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.

UNUMPROVIDENT

DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED)

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Claim Questions: 800.633.7479 **Fax To:** 423.755.3009

A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

1. Name of Patient	Date of Birth	Social Security Number

2. Diagnosis - Please include the primary diagnosis and list any secondary conditions.

Date of Last Examination	Diagnosis (including any complications) include **ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number**

Objective findings (including current x-rays, EKGs, pyschiatric testing, laboratory data and any clinical findings)

Symptoms

Is this condition due to ☐ an Accident ☐ a Sickness?	Date symptoms first appeared or accident occurred:
Is the accident or sickness related to the patient's employment? ☐ Yes ☐ No ☐ Unknown	
Date restrictions and limitations began.	Has patient ever been treated for the same or similar condition? ☐ Yes ☐ No If yes, state when and describe.

3. Information About the Patient's Ability to Work - this information is critical to understanding your patient's condition

Has patient been released to work in his/her occupation? ☐ Yes ☐ No in any ocupation? ☐ Yes ☐ No

If the patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in the space provided below.

Fully describe restrictions and limitations.
RESTRICTIONS (What the patient should not do)

LIMITATIONS (What the patient cannot do)

When should the patient be able to return to work? Full Time: Part Time:

Height/Weight	Blood Pressure Last Visit	If Pregnancy, Expected Delivery Date	If Delivered, Actual Delivery Date	Delivery Type ☐ Normal ☐ C-Section

Date of first visit for this illness or injury	Date of next visit	Date of last visit	Frequency of visits

Is patient: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined	Has patient been admitted to hospital? ☐ Yes ☐ No Confined From: To:

If Hospital Confined, give name and address of hospital

Have you completed claim forms regarding this patient for other insurance carriers? ☐ Yes ☐ No If yes, state date and name of insurance company:

4. Names and Addresses of Other Treating Physicians

Referring physician or other treating physicians (names, address, phone #'s):

REQUIRED ATTACHMENTS AND SIGNATURES

Please make sure that office notes, test results, and discharge summaries are attached. This will help reduce additional requests.
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.
The above statements are true and complete to the best of my knowledge and belief.

Print or Type Name		Degree	Medical Specialty
Street Address			Phone Number ( )
City	State	Zip Code	Fax ( )
Signature of Physician			Date

SSN or Employer's ID Number:

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B. CLAIMANT'S STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

☐ **Short Term Disability** ☐ **Long Term Disability** ☐ **Individual Disability** ☐ **Waiver of Premium (Life Insurance)** ☐ **Voluntary Benefits/Payroll Deduction**

Policy Numbers:	The State in which You Work:

1. Claimant's Name

Home Address (Street, City, State, Zip)

Home Phone Number ( )	Date of Birth	Social Security Number	☐ Male ☐ Female

2. Is this condition due to ☐ Accident ☐ Sickness? | Is this disability related to your employment? ☐ Yes ☐ No

Describe the injury incurred (what, how, where, when) or the nature and details of the sickness and when it began:

You have been unable to work because of this condition as of what date?

3. Employer's Name and Address

Claimant's Work Phone Number ( )	Occupational Title	List the duties of your occupation at the time of your disability. Duty	# of weekly hours spent at duty
Have you returned to work? If yes, When? Part Time: Full Time:			
Hours per week:			
If you have not returned to work, when do you expect to return? Part Time: Full Time:			

How does your injury or sickness impede your ability to do your occupational duties?

4. Information about physicians and hospitals
NOTE: TO AVOID DELAY IN EVALUATING YOUR CLAIM, ADVISE YOUR DOCTOR(S) TO ATTACH COPIES OF MEDICAL RECORDS AND TEST RESULTS.

First medical attention for the current disability was given by (complete below):

Doctor's Name	Doctor's Specialty
Address (Street, City, State, Zip)	Phone Number ( )
Hospital Name	Hospital Phone Number ( )

Address (Street, City, State, Zip)

Dates of Confinement: From: To: From: To:

If other doctors or hospitals were consulted in the last five years, please attach a separate sheet of paper.

5. Martial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	If you are married: Spouse's Name	Spouse's Date of Birth	Is Spouse Employed? ☐ Yes ☐ No

List your children who are under age 25: (*Please attach additional sheets if necessary).

