



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 3-6):** 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 7):** 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/claims.
- **Authorization to Share Information with Third Parties (page 8):** 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 9-11):** 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 12-14):** 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.

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this claim form.

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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California: Any person who knowingly presents 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.

Colorado: 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.

District of Columbia: 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.

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

Kentucky: 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.

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

New Hampshire: 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.

New Jersey: 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, subject to criminal prosecution and civil penalties.

New York: 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 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.

Pennsylvania: 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.

Puerto Rico: 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 (5,000) dollars and not more than ten thousand (10,000) dollars, 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 (PLEASE PRINT)

A. Information About You

Last Name	Suffix	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth (mm/dd/yy)	Social Security Number	Gender	The state in which you work
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>

Home Address

City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>

Telephone Number where you can be reached	Preferred e-mail address (for confirmation purposes only)
<input type="text"/>	<input type="text"/>

Employer Name

Language Preference English Spanish Other

Please check all types of coverage you have with Unum.

- Short Term Disability Long Term Disability Individual Disability Life Insurance Voluntary Benefits Disability
- Voluntary Benefits Cancer/Critical Illness Voluntary Benefits Accident Voluntary Benefits MedSupport

Are you currently self-employed? Yes No Do you work for another employer? Yes No

If yes, employer name:	Telephone Number
<input type="text"/>	<input type="text"/>

B. Information About Your Disability

Date last worked (mm/dd/yy):	Number of hours worked on date last worked:	Date you were first unable to work due to this medical condition (mm/dd/yy):
<input type="text"/>	<input type="text"/>	<input type="text"/>

C. Information About the Condition(s) Causing Your Disability

1. For **illness**, answer the following questions then go to #4:

What is the name of your medical condition?	What were your first symptoms?
<input type="text"/>	<input type="text"/>
Describe when you first noticed the symptoms.	Date you were first treated by a physician (mm/dd/yy):
<input type="text"/>	<input type="text"/>

2. For an **injury**, answer the following questions then go to #4:

What is the name of your medical condition?
<input type="text"/>
Describe where and how the injury occurred.
<input type="text"/>

Date the injury occurred (mm/dd/yy):	If related to a motor vehicle accident, was an accident report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date you were first treated by a physician (mm/dd/yy):
<input type="text"/>	<input type="text"/>	<input type="text"/>

3. For **pregnancy**, answer the following questions then go to #4:

What is your expected delivery date?	
<input type="text"/>	
Were there any complications causing you to stop work prior to your expected delivery date? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
<input type="text"/>	<input type="text"/>



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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for name entry

Grid for date of birth entry

Have you already delivered? Yes No If yes, what type of delivery? Vaginal C-Section If yes, date of delivery:

4. For all medical conditions, answer the following questions:

What specific duties of your occupation are you unable to perform due to your medical condition?

Have you been treated for this condition(s) in the past? If yes, when and by whom?

Yes No

Is your condition related to your occupation? If yes, please explain:

Yes No If no, go to Section C.

Have you filed a Workers' Compensation claim? Yes No If no, do you intend to file a Workers' Compensation claim? Yes No

D. Information About Physicians, Hospitals and Medications: This information will assist us in the evaluation of your claim.

Please provide the following information about all your current medical treatment providers (physicians, hospitals, physical therapists, etc). If you are being treated by more than two, please use a separate sheet of paper and include it with this form.

1. Provider Name, Mailing Address, Telephone No., Specialty, City, State, Zip, Fax No., Date of First Visit (mm/dd/yy), Date of Next Visit (mm/dd/yy)

2. Provider Name, Mailing Address, Telephone No., Specialty, City, State, Zip, Fax No., Date of First Visit (mm/dd/yy), Date of Next Visit (mm/dd/yy)

Please list any recent (within the last 12 months) hospital visits/admissions. If you have had more than two, use a separate sheet of paper and include it with this form.

