SHORT TERM DISABILITY CLAIM FORM

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

Pacific Time Zone Toll-free: 1-877-851-7637
All Other Time Zones Toll-free: 1-800-858-6843
Fax (All Time Zones) Toll-free: 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

OUR COMMITMENT TO YOU

We understand that a disabling 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

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

- **Employee Statement (pages 4-5):** Please complete this section of the claim form and fax it to 1-800-447-2498. If you prefer, it may be mailed it to the address noted above.
- Please complete the name and date of birth fields at the top of every page for easy identification purposes 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.
- **Employee 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 7-8):** Please ask your employer to complete, sign and date the form and fax it to 1-800-447-2498 or mail it to the address noted above. If you are applying for Individual Short Term Disability benefits only, we do not require the Employer Statement.
- **Attending Physician Statement (pages 9-10):** Please complete Part I of this statement, then give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to complete Part II and fax the completed form to 1-800-447-2498. If s/he prefers, it may be mailed to the address noted above.

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.

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 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.

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.

Instructions (continued) / Claim Fraud Statements

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 STATEMENT (PLEASE PRINT)

A. Information About You

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female | The state in which you work

Home Address

City | State | Zip

Telephone Number where we can reach you | Preferred e-mail address (for confirmation purposes only)

Employer Name

Language Preference ☐ English ☐ Spanish

Please check all types of coverage you have with Unum. ☐ Group Short Term Disability ☐ Individual Short Term Disability

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

If yes, employer name | Telephone Number

B. Information About Your Disability

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

What is your expected delivery date? | If you have delivered, what was your delivery date? (mm/dd/yy) | What type of delivery? ☐ Vaginal ☐ C-Section

Were there any complications causing you to stop work prior to your expected delivery date? ☐ Yes ☐ No | If yes, please explain:

2. For **other than pregnancy**, is your disability caused by ☐ Illness or ☐ Injury?

What is the name of your medical condition? | Date you were first treated by a physician (mm/dd/yy)

If related to an injury, when, where and how did the injury occur?

3. Is your condition work related? ☐ Yes ☐ No | If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

If yes, please explain how the work related injury/illness occurred:

4. Have you been hospitalized? ☐ Yes ☐ No | If yes, date hospitalized (mm/dd/yy): | through (mm/dd/yy):

5. Last day you were at work (mm/dd/yy) | Number of hours worked on date last worked | First date you missed work due to this medical condition (mm/dd/yy)

6. Have you returned to work? ☐ Yes ☐ No If yes, indicate date below.
Part Time (mm/dd/yy): Part-time hours per week: Full Time (mm/dd/yy):

If you have not returned to work, when do you expect to return?
Part Time (mm/dd/yy): Part-time hours per week: Full Time (mm/dd/yy): ☐ Unknown

C. Information About Your Medical Providers

Please provide the following information about your current medical treatment providers (physicians, hospitals, physical therapist, etc.). **If you are being treated by more than one, please share the following information for each provider on a separate sheet of paper and include it with this form**.

Provider Name | Telephone No. ( ) | Fax No. ( )

Date of first visit for this condition (mm/dd/yy) | Date of next visit for this condition (mm/dd/yy)

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EMPLOYEE STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

D. Information About Income Tax Withholding. The following information will ensure your benefit is taxed appropriately according to Federal and State regulations.

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 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 benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.

Fraud Warning: For your protection, **Arizona** law requires the following to appear directly above your signature:

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 directly above your signature:

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.

E. Signature of Employee/Individual

I have read and understand the fraud notices listed 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 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 authorize Unum to leave messages about my claim on my voicemail / answering machine.
☐ Yes ☐ No

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.

_____ _____

Employee Signature Date

_____ _____

Printed Name Social Security Number

I signed on behalf of the employee 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 Telephone Number

Employer Address

City

State

Zip

B. Information About the Employee

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

Employee 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 provide the information requested.

