



DISABILITY CLAIM FORM

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
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

When should you use this claim form?

Use this claim form to submit a disability claim to Unum. This form should be used for the following types of claims only:

- Long Term Disability
- Any combination of the following: Long Term Disability, Individual Disability and Life Insurance Waiver of Premium. If you are covered for more than one of these products, this is the only form you need to complete.

Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for disability benefits. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- **Employee/Individual Statement (pages 4-7):** Please complete this section of the claim form and fax it to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If you prefer, it may be mailed 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.
- **Direct Deposit Request (page 8):** Please complete this form if you wish to have your Long Term Disability benefits deposited directly into your bank account.
- **Authorization to Share Information with Third Parties (page 9):** If you wish to give us permission to share the details of your claim with a third party (such as your spouse, child, sibling, friend, etc.), please sign and date this form and fax it to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If you prefer, it may be mailed to the address noted above.
- **Employee/Individual Authorization (last page):** Please sign and date this form and provide a copy to your attending physician. Fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones) or mail it to the address noted above.
- **Employer Statement (pages 10-12):** Please give this section of the claim form to your employer and ask him/her to complete, sign and date the form. Your employer should fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones) or mail it to the address noted above.
- **Attending Physician Statement (pages 13-15):** 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 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). 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.



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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.



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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/INDIVIDUAL STATEMENT (Continued)

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

Date of Birth (mm/dd/yy)

Grid for name entry

Grid for date of birth entry

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

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

Have you been treated for this condition(s) in the past? If yes, when and by whom?
Yes No

Is your condition related to your occupation? If yes, please explain:
Yes No If no, go to Section C.

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

C. Information About Your Disability

Date last worked (mm/dd/yy): Number of hours worked on date last worked: Date you were first unable to work due to this medical condition (mm/dd/yy):

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

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

Form for medical providers with fields for Provider Name, Mailing Address, Telephone No., Specialty, City, State, Zip, Fax No., Date of First Visit, Date of Next Visit.

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

Form for hospital visits with fields for Hospital, Address, Date of Visit/Admission, Procedure, City, State, Zip, Date of Discharge.

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

Table for medications with columns: Prescription Name, Dosage/Frequency, Prescribing Physician, Pharmacy Name.



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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

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

Date of Birth (mm/dd/yy)

Grid for name and date of birth input

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

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

Table with 5 columns: Other Source of Income, Eligible to Receive, Receiving, Amount, Benefit Begin Date. Rows include Short Term Disability, State Disability Plan, Workers' Compensation, Motor Vehicle Insurance, Third Party Settlement/Income, Social Security/Disability, Social Security/Family, Social Security/Retirement, Unemployment, Pension/Disability, Pension/Retirement, Canada Pension, Public Employee Retirement System, State Teachers Retirement System.

F. Information About Your Return-to-Work

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

Part Time (mm/dd/yy):

Full Time (mm/dd/yy):

Hours per week:

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

Part Time (mm/dd/yy):

Full Time (mm/dd/yy):

Unknown

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

Marital Status: Single Married Widowed Divorced Domestic Partner Separated

Spouse/Partner's Name

Spouse/Partner's Date of Birth (mm/dd/yy)

Is he/she employed? Yes No

List your dependent children who are under age 25 (include additional sheets if necessary).

Table with 3 columns: Name, Date of Birth (mm/dd/yy), Attending School? (Yes/No)

H. 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-funded plan, please contact your employer for assistance.

- For Fully-Insured Plans – If your request for benefits is approved, should Unum withhold Federal and/or State Income Taxes from your benefit checks?

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

Minimum Withholding: \$20/week for Short Term Disability and \$88/month for Long Term Disability.

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

- For Self-Funded 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.



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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 claimant as _____ (indicate relationship). If Power of Attorney Designee, Personal Representative, Guardian, or Conservator, please attach a copy of the document granting authority.



