning rtio	g fa n o	lse f the	or m e cla	nisl im	ead for	ling m.	info	rma	ation
D. Signature of Attending Physician																			
The above statements are true and complete to				owled	ge a	nd b	elief.												
Physician Name (Last Name, First Name, MI, Suff	fix) Please	e Print																	
Medical Specialty				Deg	gree														
Address																			
City								St	tate		Zip								
Telephone Number	F	ax Num	nber								P	hysid	cian's	Tax	x ID	Num	ber:		
	h . () . ()	1 . 6																	
Are you related to this patient? ☐ Yes If yes, w ☐ No	vhat is the	e relatio	onshi	ıp'?															
Signature of Physician		·											D	ate					



The Benefits Center
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Toll-free: 1-800-858-6843 Fax: 1-800-447-2498

Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Authorization to Collect and Disclose Information (Not for FMLA Requests)

I authorize the following persons: health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocator Group and other Social Security advocacy vendors, professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

To disclose information, whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits ("My Information");

To Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies ("Unum");

So that Unum may evaluate and administer my claims, including providing assistance with return to work. For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits (to include any subsequent financial management and/or benefit recovery review), whichever is shorter. I understand that once My Information is disclosed to Unum, any privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum may then disclose My Information only as permitted by law, including, state fraud reporting laws or as authorized by me.

I also authorize Unum to disclose My Information to the following persons (for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum; or, the Social Security Administration. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purposes of these disclosures by Unum, this authorization is valid for one year or for the length of time otherwise permitted by law.

If I do not sign this authorization or if I alter or revoke it, except as specified above, Unum may not be able to evaluate or administer my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that Unum requests or discloses prior to Unum receiving my revocation request.

Insured's Signature	Date Signed
Printed Name	Social Security Number
I signed on behalf of the Insured as Attorney Designee, Guardian, or Conservator, please attach a copy	(Relationship). If Power of of the document granting authority.

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