☐ Short Term Disability	Policy Number	Division Number	Effective Date
☐ Long Term Disability	Policy Number	Division Number	Effective Date
☐ Voluntary Benefits Disability	Policy Number		Effective Date

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

Previous Plan Year:
Date of Open Enrollment (mm/dd/yy): _____ Option: _____

Current Plan Year:
Date of Open Enrollment (mm/dd/yy): _____ Option: _____

Is this employee: ☐ Full-time ☐ Part-time ☐ Exempt ☐ Non-exempt ☐ Bargaining ☐ Non-bargaining

Date Last Worked (mm/dd/yy)

Number of hours worked on date last worked

Check off regular work days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Hours scheduled to work per week:

Did this employee reduce his/her hours **prior** to his/her last day worked due to this medical condition? ☐ Yes ☐ No

If yes, please provide specific dates and hours worked.

Occupation Title (please attach a copy of the employee's job description)

Has the employee's employment been terminated? ☐ Yes ☐ No

If yes, termination date (mm/dd/yy):

How was the employee paid? (please check all that apply)
☐ Hourly ☐ Salary ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other

If the policy defines earnings as prior year W-2, please attach a copy.

Salary/Wage prior to date last worked
☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
$ _____

Bonuses (per week) $ _____
Commissions (per week) $ _____

Employee Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability so that earnings will be calculated as defined by the policy.

401(k)/403(b)
_____%

Pre-tax medical and other insurance
$ _____/week

Flexible spending account
$ _____/week

Date paid through (mm/dd/yy):

For: ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick pay ☐ Other

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

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EMPLOYER STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

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

Complete only for New York Disability Benefits Law or New Jersey Temporary Disability Benefits Salary Information

If this policy provides New York Disability Benefits Law or New Jersey Temporary Disability Benefits coverage, please provide the earnings for the 8 weeks prior to disability. (For Disability Benefits Law - include the week in which disability began. For Temporary Disability Benefits - include the **8 full** weeks of income just prior to date disability began.)

	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					

C. Information Needed for Calculation of FICA

What percentage of the Short 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.

D. Information About Your 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, who should we contact to discuss a return-to-work plan?

Name | 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 Employer portions of the claim form.

E. 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

Telephone Number	Fax Number	E-mail Address

Signature

X

Date Signed

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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT

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

Social Security Number

Date of Birth (mm/dd/yy)

Home Telephone Number

Employer Telephone Number

Employer Name

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

A. Complete this section for pregnancy, then go to section C

Expected Delivery Date (mm/dd/yy):	Actual Delivery Date (mm/dd/yy):	Delivery Type: ☐ Vaginal ☐ C-Section	Date of first visit for this pregnancy (mm/dd/yy):	Date Hospitalized (mm/dd/yy):
Diagnosis:	ICD Code:	Did you advise your patient to stop working? ☐ Yes ☐ No		If yes, on what date (mm/dd/yy)?

Were there any complications causing your patient to stop working prior to her expected delivery date? ☐ Yes ☐ No
If yes, please explain:

B. Complete this section for all conditions except pregnancy, then go to Section C

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, on what date (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

Primary Diagnosis:	Primary ICD Code:
Secondary Diagnosis:	Secondary 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):

What is your treatment plan? Please include all medications.

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient Name (Last Name, First Name, MI, Suffix) | Date of Birth (mm/dd/yy)

Other Providers: Are you aware of or have you referred your patient to other treating providers? If yes, please provide complete name, contact information and specialty of any other treating physicians.

Name	Specialty	Address	Phone #

Have you advised the patient to return to work? ☐ Yes ☐ No

Expected return to work date (mm/dd/yy): ☐ Full Time ☐ Part Time

Part-time hours per day

CURRENT RESTRICTIONS (activities patient should not do) and CURRENT LIMITATIONS (activities patient cannot do). Please be specific and understand that a reply of "no work" or "totally incapacitated" will not enable us to evaluate the claim for benefits.

What diagnostic or clinical findings support your patient's work restrictions and limitations?

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.

C. 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 | Degree/Specialty

Address

City | State | Zip

Telephone Number | Fax Number | Physician Tax ID Number: | Are you related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

Signature of Physician | **Date**

X

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EMPLOYEE/INDIVIDUAL AUTHORIZATION – FOR EMPLOYEE TO COMPLETE

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

I authorize 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, credit bureaus, the MIB Group, Inc., GENEX Services, Inc., The Advocator Group and other Social Security advocacy vendors, The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), 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;

To the following persons: 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"), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims, including assistance with return to work. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate 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 is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

_____ _____
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.

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