LONG TERM DISABILITY CLAIM FORM

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

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, or 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.

Instructions

The information provided on this claim form will be used to evaluate your eligibility for disability benefits.

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

- **Employee/Individual Statement (pages 4-7):** Please complete this section of the claim form and fax it to 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- **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. You may also sign up via your online account at www.unum.com/cclaims.
- **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 1-800-447-2498. 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 1-800-447-2498 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 1-800-447-2498 or mail it to the address noted above.
- **Attending Physician Statement (pages 13-15):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to complete and fax the completed form to 1-800-447-2498. If s/he prefers, it may be mailed to the address noted above.

Unum Online Services

Unum has developed a secure and easy way for you to submit and manage your claim online via our secure website at www.unum.com/claims. Our secure web services allow you to access and make changes to your open claims, as well as view updates and available correspondence. Please contact your employer's human resource department to verify online filing is available to you.

Once you have submitted your claim, you may manage it with the Unum Customer App. The Unum Customer App is available for Apple and Android.

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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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 Alabama Residents

For your protection, Alabama law requires the following to appear on this claim form:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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.

Claim Fraud Statements

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.

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 (PLEASE PRINT)

A. Information About You

Last Name | Suffix | First Name | MI

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

Home Address

City | State | Zip

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

Employer Name

Language Preference ☐ English ☐ Spanish

Please check all types of coverage you have with Unum.

☐ Short Term Disability ☐ Long Term Disability ☐ Individual Disability ☐ Life Insurance ☐ Voluntary Benefits Disability
☐ Voluntary Benefits Cancer/Critical Illness ☐ Voluntary Benefits Accident ☐ Voluntary Benefits MedSupport

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

If yes, employer name: | Telephone Number

B. Information About Your Disability

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):

C. Information About the Condition(s) Causing Your Disabililty

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

What is the name of your medical condition? | What were your first symptoms?

Describe when you first noticed the symptoms. | Date you were first treated by a physician (mm/dd/yy):

2. For an **injury**, answer the following questions then go to #4:

What is the name of your medical condition?

Describe where and how the injury occurred.

Date the injury occurred (mm/dd/yy): | If related to a motor vehicle accident, was an accident report filed? ☐ Yes ☐ No | Date you were first treated by a physician (mm/dd/yy):

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

What is your expected delivery date?

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

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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

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

Have you already delivered? ☐ Yes ☐ No | If yes, what type of delivery? ☐ Vaginal ☐ C-Section | If yes, date of delivery:

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? ☐ Yes ☐ No | If yes, when and by whom?

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

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

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.

1. Provider Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | ( ) Fax No.
Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

2. Provider Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | ( ) Fax No.
Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

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.

1. Hospital | Address | Date of Visit/Admission (mm/dd/yy)
Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

2. Hospital | Address | Date of Visit/Admission (mm/dd/yy)
Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

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

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

	Prescription Name	Dosage/Frequency	Prescribing Physician	Pharmacy Name
1.				
2.				
3.				
4.				
5.				

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.

Other Source of Income	Eligible to Receive	Receiving	Amount	Benefit Begin Date
Short Term Disability	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
State Disability Plan (CA, HI, NJ, NY, PR, RI)	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Workers' Compensation	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Motor Vehicle Insurance	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Third Party Settlement/Income	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Social Security/Disability	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Social Security/Family	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Social Security/Retirement	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Unemployment	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Pension/Disability	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Pension/Retirement	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Canada Pension	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
Public Employee Retirement System	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		
State Teachers Retirement System	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown		

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). Name	Date of Birth (mm/dd/yy)	Attending School?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

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

H. Information About Income Tax Withholding: Unum will not withhold Federal and State Income Tax if your benefit is not taxable.

TAX INFORMATION

If you do not know if you are covered under a fully-insured or self-insured plan, please contact your employer for assistance.

