



**CLAIM FOR SELECT INCOME PROTECTION BENEFITS**

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

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

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

**Please mail or fax this form to:**

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

This form should be used for the following types of claims only:

- Educator Select Income Protection Plan (Employees of any Educational Institution)
- Educator Select Short Term Income Protection Plan (Employees of any Educational Institution)
- Select Income Protection Plan
- Select Short Term Income Protection Plan

This form must be completed by the Attending Physician, the Employee, and the Employer, 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 keep a copy of this form and any attachments for your records.

Our centralized mail processing center, located in Columbia, SC, services our Benefits Centers located in:  
• Chattanooga, TN • Glendale, CA • Portland, ME

**The employee is responsible for completion of all portions of this form without expense to the Unum 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. Advise your physician(s) to attach copies of medical records and test results.
- B. Employee's Statement:** This section must be completed by you, the employee. It includes a Physician/ Medication page that must also be completed by you. If necessary, you may include additional information on the back of this page. To avoid delay in evaluating your claim, advise your physician(s) to attach copies of medical records and test results.
- C. Employer's Statement:** The employer must complete this form.

**Authorization:** Sign and date this form. Provide a copy of the signed and dated form to your attending physician.

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



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**ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)**

Name of Patient	Home Telephone Number ( )	Date of Birth	Social Security Number
Employer Name/Address			Employer Telephone Number ( )

**Instructions:** The following sections must be completed and signed by the attending physician. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete the normal pregnancy section. **Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, you must complete the signature block at the bottom of this form.**

**NORMAL PREGNANCY**

a) Expected Delivery Date: \_\_\_\_\_ b) Actual Delivery Date: \_\_\_\_\_ c) Delivery Type:  Vaginal  C-Section

d) Date of first visit for this pregnancy: \_\_\_\_\_ e) LMP: \_\_\_\_\_

Date First Unable to Work \_\_\_\_\_ Date Hospitalized \_\_\_\_\_ through: \_\_\_\_\_

Has patient been released to return to work in her own occupation?  Yes  No In any occupation?  Yes  No

If not, when should patient be able to return to work? Full-time: \_\_\_\_\_ Part-time: \_\_\_\_\_

**ALL OTHER CONDITIONS**

**Patient Information**

a) Height \_\_\_\_\_ Weight \_\_\_\_\_ b) Date of first visit regarding current conditions? \_\_\_\_\_

c) Date patient ceased work because of condition? \_\_\_\_\_ d) Did you advise patient to cease work?  Yes  No If yes, when? \_\_\_\_\_

e) Has the patient been treated for the same/similar condition in the past?  Yes  No If yes, when? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

f) Is the patient's condition due to injury or sickness involving the patient's employment?  Yes  No  Unknown

**Diagnosis and Treatment**

**Primary Diagnosis**

a) What is the primary diagnosis preventing your patient from working?  
Please include Primary ICD - 9 and/or DSM IV Multi-Axial Diagnoses and Codes \_\_\_\_\_

b) Date of last examination \_\_\_\_\_

c) Describe Reported Symptoms \_\_\_\_\_

d) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.) \_\_\_\_\_

**Other Conditions (Please attach additional information as necessary)**

Are there other conditions that prevent your patient from working? If so, please list with information as follows:

a) Secondary ICD-9s \_\_\_\_\_ Diagnosis \_\_\_\_\_  
Secondary ICD-9s \_\_\_\_\_ Diagnosis \_\_\_\_\_

b) Describe Reported Symptoms \_\_\_\_\_

c) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.) \_\_\_\_\_

**Treatment**

a) Describe the patient's current treatment program: (include facilities name/address if applicable) \_\_\_\_\_

b) Medications (Please list all medications including dosage and frequency) \_\_\_\_\_

c) Has patient been hospitalized?  Yes  No Date Hospitalized \_\_\_\_\_ through \_\_\_\_\_

d) Was surgery performed? CPT 4 Code(s) \_\_\_\_\_ Date Surgery Performed: \_\_\_\_\_  
Name/Address of facility \_\_\_\_\_

e) Is the patient still under your care?  Yes  No Final Date of Treatment \_\_\_\_\_

Claimant Name:

Social Security Number:

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment		
					From	To	

Physical Capabilities

a) Patient's ability to: ( Please Check Number of Hours Per Workday and How Often)