Name	Date of Birth	Married?	Attending High School?
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

6. If you have been approved or denied for any of these benefits, please send a copy of Award or Denial Notification.
(Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.)

Social Security/Retirement	☐ Yes ☐ No	Social Security/Disability	☐ Yes ☐ No	Canada Pension Plan	☐ Yes ☐ No	State Disability	☐ Yes ☐ No
Worker's Compensation	☐ Yes ☐ No	Pension/Retirement	☐ Yes ☐ No	Pension/Disability	☐ Yes ☐ No	Unemployment	☐ Yes ☐ No
No-Fault Insurance	☐ Yes ☐ No	Short Term Disability	☐ Yes ☐ No – Ins. Co. Name and Policy #				
Other (Include Individual Disability or Group Disability Benefits)			☐ Yes ☐ No – Ins. Co. Name and Policy #				

7. If your request for benefits is approved, do you want Federal Income Tax Withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ (Note: Minimum withholding is $20.00 per week or $87.00 per month)
Do you want State Income Tax withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ (Note: The amount indicated must be a whole dollar increment)

UnumProvident

DISABILITY CLAIM
CLAIMANT'S AUTHORIZATION

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FOR CLAIMANT TO COMPLETE

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 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.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility, insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation, other organization, institution, or person that has any records or knowledge of me, my health (including any disorder of the immune system including HIV or AIDS, any information relating to the use of drugs and alcohol, and any information relating to mental and physical history, condition, advice or treatment), financial or credit information, earnings, employment history or other insurance benefits, to release this information to any of the UnumProvident Corporation subsidiaries or their duly authorized representatives. I also authorize the UnumProvident Corporation subsidiaries to request a report from the Medical Information Bureau (MIB), and the association of life insurance companies which operates the Health Claims Index (HCI) and the Disability Income Record System (DIRS). I understand that the dates of my past and present claims with any of the UnumProvident Corporation subsidiaries, excluding medical or personal information, may be reported to MIB and that an HCI or DIRS report may reflect this information including the identity of other insurance companies to which I have submitted claims. I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering a claim for benefits.

This authorization is valid for the duration of my claim. I know that I or my authorized representative has a right to request a copy of this authorization. A copy of this authorization shall be as valid as the original.

I further authorize the UnumProvident Corporation subsidiaries or other authorized representatives to release all information (including information pertaining to HIV or AIDS, mental illness, and drug and alcohol abuse) related to this insurance claim to insurance companies, third party administrators, physicians, rehabilitation professionals, vocational evaluators, employers, my insurance agent, and any institution or person on a need to know basis for the purpose of verifying, evaluating, negotiating, or other pertinent uses with respect to my claim for benefits or service.

The statements made by me on this claim are true and complete.

I further authorize the UnumProvident Corporation subsidiaries or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

I am the individual to whom this release/request applies or that person's legal Guardian, Power of Attorney, or Conservator. I know that if I make any representation which I know is false to obtain information from federal records, I could be punished by fine or imprisonment or both.

Signature of Claimant **X** _____

Please Print Name _____

Date Signed _____ | Social Security Number _____

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

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C. EMPLOYMENT STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

☐ **Short Term Disability** ☐ **Long Term Disability** ☐ **Individual Disability** ☐ **Waiver of Premium (Life Insurance)** ☐ **Voluntary Benefits/Payroll Deduction**

1. Employer Name	Employer's Phone Number ( )

Employer Address (Street, City, State, Zip)

Policy Numbers	Division Number / Class Number	Division / Class Description

2. Claimant's Name

Claimant's Address (Street, City, State, Zip)

Claimant's Home Phone	Date of Birth	Social Security Number	Date of Hire	Effective Date of Insurance	Date Last Worked

Claimant's Work Status: ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-exempt ☐ Bargaining ☐ Non-Bargaining

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

General Information About the Claimant's Job

3. Job Title	Minimum education or training required

Does the claimant perform supervisory function? ☐ Yes ☐ No | If yes, how many people are supervised?

4. Describe job duties:

Duty	# of Weekly Hours Spent at Duty
Duty	# of Weekly Hours Spent at Duty
Duty	# of Weekly Hours Spent at Duty
Duty	# of Weekly Hours Spent at Duty

Name of Direct Supervisor	Telephone Number of Direct Supervisor ( )

Please attach a copy of the claimant's job description.