- **For Fully-Insured Plans** – If your claim is approved and your employer tells us your benefit is taxable, we are required by law to withhold FICA taxes. Do you want Unum to also withhold Federal and/or State Income Taxes from your taxable benefit checks?
  Federal Income Tax: ☐ Yes ☐ No If yes, how much do you want withheld from each check? (whole dollar amount) $_____
  Minimum Withholding: $20/week for Short Term Disability.
  State Income Tax: ☐ Yes ☐ No If yes, how much do you want withheld from each check? (whole dollar amount) $_____
- **For Self-Insured Plans** – Attach a copy of your completed W-4 for accurate calculation of Federal and State Income Taxes. **Note:** If not provided, we are required by law to withhold 25% of your taxable benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.
- **If your benefits are not taxable, Federal and State Income Taxes will not be withheld.**

Fraud Warning: For your protection, Arizona law requires the following 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 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.

I. Signature of Employee/Individual

I have read and understand the fraud notices listed on pages 2 and 3 of this form. I also acknowledge that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

X _____ _____
Signature **Date**

Reminder: Please sign and date the Authorization (last page of this claim form).

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Please provide the information requested below. Once completed, sign and date the form, attach the appropriate documentation and mail or fax it to the address or fax number indicated above. As a convenience, we also offer a secure website at www.unum.com/claimant where you can sign up for direct deposit.

A. Information About You

Last Name | First Name | MI

Address

City | State | Zip

Social Security Number | Home Telephone Number

B. Information About How to Set-up or Change Your Direct Deposit

☐ Set-up Direct Deposit ☐ Change Direct Deposit Account

Bank/Financial Institution Information

Name

City | State | Zip

Choose Type of Account – Note: We are only able to deposit benefit payments into one account.

☐ Checking OR ☐ Savings

REQUIRED FOR CHECKING: Please provide either 1.) a voided check imprinted with your name; or 2.) the top portion of a bank statement or a letter from your bank, on bank letterhead, signed and dated by a bank representative. One of these items must be received to process your request.

Please note: additional documentation is not required for direct deposit into a savings account.

Please verify the Transit Routing number with your bank.
A Routing Number beginning with the number 5 is not valid. (Ex: 502000027)

Bank Transit/Routing Number | Personal Account Number

C. Direct Deposit Cancellation Request

Please complete this section if you are canceling your direct deposit agreement.

☐ Cancel my direct deposit agreement Effective Date

D. Signature of Individual

X _____ _____

Signature of Individual | Date

Frequently Asked Questions About Direct Deposit

- **What is Direct Deposit?**
  Unum will deposit your benefits directly into your checking or savings account on a weekly or monthly basis as per policy provisions.
- **When can I expect the money to be in my account?**
  Because this can vary from person to person, please discuss the details with a Direct Deposit Specialist. Funds will be credited on the second business day after the date of release of funds with the exception of a Federal Reserve Bank Holiday.
- **What if I have questions?**
  Please call our toll-free Direct Deposit Customer Service line at 1-800-413-7671. Knowledgeable and courteous representatives are available to answer your questions, Monday through Friday, 8 a.m. to 4 p.m. Eastern Standard Time.

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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 | Employer's Phone Number

Employer Address

City | State | Zip

Prior LTD Carrier Name | Prior LTD Carrier Employee Effective Date | Prior LTD Carrier Policy Termination Date

B. Information About the Employee

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

Employee's Address

City | State | Zip

Employee Telephone Number | Social Security Number | Date of Hire (mm/dd/yy)

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

☐ Short Term Disability _____ ☐ Long Term Disability _____ ☐ Individual Disability _____
☐ Life Insurance _____ Premium paid thru date _____ ☐ Voluntary Benefits Disability _____
☐ Voluntary Benefits Cancer/Critical Illness _____ ☐ Voluntary Benefits MedSupport _____

Short Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description
Long Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description
Individual Disability Policy Number	Division Number	Class Number	Division Description / Class Description

Life Insurance 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
Date of Open Enrollment (mm/dd/yy) _____ Option _____

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
If yes, please explain:

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)

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 $ _____
☐ Weekly $ _____
☐ Bi-Weekly $ _____
☐ Semi-Monthly $ _____
☐ Bonuses $ _____
☐ Commissions $ _____

Date paid through for (mm/dd/yy):
☐ Salary Continuation _____
☐ Vacation Pay _____
☐ Accrued Sick pay _____
☐ Other _____

Paid Time Off balance as of last day worked:

Sick Leave balance as of last day worked:

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.