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

A. Information About the Employer

Employer Name

Grid for Employer Name

Employer's Phone Number

Grid for Employer's Phone Number

Employer Address

Grid for Employer Address

City

Grid for City

State

Grid for State

Zip

Grid for Zip

Prior LTD Carrier Name

Grid for Prior LTD Carrier Name

Prior LTD Carrier Employee Effective Date

Grid for Prior LTD Carrier Employee Effective Date

Prior LTD Carrier Policy Termination Date

Grid for Prior LTD Carrier Policy Termination Date

B. Information About the Employee

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

Grid for Employee's Name

Employee's Address

Grid for Employee's Address

City

Grid for City

State

Grid for State

Zip

Grid for Zip

Employee Telephone Number

Grid for Employee Telephone Number

Social Security Number

Grid for Social Security Number

Date of Hire (mm/dd/yy)

Grid for Date of Hire

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

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

Table with columns for Policy Number, Division Number, Class Number, Division Description / Class Description, Basic Life Amount, Supplemental Life Amount

Date Last Worked (mm/dd/yy): Number of hours worked on date last worked: Days/Week, Hours/Day, Regular Work Schedule Hours/Week

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

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

Previous Plan Year, Current Plan Year, Date of Open Enrollment (mm/dd/yy) Option

C. Information About the Employee's Occupation

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

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

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

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

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

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



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EMPLOYER STATEMENT (Continued)

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

Date of Birth (mm/dd/yy)

Grid for entering employee name and date of birth

D. Information About the Employee's Salary

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

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

Date paid through for (mm/dd/yy): Paid Time Off balance as of last day worked:
Salary Continuation _____
Vacation Pay _____ Sick Leave balance as of last day worked:
Accrued Sick pay _____
Other _____

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

Type of business: Regular Corporation S Corporation Partnership Sole Proprietorship

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

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

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

E. Information Needed for Calculation of FICA

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

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

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

What percent of the Individual Disability benefit is taxable? %

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

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

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

F. Information About Other Disability Income

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



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EMPLOYER STATEMENT (Continued)

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

Date of Birth (mm/dd/yy)

Grid for employee name input

Grid for date of birth input

Is the claim the result of a work related injury or illness? Yes No | If yes, has a Workers' Compensation claim been filed? Yes No

If yes, name of Workers' Compensation carrier

Telephone Number

Address of Carrier

Fax Number

City

State

Zip

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

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

Do you have a pension plan? Yes No

If yes, what type? Defined benefit Defined contribution 401(k)/403(b) Profit Sharing Other: (specify)

Is the employee eligible for your pension plan? Yes No

What percentage does the employee contribute?

If eligible, does the employee participate? Yes No

_____ %

If yes, when is the employee eligible to withdraw from the plan?

H. Information About Your Rehire or Return-to-Work Program

If the employee is released to return to work in restricted duty, are you willing to discuss accommodations? Yes No

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

Name

Title

Telephone Number

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

I. Signature of Benefit Administrator (Please Print)

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

Name of Person Completing Form

Title of Person Completing Form

Telephone Number

Fax Number

Employer Tax ID Number

E-mail Address

Signature

X

Date



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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT

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

[Grid for patient name]

Social Security Number

[Grid for social security number]

Date of Birth (mm/dd/yy)

[Grid for date of birth]

Home Telephone Number

[Grid for home telephone number]

Employer Name

[Grid for employer name]

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

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

A. Patient Information

Date of first visit for this current condition(s) (mm/dd/yy):	Date of last office visit (mm/dd/yy):	Date of next office visit (mm/dd/yy):	Did you advise your patient to stop working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective when? (mm/dd/yy):
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Patient's Height:	Patient's Weight
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What is the primary diagnosis that may impact your patient's functional capacity?

Please include primary ICD Code or DSM-IV Multi-Axial diagnoses codes		ICD Code:		
DSM-IV: I	II	III	IV	V

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

Secondary Diagnosis:	ICD Code:
Secondary Diagnosis:	ICD Code:

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

Was surgery performed? Yes No If yes, what procedure was performed? _____ CPT Code: _____ Date Surgery Performed (mm/dd/yy): _____



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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name

Grid for Patient's Name

Date of Birth (mm/dd/yy)

Grid for Date of Birth

C. Other Treating Providers, Facilities or Hospitals

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

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

D. Signature of Attending Physician

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

Physician Name (Last Name, First Name, MI, Suffix) Please Print

Medical Specialty, Degree

Address

City, State, Zip

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

Are you related to this patient? Yes No

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.