	Number of Hours								How Often			
Sit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently	
Stand	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently	
Walk	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently	

b) Patient's ability to: (Please Check)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist/bend/stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate heavy machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c) Patient's ability to lift/carry: (Please Check)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d) Patient's ability to perform: (Please Check)

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
	R	L	R	L	R	L	R	L
Fine Finger movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand/eye coordinated movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dominant Hand	<input type="checkbox"/> Right		<input type="checkbox"/> Left					

Psychological Features

Are there any cognitive deficits or psychiatric conditions that interfere with the patient's ability to perform his/her occupation? If so, please describe specifically how any identified condition prevents the patient from performing his/her occupation.

Return to Work

a) When do you expect improvement in the patient's capabilities?

b) Have you advised patient to return to work?  Yes  No Expected Return to Work Date  Full Time  Part Time

If yes, please indicate any ongoing restrictions and limitations in the space provided below.

If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below.

c) RESTRICTIONS (activities patient should not do)

d) LIMITATIONS (activities patient cannot do)

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.

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

SSN or Employer's ID Number:

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



Employee Name: \_\_\_\_\_

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

10. Are you currently employed by another employer?  Yes  No If yes, please advise the name and telephone number of that employer.

**If you work for an educational institution (school, college, university, etc.) , please complete questions #11 through #13. If not, continue to the signature block.**

11. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.

**If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.**

Have you filed for Sabbatical Leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Payment Began: _____
Do you intend to file?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Payment Amount \$ _____ week/month
If filed, has it been approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Leave:	<input type="checkbox"/> Yes <input type="checkbox"/> No	What Type? _____
If yes, date benefits began: _____		Payment Amount \$ _____ week/month

Have you filed for:		PAYMENT AMOUNT	WEEKLY	MONTHLY	Begin Date	Through Date
Teachers' Retirement - Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teachers' Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
If no, do you intend to file?	<input type="checkbox"/> Yes <input type="checkbox"/> No					

12a. Have you ever been employed by any other school(s) or District(s)?  Yes  No

12b. Please list name(s) of school(s)/District(s) and years employed.

13. If you work in the state of Louisiana:

Have you filed for LA 90-day Extended Sick Leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Payment Began: _____
Do you intend to file?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Payment Amount \$ _____ week/month
If filed, has it been approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

### Employee Signature Required

I have read and understand the fraud notices listed below.

The above statements and the information provided on the Physician/Medication list (if applicable) are true and complete to the best of my knowledge and belief.

**(Your signature is required for benefit consideration.)**

Signature \_\_\_\_\_

Date \_\_\_\_\_

### 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 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 Statement for Puerto Rico Residents

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 STATEMENT — Physician/Medication List (PLEASE PRINT)**

To avoid delay please answer all questions as completely as possible. Please attach additional pages if needed.

Claimant's Full Name	Policy No.
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**Please list ALL treatment providers with whom you are currently treating.**

1) \_\_\_\_\_ ( )  
 Provider Name Mailing Address Telephone No.  
 ( )  
 Specialty City State Zip Fax No.  
 Frequency of Treatment Date of Last Visit

2) \_\_\_\_\_ ( )  
 Provider Name Mailing Address Telephone No.  
 ( )  
 Specialty City State Zip Fax No.  
 Frequency of Treatment Date of Last Visit

3) \_\_\_\_\_ ( )  
 Provider Name Mailing Address Telephone No.  
 ( )  
 Specialty City State Zip Fax No.  
 Frequency of Treatment Date of Last Visit

**Please list any recent hospital confinements.**

1) \_\_\_\_\_  
 Hospital Address Dates of Confinement  
 Procedure City State Zip

2) \_\_\_\_\_  
 Hospital Address Dates of Confinement  
 Procedure City State Zip

**Please list all current medications.**

Prescription Name	Dosage	Prescribing Physician
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____



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**C. EMPLOYER'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 Workplace Benefits
- Select Income Protection  Select Short Term Income Protection  Educator Select Income Protection  Educator Select Short Term Income Protection

1. Employer Name \_\_\_\_\_ Employer's Phone Number ( ) \_\_\_\_\_

Employer Address (Street, City, State, ZIP) \_\_\_\_\_

Policy Numbers	Division Number / Class Number	Division Description / Class Description
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2. Employee's Name \_\_\_\_\_ Employee's Phone Number ( ) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employee's Address (Street, City, State, ZIP) \_\_\_\_\_

Date of Hire	Effective Date of STD or Select Short Term Income Protection Insurance	Effective Date of LTD or Select Income Protection Insurance
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Effective Date of ID Insurance	Effective Date of Life Insurance	Effective Date of Voluntary Workplace Benefits	Date Last Worked
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Please attach a copy of current year and prior year enrollment forms.

