



## ACCIDENT CLAIM FORM

The Benefits Center  
P.O. Box 100158, Columbia, SC 29202-3158

Toll-free: 1-800-635-5597 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 Unum Insurance Company

Provident Life and Accident Insurance Company Provident Life and Casualty Insurance Company

### OUR COMMITMENT TO YOU

We understand an illness or injury creates emotional, physical and financial challenges and we want to do whatever we can to help you. You have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during the claim process.

### INSTRUCTIONS

#### When should you use this claim form?

Use this claim form to submit an Accident claim to Unum.

#### Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for Accident benefits. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- **Employee Statement (pages 4-5):** Please complete this section of the claim form and fax the completed form to 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- Please complete the name and date of birth fields at the top of every page for easy identification in case the pages become separated.
- **Authorization to Share Information with Third Parties (page 6):** If you wish to give us permission to share the details of your claim with a third party (such as your spouse, son, daughter, 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.
- **Attending Physician Statement (page 7):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete. Your physician or treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above. Unum is not responsible for expenses associated with the completion of this form.
- **Patient Authorization (last page):** Please sign and date this form, provide a copy to your attending physician, and fax the completed form to 1-800-447-2498. If you prefer, it may be mailed to the address noted above. This form authorizes the release of medical and other types of information needed to evaluate your claim.

#### 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. Eastern Time, 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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**Instructions (continued) / 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/PATIENT STATEMENT (Continued)**

Employee's Last Name

[Grid for Employee's Last Name]

Employee's First Name and MI

[Grid for Employee's First Name and MI]

Date of Birth (mm/dd/yy)

[Grid for Date of Birth]

Patient's Last Name

[Grid for Patient's Last Name]

Patient's First Name and MI

[Grid for Patient's First Name and MI]

Date of Birth (mm/dd/yy)

[Grid for Date of Birth]

**D. Information About Physician and Hospital**

Hospital Name

Mailing Address

Telephone Number

City, State, Zip

Fax Number

Treating Physician Name

Mailing Address

Telephone Number

City, State, Zip

Fax Number

**E. Additional Medical Information Required**

Please attach itemized copies of any bills related to this accident 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 to evaluate your claim.

**F. Tax Considerations**

Benefit payments under this policy could be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.

**Fraud Warning:** For your protection, Arizona law requires the following 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 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.

**G. Signature of Insured/Policyholder**

I have read and understand the fraud notices listed above and on pages 2 and 3 of this form. I also understand that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

X

Signature

Date

I signed on behalf of the insured, as \_\_\_\_\_ (Indicate relationship). **If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.**



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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 claim, 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 my claim(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health and financial information relating to my claim with the family members, friends, and/or other third parties listed below:

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 may include information about my health and that such information about my health may be related 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 do not wish the following information about my claim to be shared (leave blank if not applicable):

\_\_\_\_\_ 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.

I may revoke this authorization in writing at any time except to the extent Unum or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of my claim. I may request a copy of the Authorization and a copy shall be as valid as the original.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Social Security Number

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

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**ATTENDING PHYSICIAN STATEMENT**

Employee's Last Name

Grid for Employee's Last Name

Employee's First Name and MI

Grid for Employee's First Name and MI

Date of Birth (mm/dd/yy)

Grid for Date of Birth

Patient's Last Name

Grid for Patient's Last Name

Patient's First Name and MI

Grid for Patient's First Name and MI

Date of Birth (mm/dd/yy)

Grid for Date of Birth

**ACCIDENT DETAILS**

Is this condition the result of an accidental injury?  Yes  No If yes, date of accident (mm/dd/yy) [Grid]

Is this condition the result of his/her employment  Yes  No  Unknown

Please verify treatment for the accident listed above. Please print in fields provided below.

Primary Diagnosis (ICD): \_\_\_\_\_ Primary Diagnosis Description: \_\_\_\_\_

Secondary Diagnosis Code (ICD): \_\_\_\_\_ Secondary Diagnosis Description: \_\_\_\_\_

First Office Visit Date (mm/dd/yy): \_\_\_\_\_ Last Office Visit Date (mm/dd/yy): \_\_\_\_\_

Next Office Visit Date (mm/dd/yy): \_\_\_\_\_ Was patient hospitalized as a result of this accident?  Yes  No (If yes, please provide dates below.)

Hospital Admission Date (mm/dd/yy): \_\_\_\_\_ Hospital Discharge Date: (mm/dd/yy): \_\_\_\_\_

Hospital Facility Name: \_\_\_\_\_

Hospital Facility City: \_\_\_\_\_ Hospital Facility State: \_\_\_\_\_

Was surgery performed?  Yes  No Surgery Date (mm/dd/yy): \_\_\_\_\_

Surgery/Procedure Description: \_\_\_\_\_

Was the patient referred to Physical/Speech/Occupational Therapy?  Yes  No

If yes, please provide the therapy facility patient was referred to or prescribed therapy frequency on the line provided below.

Was the patient treated in the Emergency Room related to the accidental injury?  Yes  No

Date of Emergency Room Treatment (mm/dd/yy): \_\_\_\_\_

Did you advise the patient to stop working?  Yes  No If yes, as of what date? (mm/dd/yy) [Grid]

Have you advised the patient to return to work?  Yes  No If yes, as of what date? (mm/dd/yy) [Grid]

**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 Attending Physician portions of the claim form.**

**Attending Physician's Information**

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, First Name, MI, Suffix) Please Print: \_\_\_\_\_

Medical Specialty: \_\_\_\_\_ Degree: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Physician's Tax ID Number: \_\_\_\_\_

Are you related to this patient?  Yes  No If yes, what is the relationship? \_\_\_\_\_

**X**  
\_\_\_\_\_  
**Physician Signature** \_\_\_\_\_  
**Date**



The Benefits Center  
 P.O. Box 100158, Columbia, SC 29202-3158  
 Pacific Time Zone Toll-free: 1-877-851-7637 Fax: 1-877-851-7624  
 All Other Time Zones 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 Advocate 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, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty 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 \_\_\_\_\_ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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