5. How was claimant paid? (please check one)
☐ Hourly ☐ Commissions ☐ Salaried ☐ Salary and Bonus ☐ Commissions Only ☐ Salary and Commissions

What is the earnings figure you use to compute premium payments for this claimant? $

Salary/Wage prior to date last worked ***(refer to Earnings definition in your contract).***

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly $	Bonuses (per week) $	Overtime (prior year) $	Commissions (per week) $	W-2 Earnings $

6. Does the claimant contribute toward the premiums? (Complete all that apply)

STD: ☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:	% paid by employer	% paid by claimant
State Plans: ☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:	% paid by employer	% paid by claimant
LTD: ☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:	% paid by employer	% paid by claimant
IDI: ☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:	% paid by employer	% paid by claimant
Life: ☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:	% paid by employer	% paid by claimant

7. Year to Date Earnings as of Date of Disability (For FICA % Deductions) $

8. Financial Documentation (please refer to your contract for your Earnings definition and attach the appropriate documentation).
Salary Only/Current Earnings definition: Attach copy of payroll records or paystubs for 2 periods just prior to disability.
Bonus/Commissions Included: Attach copy of payroll records for the 12 or 24 months (see definition) just prior to disability.
Other Earnings definitions: Attach referenced document per Earnings definition (W-2, K-1's, Schedule C's, teacher's contract, etc.).

9. Claimant Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability:
401(k)/403(b) %; Pre-tax medical and other insurance $ /week; Flexible spending account $ /week

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C. EMPLOYMENT STATEMENT (continued)

10. Date of last Salary/Wage Increase | Work Schedule at time last worked: Days/Week Hours/Day Hours/Week

Check off regular work days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat. | Number of hours on date last worked:

Date paid through: For: ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick Pay ☐ Other

11. Has claimant returned to work? ☐ Yes ☐ No If yes, date: ☐ Full Time ☐ Part Time Hours Per Week

12. Does the claimant have an ownership interest in this business? ☐ Yes ☐ No If yes, what is the % of ownership? %
Type of business entity? ☐ Regular Corporation ☐ S corporation ☐ Partnership ☐ Sole Proprietorship

13. If this is a Flexible Benefits Plan, indicate which option of coverage this claimant has chosen.
Previous Plan Year - Date of Open Enrollment: Option Current Plan Year - Date of Open Enrollment: Option

14. Prior LTD Carrier Name	Effective Date
Address (Street, City, State, Zip)	Termination Date

15. Is claimant eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	When do benefits begin?	When do benefits end?
Salary Continuation	☐	☐	$	☐	☐		
State Disability	☐	☐	$	☐	☐		
Other Disability Benefits	☐	☐	$	☐	☐		
Social Security	☐	☐	$	☐	☐		
Worker's Compensation	☐	☐	$	☐	☐		

Is the claim the result of a work related injury or sickness? ☐ Yes ☐ No

If so has Workers' Compensation claim been filed?	☐	☐	If yes, Name and Address of Carrier
Health Insurance	☐	☐	If yes, Name and Address of Carrier
Life Insurance	☐	☐	If yes, please provide the amount of coverage: $

If Workers' Compensation claim has been denied, please submit a copy of denial with this claim.

16. If New York DBL or New Jersey TDB applies, complete this question.

Earnings 8 weeks prior to disability

Week Ending	Mo.	Day	Yr.	No. Days Worked	Amount	Week Ending	Mo.	Day	Yr.	No. Days Worked	Amount
1						5					
2						6					
3						7					
4						8					

17. Information about your pension plan (Please send copy of Plan Summary) (Do not complete for maternity claim)

Do you have a pension plan? ☐ Yes ☐ No | If yes, what type? ☐ Defined benefit ☐ Defined contribution ☐ 401(k)/403(b) ☐ Profit Sharing ☐ Other: (specify)

Is claimant eligible for your pension plan? ☐ Yes ☐ No	If eligible, does the claimant participate? ☐ Yes ☐ No	What % does claimant contribute?

If the claimant is participating, when is he or she eligible for benefits under the plan?

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

Name of Person Completing Form	Telephone Number ( )
Title of Person Completing Form	Fax Number ( )
Signature	Date Signed