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

Is employee eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	Date benefits begin	Date benefits end
Salary Continuation	☐	☐	$	☐	☐		
Short Term Disability	☐	☐	$	☐	☐		
State Disability	☐	☐	$	☐	☐		
Other Disability Benefits	☐	☐	$	☐	☐		
Social Security Disability Insurance	☐	☐	$	☐	☐		
Workers' Compensation	☐	☐	$	☐	☐		

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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).

EMPLOYER STATEMENT (Continued)

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

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

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? ☐ PERS/STRS $_____ ☐ Defined benefit

☐ Cash Balance ☐ 401(k)/403(b) ☐ Profit Sharing ☐ Money Purchase Plan/401A ☐ 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, what is the earliest age or date the employee is eligible to withdraw?

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**

LONG TERM DISABILITY CLAIM FORM
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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

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.

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

Social Security Number

Date of Birth (mm/dd/yy)

Patient Telephone Number

Employer Name

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? ☐ Yes ☐ No If yes, effective when? (mm/dd/yy):

Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yy): From Through

Is the patient's condition work related? ☐ Yes ☐ No ☐ Unknown	Patient's Height:	Patient's Weight

What is the primary diagnosis that may impact your patient's functional capacity?

Please include primary ICD or DSM codes	ICD Code: DSM:

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 | Date of Birth (mm/dd/yy)

B. Functional Capacity

If your patient ***does not*** have physical and/or behavioral health RESTRICTIONS (activities patient should not do) and/or LIMITATIONS (activities patient cannot do), please initial here _____ and go to ***SECTION D.***

Please note: When considering a standard 8 hour workday with breaks (approximately every two hours) please quantify terms that may not be uniformly understood such as "prolonged", "repetitive", "light-duty", "heavy lifting", or "stressful situations". In addition, never means not at all, occasional means more than never but less than 33% of the time; frequent means 34-66% of the time, and constant means 67-100% of the time.

Physical Restrictions and/or Limitations

If your patient has CURRENT PHYSICAL RESTRICTIONS (activities patient should not do) and/or PHYSICAL LIMITATIONS (activities patient cannot do) list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yy): _____ To (mm/dd/yy): _____

Behavioral Health Restrictions and/or Limitations

If your patient has CURRENT BEHAVIORAL HEALTH RESTRICTIONS (activities patient should not do) and/or BEHAVIORAL HEALTH LIMITATIONS (activities patient cannot do) please list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yy): _____ To (mm/dd/yy): _____

What diagnostic or clinical findings support your patient's restrictions and/or limitations as noted above?

What is your treatment plan? Please include all medications.

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name | Date of Birth (mm/dd/yy)

C. Other Treating Providers, Facilities or Hospitals

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

Name	Specialty	City, State

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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 If yes, what is the relationship?

Signature of Physician	**Date**
X	

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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 to Collect and Disclose Information
(Not for FMLA Requests)

I authorize the following persons: 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, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocator Group and other Social Security advocacy vendors, 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 ("My Information");

To 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");

So that Unum may evaluate and administer my claims, including providing assistance with return to work. For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits, whichever is shorter. I understand that once My Information is disclosed to Unum, any privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum may then disclose My Information only as permitted by law, including, state fraud reporting laws or as authorized by me.

I also authorize Unum to disclose My Information to the following persons (for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum; or, the Social Security Administration. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purposes of these disclosures by Unum, this authorization is valid for one year or for the length of time otherwise permitted by law.

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, except as specified above, Unum may not be able to evaluate or administer 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 Unum requests or discloses prior to Unum receiving my revocation request.

_____ _____
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.