1. Hospital, Address, Date of Visit/Admission (mm/dd/yy), Procedure, City, State, Zip, Date of Discharge (mm/dd/yy)

2. Hospital, Address, Date of Visit/Admission (mm/dd/yy), Procedure, City, State, Zip, Date of Discharge (mm/dd/yy)



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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for name entry

Grid for date of birth entry

Please list all current medications. If you have more than five, use a separate sheet of paper and include it with this form.

Table with 4 columns: Prescription Name, Dosage/Frequency, Prescribing Physician, Pharmacy Name. Rows 1-5.

E. Information About Other Disability Income: This information is important to ensure the accuracy of your disability benefit calculation.

You may be receiving income from other sources that could reduce your benefit from Unum. Please indicate what other income benefits you are eligible to receive or are receiving as a result of your disability and complete the information requested.

Table with 5 columns: Other Source of Income, Eligible to Receive, Receiving, Amount, Benefit Begin Date. Rows include Short Term Disability, State Disability Plan, Workers' Compensation, etc.

F. Information About Your Return-to-Work

Have you returned to work? Yes No If yes, indicate information below.

Part Time (mm/dd/yy): Full Time (mm/dd/yy): Hours per week:

If you have not returned to work, when do you expect to return?

Part Time (mm/dd/yy): Full Time (mm/dd/yy): Unknown

G. Information About Your Family: This information is important to assist us in determining if your family may be eligible for other benefits.

Marital Status: Single Married Widowed Divorced Domestic Partner Separated

Table with 3 columns: Spouse/Partner's Name, Spouse/Partner's Date of Birth, Is he/she employed? Rows for spouse and dependent children.



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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

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H. Information About Income Tax Withholding: Unum will not withhold Federal and State Income Tax if your benefit is not taxable.

TAX INFORMATION

If you do not know if you are covered under a fully-insured or self-insured plan, please contact your employer for assistance.

• **For Fully-Insured Plans** – If your claim is approved and your employer tells us your benefit is taxable, we are required by law to withhold FICA taxes. Do you want Unum to also withhold Federal and/or State Income Taxes from your taxable benefit checks?

Federal Income Tax: Yes No If yes, how much do you want withheld from each check? (whole dollar amount) \$ _____

Minimum Withholding: \$20/week for Short Term Disability.

State Income Tax: Yes No If yes, how much do you want withheld from each check? (whole dollar amount) \$ _____

• **For Self-Insured Plans** – Attach a copy of your completed W-4 for accurate calculation of Federal and State Income Taxes. **Note:** If not provided, we are required by law to withhold 25% of your taxable benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.

• **If your benefits are not taxable, Federal and State Income Taxes will not be withheld.**

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.

I. Signature of Employee/Individual

I have read and understand the fraud notices listed above and on this form. I also acknowledge 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 _____

Reminder: Please sign and date the Authorization (last page of this claim form).



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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 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:

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) and/or leave(s) 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(s) and/or leave(s) 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 any of my claim(s) and/or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

Claimant 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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EMPLOYER STATEMENT - To be completed by the Employer (PLEASE PRINT)

A. Information About the Employer

Employer Name Employer's Phone Number

Employer Address

City State Zip

Prior LTD Carrier Name Prior LTD Carrier Employee Effective Date Prior LTD Carrier Policy Termination Date

B. Information About the Employee

Employee's Name (Last Name, Suffix, First Name, MI)

Employee's Address

City State Zip

Employee Telephone Number Social Security Number Date of Hire (mm/dd/yy)

Please check all types of coverage this employee has with Unum and indicate the effective date of his/her coverage.

