



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

Group Life

Disability Benefit Forms

These forms are to be used when requesting that premiums be waived due to total disability of an employee. Claim forms should be submitted when it appears the employee will be totally disabled beyond the Elimination Period as defined in your policy. Proof of total disability must be received no later than the time frames specified in your policy following the employee's date of loss.

Instructions:

1. Employer's Authorized Representative to complete Employee, Policyholder and Job Analysis sections.
2. Employee to complete Claimants Statement.
3. Employee's physician to complete Attending Physician's Statement.
4. Authorization Form to be signed and dated by employee and submitted with other forms to:

Please mail or fax:

Unum

Group Life Disability

The Benefits Center

P.O. Box 100158

Columbia, SC 29202-3158

1-800-445-0402

Fax 800-447-2498 or 877-851-7624

Note:

Certain states require that we inform you regarding Fraudulent Claims Statutes. Please see below for applicable states.

Attention should be given to the following 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 and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

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

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Statement for New York Residents

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.



GROUP LIFE INSURANCE DISABILITY BENEFIT FORM
POLICYHOLDER'S CERTIFICATE OF COVERAGE

Group Life Disability

The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
1-800-445-0402 Fax 800-447-2498 or 877-851-7624

Instructions: Have the reverse side of this form completed by insured claimant. If all questions have been answered, complete this portion in full.

- Attach: [] Photocopy of the insured's enrollment card(s) from initial enrollment to present
[] Photocopy of any change of beneficiary
[] Photocopy of Social Security award/denial
[] Salary Verification - payroll records for last month of full-time employment just prior to date last worked for benefit amounts that are a multiple of the employee's salary. Note: If earnings definition is prior years W-2, please submit.
[] Job Description
[] Retirement Plan Summary

Please retain original.

This form represents initial notice of claim. Additional documentation may be requested upon review of this claim.
Statement of Policy Holder (Employer) - Please Complete All Items, Omissions May Cause A Delay.

Employee Information (Complete for all claims)

Form section for Employee Information including fields for Full Name of Insured Employee, Social Security No., Date of Birth, U.S. Citizen status, Occupation, Salary/Rate of Pay, Date Effective, Work week, Amount of Unum Group Insurance, Date Employed, Effective Date of Unum Insurance, Date Last Worked, Reason for Ceasing Work, and premium termination status.

Retirement Plan Information - Note: Please send copy of Plan Summary

Form section for Retirement Plan Information including questions about retirement plan participation, eligibility, and benefit types.

Policyholder Data

Form section for Policyholder Data including fields for Policy No., Div. No., Name of Policyholder, Name of Subsidiary or Division, Company Name, Claim Correspondent, Title, Address, and Telephone Number.

The information Given Above is Correct and Complete According To Our Records

Signature line for employer's authorized representative and Date (mm/dd/yyyy)

GROUP LIFE CLAIMANT'S STATEMENT

To Avoid Delay, Answer All questions

Full Name (Last First)	Last	First	Middle	Social Security Number
Address	City	State		Zip Code
Date of Birth (mm/dd/yyyy)	Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status
I have been unable to work because of this disability since: _____ (mm/dd/yyyy)			Date of your accident or the date you first noticed the symptoms of your illness: _____ (mm/dd/yyyy)	Name of Employer
				Occupation
				State nature of your disability

Describe how and where accident occurred or describe the first symptoms of your illness:

Date you were first treated for your illness or injury: _____ (mm/dd/yyyy)	Treated By:
	Hospital _____ Name Address Phone
	Doctor _____ Name Address Phone
Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes If "Yes," When? <input type="checkbox"/> No	Treated By:
	Hospital _____
	Doctor _____

Occupational History

Company Name	Occupation	Date of Employment (mm/dd/yyyy)

My present daily activities consist of:

Educational Background:

No. of Grade Completed _____ Highest Degree Received _____

Other Training or Education _____

Describe any other income you are receiving or are eligible to receive as a result of your disability:
(Examples: Social Security; Workman's Compensation; State Disability; Pension Disability, etc.)

Describe Source	Amount of Income	Date Income Began (mm/dd/yyyy)	Date Income Ended (mm/dd/yyyy)

FRAUD NOTICE: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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

Social Security No. _____ - _____ - _____

Employee's Signature _____

Date (mm/dd/yyyy) _____



DISABILITY CLAIM
JOB ANALYSIS

To Be Completed By The Employee's Supervisor

This claim is for (Employee's Name)

Employee's Social Security Number

Last Date Worked (mm/dd/yyyy)

A. General information about the employee's job

Job Title

Minimum education or training required

Does the employee perform supervisory functions?

Yes No If yes, how many people?

Describe duties

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:

- Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Table with 4 columns: Activity, Occasionally, Frequently, Continuously. Rows include: Relate to others, Written and verbal communication, Reasoning, math and language, Make independent judgments.

Which of the following describe the employee's working environment? Check all that apply.

- Unprotected heights, Changes in temperature or humidity, Exposure to dust, fumes and gases, Being near moving machinery, Driving automotive equipment, Other hazards

Is the employee required to travel?

Yes No If yes, complete the following information:

How does the employee travel? (Automobile, plane, train, etc.) Where does the employee travel? What percent of the time does the employee travel?