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

Has the employee's employment been terminated?  Yes  No If yes, please provide termination date \_\_\_\_\_

3. Has employee returned to work?  Yes  No If yes, date \_\_\_\_\_  Full Time  Part Time Hours Per Week \_\_\_\_\_

4. Job Title/Major Job Duties (Please attach a copy of employee's job description) \_\_\_\_\_

Did the employee's job duties and/or hours change prior to his/her last day worked due to disability?  Yes  No If yes, please explain. \_\_\_\_\_

5. How was the STD or Select Short Term Income Protection premium paid for the plan year in which the disability occurred?  
Percentage paid by Employer \_\_\_\_\_ Was the premium amount paid by the employer included in the employee's W-2?  Yes  No  
Percentage paid by Employee \_\_\_\_\_  Pre-tax  Post-tax

6. How was the LTD or Select Income Protection premium paid for the plan year in which the disability occurred?  
Percentage paid by Employer \_\_\_\_\_ Was the premium amount paid by the employer included in the employee's W-2?  Yes  No  
Percentage paid by Employee \_\_\_\_\_  Pre-tax  Post-tax

7. How was the ID premium paid for the plan year in which the disability occurred?  
Percentage paid by Employer \_\_\_\_\_ Was the premium amount paid by the employer included in the employee's W-2?  Yes  No  
Percentage paid by Employee \_\_\_\_\_  Pre-tax  Post-tax

8. Year to Date Earnings (for FICA % Deductions) \$ \_\_\_\_\_

9. Does this employee contribute to FICA:  Yes  No Medicare SSDI:  Yes  No Medicare:  Yes  No

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

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

<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly	Bonuses (per week) \$ _____	Commissions (per week) \$ _____
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11. Required for LTD, ID and Select Income Protection: 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 3 months 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-1s, Schedule Cs, teacher's contract, etc.).

Employee Name:

Social Security Number:

12. Employee 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

13. 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

Paid Time Off/Sick Leave balance as of last day worked:

14. Does the employee 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

15. Prior LTD Carrier Name and Address

Effective Date:

Termination Date:

Table with 7 columns: 16. Is employee eligible for: Yes No, If yes, weekly or monthly amount, Weekly, Monthly, When do benefits begin?, When do benefits end?. Rows include Salary Continuation, State Disability, Other Disability Benefits, Social Security, Public Employee Retirement, Health Insurance, Life Insurance, Workers' Compensation.

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

If so, has a Workers' Compensation claim been filed?

If yes, Name and Address of Carrier

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

17. Information about your pension plan

Do you have a pension plan? If yes, what type? Defined benefit Defined contribution 401(k)/403(b) Profit Sharing Other: (specify)

Is employee eligible for your pension plan? If eligible, does the employee participate? What % does employee contribute?

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

18. If the employee is released to return to work with restrictions and limitations, are you willing to accommodate?

Educational Institution Employers (schools, colleges, universities, etc.) complete question #19

Table with 2 columns: 19. Has the employee filed for: Sabbatical Leave? Teachers' Retirement, Teachers' Retirement Disability. Includes sub-questions on eligibility, approval, and payment amount.

Louisiana Educational Employers Only

Is the employee eligible for LA 90-day Extended Sick Leave? Yes No. If yes, does he/she intend to file? Yes No. If filed, has it been approved? Yes No. Includes date and amount of payment.

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

Form with fields: Name of Person Completing Form (please print), Telephone Number, Title of Person Completing Form, E-mail Address, Fax Number, Signature, Date Signed.



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**FOR EMPLOYEE TO COMPLETE**

**NOTE:** This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

**Authorization**

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum Group, its insurance subsidiaries\* and duly authorized representatives ("Unum"). Information about my health may relate 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 understand that any information Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. 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.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

\_\_\_\_\_  
(Claimant Signature)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Social Security Number)

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

\* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.