- Short Term Disability _____ Long Term Disability _____ Individual Disability _____
- Life Insurance _____ Premium paid thru date _____ Voluntary Benefits Disability _____
- Voluntary Benefits Cancer/Critical Illness _____ Voluntary Benefits MedSupport _____

Short Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description		
Long Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description		
Individual Disability Policy Number	Division Number	Class Number	Division Description / Class Description		
Life Insurance Policy Number	Division Number	Class Number	Division Description / Class Description	Basic Life Amount	Supplemental Life Amount
Date Last Worked (mm/dd/yy):	Number of hours worked on date last worked: Days/Week _____ Hours/Day _____		Regular Work Schedule Hours/Week _____		

Check off regular work days: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

If this is a Section 125/Cafeteria plan, indicate which option of coverage this employee has chosen.

Previous Plan Year _____ Current Plan Year _____

Date of Open Enrollment (mm/dd/yy) _____ Option _____ Date of Open Enrollment (mm/dd/yy) _____ Option _____

C. Information About the Employee's Occupation

Occupation Title (please include a copy of the employee's job description): _____

Primary duties of the employee's occupation on date last worked: _____

Employee's Pre-disability Work Status: Full-time Part-time Exempt Non-exempt Bargaining Non-bargaining

Did the employee's occupational duties and/or hours change due to disability or medical condition prior to his/her last day worked? Yes No
If yes, please explain: _____

Has employee returned to work? Yes No If yes, date (mm/dd/yy): _____ Full Time Part Time Hours Per Week: _____

Has the employee's employment been terminated? Yes If yes, termination date (mm/dd/yy): _____
 No



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EMPLOYER STATEMENT (Continued)

Employee's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for employee name input

Grid for date of birth input

D. Information About the Employee's Salary

How was the employee paid prior to date last worked? Please check all that apply and indicate the amount paid.

- Hourly \$ _____
Weekly \$ _____
Bi-Weekly \$ _____
Semi-Monthly \$ _____
Bonuses \$ _____
Commissions \$ _____

- Date paid through for (mm/dd/yy):
Salary Continuation
Vacation Pay
Accrued Sick pay
Other

Paid Time Off balance as of last day worked:

Sick Leave balance as of last day worked:

Does the employee have an ownership interest in this business? Yes No If yes, what is the % of ownership? %

Type of business: Regular Corporation S Corporation Partnership Sole Proprietorship

Other than payments under this policy, will the employee be receiving any other income from you, such as K-1 earnings, bonuses, commissions, salary continuation, PTO? Yes No

Financial Documentation: We are requesting this information so we can accurately calculate your employee's benefit. Please refer to the definition of earnings in your policy and provide us with the appropriate payroll information.

Table with 2 columns: If your earnings definition is: Then we need:
Salary Only/Current Earnings: Payroll records or paystubs for the 3 months just prior to disability
Bonus/Commissions Included: Payroll records for either 12 or 24 months (per your definition of earnings) just prior to disability
Other: Payroll documentation referenced in your definition of earnings (e.g. W-2, K-1, Schedule C, teacher contract, etc.)

E. Information Needed for Calculation of FICA

What percent of the Long Term Disability benefit is taxable? %

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

What percent of the Individual Disability benefit is taxable? %

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

Year to Date Earnings (from January 1 to the present for FICA Deductions) \$ _____

F. Information About Other Disability Income

Table with 7 columns: Is employee eligible for: Yes No If yes, weekly or monthly amount Weekly Monthly Date benefits begin Date benefits end
Rows include Salary Continuation, Short Term Disability, State Disability, Other Disability Benefits, Social Security Disability Insurance, Workers' Compensation



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EMPLOYER STATEMENT (Continued)

Employee's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for employee name input

Grid for date of birth input

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

If yes, has a Workers' Compensation claim been filed? Yes No

If yes, name of Workers' Compensation carrier

Telephone Number

Address of Carrier

Fax Number

City

State

Zip

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

G. Information About Your Pension Plan: This information is necessary to ensure the benefit is calculated accurately. (Do not complete for a maternity claim.)

Do you have a pension plan? Yes No If yes, what type? PERS/STRS \$ _____ Defined benefit

Cash Balance 401(k)/403(b) Profit Sharing Money Purchase Plan/401A Other: (specify)

Is the employee eligible for your pension plan? Yes No

What percentage does the employee contribute?