B. Information about the physical aspects of the employee's job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

- Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Table with 4 columns: Activity, Occasionally, Frequently, Continuously. Rows include: Standing, Walking, Sitting, Balancing, Stooping, Kneeling, Crouching, Crawling, Reaching/working overhead, Climbing, Stairs, Ladders, Pushing, Pulling, Lifting/carrying. Includes 'Describe Activity' and 'Weight' columns.

Can the job be performed by alternating sitting and standing?

Yes No

Does the job require using the feet to operate foot controls?

Yes No If yes, on what type of equipment?

How important is good vision in the job?

What are the major tasks requiring use of one or both hands?

One Hand

Both Hands

C. Information about the job as it relates to the disability

Can the job be modified to accommodate the disability either temporarily or permanently?

Yes No If yes, explain

Is it possible to offer the employee assistance in doing the job (through use of technology or personal assistance for example)?

Yes No If yes, explain

D. Attachments and Signature (Attach a copy of the employee's job description)

Name of person completing this form

X

Signature

Title

Date (mm/dd/yyyy)

Telephone ()

Fax ()



ATTENDING PHYSICIAN'S PRELIMINARY STATEMENT OF DISABILITY

Group Life Disability

The Benefits Center

P.O. Box 100158

Columbia, SC 29202-3158

1-800-445-0402 Fax 800-447-2498 or 877-851-7624

The insured is responsible for having their Attending Physician complete this form without expense to Unum.

Name	Policy Number
Present Address (No., Street, City, State, Zip Code)	Date of Birth

History

When did symptoms first appear or accident happen?	Date patient ceased work because of disability (mm/dd/yyyy)	Has patient ever had same or similar condition? <input type="checkbox"/> Yes If "Yes" state when and describe. <input type="checkbox"/> No
Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Names and addresses of other treating physician who referred patient to you.	

Diagnosis (including any complications)

Date of last examination (mm/dd/yyyy)	Diagnosis - ICD - 9 code (including any complications)
Subjective Symptoms	Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)

Nature of Treatment

Nature of Treatment (including surgery and medications prescribed, if any)

Dates of Treatment

Date of First Visit (mm/dd/yyyy)	Date of Last Visit (mm/dd/yyyy)	Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)
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Progress

Has Patient: <input type="checkbox"/> Recovered <input type="checkbox"/> Unchanged	<input type="checkbox"/> Retrogressed	Is Patient: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed Confined	<input type="checkbox"/> House Confined <input type="checkbox"/> Hospital Confined
Has patient been Hospital Confined? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Cardiac (if Applicable)

Functional Capacity (American Heart Association) <input type="checkbox"/> Class 1 (No Limitation) <input type="checkbox"/> Class 2 (Slight Limitation)	<input type="checkbox"/> Class 3 (Marked Limitation) <input type="checkbox"/> Class 4 (Complete Limitation)	Blood Pressure (last visit) _____ Systolic / Diastolic
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Physical Impairment

Physical Impairment (*as defined in Federal Dictionary of Occupational Titles)

Class 1 — No limitation of functional capacity; capable of heavy work.* No restrictions. (0-10%)

Class 2 — Medium manual activity.* (15-30%)

Class 3 — Slight limitation of functional capacity; capable of light work.* (33-55%)

Class 4 — Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)

Class 5 — Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)

Remarks:

Mental/Nervous Impairment (if Applicable)

Please define "stress" as it applies to this claimant.

What stress and problems in interpersonal relations has claimant had on job?

- Class 1 — Patient is able to function under stress and engage in interpersonal relations (no limitations).
- Class 2 — Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- Class 3 — Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations. (moderate limitations).
- Class 4 — Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- Class 5 — Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).
- Remarks:

Do you believe this patient is competent to endorse checks and direct the use of the proceeds thereof?

- Yes
- No

Prognosis

Is patient now totally disabled?

If "Yes" explain.

Patient's Occupation

Any other Work

- Yes
- No

- Yes
- No

Can present job be modified to allow for handling with impairment?

When could trial employment commence?

- Yes
- No

Patient's Occupation

Any Other Work

Mo Day Yr

Mo

Day Yr

 1 mo. 3-6 mos. 1 mo. 3-6 mos. 1-3 mos. never 1-3 mos. never

If "No," please explain.

Rehabilitation

Is patient a suitable candidate for further rehabilitative services? (i.e. cardiopulmonary program, speech therapy, etc.)

If "Yes" explain.

Patient's Occupation

Any other Work

- Yes
- No

- Yes
- No

Can present job be modified to allow for handling with impairment?

When could trial employment commence?

- Yes
- No

Patient's Occupation

Any Other Work

Mo Day Yr

Mo

Day Yr

 1 mo. 3-6 mos. 1 mo. 3-6 mos. 1-3 mos. never 1-3 mos. never

Would vocational counseling and/or retraining be recommended?

- Yes
- No

Remarks

Name (Attending Physician) — Print

Degree

Specialty

Telephone Number

Street

City or Town

State of Province

Zip Code

NOTE: Please include last six office treatment notes and appropriate test results.

FRAUD NOTICE: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Attending Physician Signature

Date (mm/dd/yyyy)



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NOTE: Federal law requires that we obtain this authorization from you. 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 Customer Care 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; 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 to disclose any and all of this information to persons who administer claims for Unum, 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 for evaluating and administering my claim(s) for benefits, which may include assisting me in returning 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 period 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.

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