

# UNUMPROVIDENT CLAIM FOR INCOME PROTECTION BENEFITS

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

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

Mail to: Plan Administration, Ltd.  
580 Hazard Avenue  
Enfield, CT 06082  
Phone: 860-272-1135

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

- Short Term Disability (STD)
- Voluntary Workplace Benefits (VWB)
- Integrated STD, Long Term Disability (LTD) and/or Individual Disability (ID) and/or Life Insurance Waiver of Premium and/or VWB

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 UnumProvident Corporation subsidiaries.

## INSTRUCTIONS:

- A. Attending Physician's Statement:** This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form.
- B. Claimant's Statement:** This section must be completed by you, the 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. Employment 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.

## 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.



# CLAIM FOR INCOME PROTECTION BENEFITS

## A. 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: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
Date First Unable to Work	Date Hospitalized	

### 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
e) Has the patient been treated for the same/similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Subjective Symptoms

d) Describe Objective 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 Subjective Symptoms

c) Describe Objective 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	Fax ( )
Signature of Physician			Date

SSN or Employer's ID Number:

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





# CLAIM FOR INCOME PROTECTION BENEFITS

## B. CLAIMANT'S 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) _____	_____	_____



# CLAIM FOR INCOME PROTECTION BENEFITS

## C. EMPLOYMENT STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

Short Term Disability  Long Term Disability  Individual Disability  Waiver of Premium (Life Insurance)  Voluntary Workplace Benefits

1. Employer Name		Employer's Phone Number (      )
Employer Address (Street, City, State, ZIP)		

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

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

Date of Hire	Effective Date of STD Insurance	Effective Date of LTD Insurance	Effective Date of ID Insurance	Date Last Worked
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Claimant's Work Status:  Full-time  Part-time  Exempt  Non-exempt  Bargaining  Non-bargaining

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

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

3. Has claimant 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 claimant's job description)

5. How was the STD 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 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. How was the claimant paid? (please check all that apply)

Hourly  Salary  Overtime  Bonus  Commissions  Other

What is the earnings figure you use to compute premium payments for this claimant on an annual basis? \$

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)
\$	\$	\$

If this policy provides New York DBL or New Jersey TDB coverage, please provide the earnings for the 8 weeks prior to disability (For DBL - including the week in which disability began. For TDB - the 8 full weeks of income just prior to date disability began.)

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

Claimant Name:

Social Security Number:

10. Required for LTD and ID: 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.).

Claimant Name:

Social Security Number:

11. Claimant Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability

401(k)/403(b) %; Pre-tax medical and other insurance \$ /week; Flexible spending account \$ /week

12. 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:

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

Type of business entity? Regular Corporation S Corporation Partnership Sole Proprietorship

14. If this is a Flexible Benefits Plan, indicate which option of coverage this claimant has chosen.

Previous Plan Year - Date of Open Enrollment Option Current Plan Year - Date of Open Enrollment Option

15. Prior LTD Carrier Name

Effective Date

Address (Street, City, State, ZIP)

Termination Date

Table with 7 columns: 16. Is claimant 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, Worker's Compensation.

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

If so has Workers' Compensation claim been filed? If yes, Name and Address of Carrier

Health Insurance If yes, Name and Address of Carrier

Life Insurance If yes, please provide the amount of coverage: \$

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

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

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

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

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

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

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

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



**CLAIM FOR INCOME PROTECTION BENEFITS**

**FOR EMPLOYEE TO COMPLETE**

**NOTE:** This authorization has been crafted 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, UnumProvident 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; 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 UnumProvident Corporation, its insurance subsidiaries\* and duly authorized representatives ("UnumProvident"). 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 UnumProvident 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 UnumProvident 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, UnumProvident 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, UnumProvident 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 UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.