If eligible, does the employee participate? Yes No

_____ %

If yes, what is the earliest age or date the employee is eligible to withdraw?

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? Yes No

If yes, whom should we contact to discuss a return-to-work plan?

Name

Title

Telephone Number

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 the Employer portion of the claim form.

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

Employer Tax ID Number

E-mail Address

Signature

X

Date



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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete, sign and date this form. The purpose of this form is to assist us in making a disability determination. Please complete all questions on this form and provide copies of supporting reports, such as office notes, medical records, medication logs, consultations and/or testing. Be sure to sign and date this form in Section D.

Name of Patient (Last Name, Suffix, First Name, MI)

[Grid for patient name]

Social Security Number

[Grid for social security number]

Patient Address

[Grid for patient address]

City

[Grid for city]

State

[Grid for state]

Zip

[Grid for zip]

Date of Birth (mm/dd/yy)

[Grid for date of birth]

Patient Telephone Number

[Grid for patient telephone number]

Employer Name

[Grid for employer name]

A. Patient Information

Date of first visit for this current condition(s) (mm/dd/yy):

Date of last 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):

Has the patient been treated for the same/similar condition in the past? Yes No Unknown

If yes, please provide treatment dates (mm/dd/yy): From

Through

Is the patient's condition work related? Yes No Unknown

Patient's Height:

Patient's Weight

What is the primary diagnosis that may impact your patient's functional capacity?

Please include primary ICD or DSM codes

ICD Code:

DSM:

What are the other diagnoses that may impact your patient's functional capacity? NA

Secondary Diagnosis:

ICD Code:

Secondary Diagnosis:

ICD Code:

Has the patient been hospitalized? Yes No If yes, date hospitalized (mm/dd/yy):

through (mm/dd/yy):

Was surgery performed? Yes No If yes, what procedure was performed?

CPT Code:

Date Surgery Performed (mm/dd/yy):



ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name Date of Birth (mm/dd/yy)

--	--	--	--	--

B. Functional Capacity

If your patient **does not** have physical and/or behavioral health RESTRICTIONS (activities patient should not do) and/or LIMITATIONS (activities patient cannot do), please initial here _____ and go to **SECTION D**.

Please note: When considering a standard 8 hour workday with breaks (approximately every two hours) please quantify terms that may not be uniformly understood such as "prolonged", "repetitive", "light-duty", "heavy lifting", or "stressful situations". In addition, never means not at all, occasional means more than never but less than 33% of the time; frequent means 34-66% of the time, and constant means 67-100% of the time.

Physical Restrictions and/or Limitations

If your patient has CURRENT PHYSICAL RESTRICTIONS (activities patient should not do) and/or PHYSICAL LIMITATIONS (activities patient cannot do) list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yy): _____ To (mm/dd/yy): _____

Behavioral Health Restrictions and/or Limitations

If your patient has CURRENT BEHAVIORAL HEALTH RESTRICTIONS (activities patient should not do) and/or BEHAVIORAL HEALTH LIMITATIONS (activities patient cannot do) please list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yy): _____ To (mm/dd/yy): _____

What diagnostic or clinical findings support your patient's restrictions and/or limitations as noted above?

What is your treatment plan? Please include all medications.



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 (Continued)

Patient's Name

Grid for Patient's Name

Date of Birth (mm/dd/yy)

Grid for Date of Birth

C. Other Treating Providers, Facilities or Hospitals

Please provide complete name, contact information and specialty of any other treating physicians, facilities or hospitals.

Table with 3 columns: Name, Specialty, City, State

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 portion of the claim form.

D. Signature of Attending Physician

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 and Degree fields

Address field

City, State, Zip fields

Telephone Number, Fax Number, Physician's Tax ID Number fields

Are you related to this patient? Yes/No and relationship question

Signature of Physician and Date fields



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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, Brown & Brown Absence Services 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, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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 _____ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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