

CLAIM FOR DISABILITY BENEFITS

UnumProvident, Chattanooga Customer Care Center, P.O. Box 12030,
Chattanooga, TN 37401-3030
Phone: 800.633.7479 Fax: 423.755.3009

For use with policies issued by the following UnumProvident Corporation ["UnumProvident"] subsidiaries:

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

Please mail or fax this form to:
UnumProvident
Chattanooga Customer Care Center
P.O. Box 12030
Chattanooga, TN 37401-3030
Toll free 800.633.7479 Fax 423.755.3009

This form must be completed by the Attending Physician, the Claimant, and the Employer (for employer-sponsored policies), and be returned promptly for consideration of benefits. 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 be sure to keep a copy of this form and any attachments for your records.

The claimant is responsible for completion of all portions of this form without expense to the UnumProvident Corporation subsidiaries.

INSTRUCTIONS:

- A. **Attending Physician's Statement:** This section must be completed by the physician **PRIMARILY** responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form.
- B. **Claimant's Statement:** This section must be completed by you, the claimant. Please make sure you sign and date the bottom of the authorization page after you complete your section.
- C. **Employment Statement:** Group Sponsored Policies - The employer must complete this form.
Individual Policies - Please refer to the attached Instructions Sheet.

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

