UNUMPROVIDENT

CLAIM FOR LIFE / ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

UnumProvident, Group Life/Special Risk Benefits Center
P.O. Box 9061, Portland Maine 04104-5046
Telephone: 1-800-445-0402 Fax: 207-575-6096

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

First Unum Life Insurance Company
Provident Life and Casualty Insurance Company
The Paul Revere Life Insurance Company

Please fax this form to:

UnumProvident
Group Life/Special Risk Benefits Center
Fax 207-575-6096

Or mail to:

UnumProvident
Group Life/Special Risk Benefits Center
P.O. Box 9061
Portland Maine 04104-5046
Telephone 1-800-445-0402

This form must be completed and returned promptly by the Employer 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 be sure to keep a copy of this form and any attachments for your records.

Please submit the following documentation for this claim:

A completed Notice of Claim
A copy of the death certificate (a photocopy or fax is acceptable)
The original enrollment form and any enrollment forms for a change in coverage
All beneficiary designation forms

- if named beneficiary has predeceased the Insured, a copy of the deceased beneficiary's death certificate
- if the beneficiary is the Estate of the Insured, a copy of the court appointment naming the Executor, Administrator, or Personal Representative

If this is an Accidental Death Claim, also complete section A-1, and submit police and EMS reports
If this is a Dismemberment Claim, also complete sections A-2 and A-3, and submit police, EMS, and medical reports
If this is an Accelerated Death Claim, also complete sections B-1 and B-2

In order to accurately determine the Life Benefit payable; please provide the following salary verification/documentation:

If Definition of Annual Earnings is:	**Required Documentation:**
1) W-2	Include copy of Previous Year's W-2 (year prior to month/year of date last worked
2) Salary with Commissions and/or Bonus	One month's payroll records (for month preceding date last worked) plus documentation of commissions and/or bonus paid over the last 12 months (as defined in your contract).

UNUMPROVIDENT®

(1-800-445-0402)
LIFE CLAIM
CLAIMANT'S AUTHORIZATION

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 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.

Section 1. Insurance Information

Indicate the type of claim being filed:

☐ Life – Policy Number _____ Division _____
☐ Dependent? ☐ Voluntary
☐ Accelerated? ☐ Individual

☐ AD&D – Policy Number _____ Division _____
☐ Dependent?

☐ Special Risk – policy number _____ _____ GTA _____
☐ Dependent?

Section 2. Employer Information

Company Name _____ Subsidiary/Affiliate/Branch _____

Street Address_____ City_____ State_____Zip_____

Name and Title of Authorized Representative_____

Telephone number _____ Fax Number _____

E-Mail Address _____ Is it OK to correspond via e-mail? ☐ Yes ☐ No

Signature of Authorized Representative_____

Section 3. Employee Information

Full Name_____ Social Security # _____

Please provide any other names (i.e., maiden name, alias, hyphenated name, etc.) that this person is or has been known by.

_____

Address of Employee _____

Date of Birth _____ Employment Status: ☐ Full Time ☐ Part Time Hours/week _____

Hourly or Salary Employee? _____

Job Title/Class _____ Salary/Rate of Pay _____

Date of Hire _____ Effective Date of Coverage _____

Date Last Physically at Work _____ Reason for Ceasing Work _____

Is the employee receiving any company sponsored retirement benefits? ☐ Yes ☐ No

Date of Death _____ Accidental Claim being submitted? ☐ Yes ☐ No

Amount of UnumProvident Group Life Insurance:

Basic Life	$_____	Supplemental Life	$_____	Special Risk Basic	$_____
Basic AD&D	$_____	Supplemental AD&D	$_____	Special Risk Supp	$_____
		Travel Accident	$_____		

Date of Last Change in Amount of Insurance _____

Amount of Last Change

Basic Life	$_____	Increased	Decreased
Supplemental Life	$_____	Increased	Decreased
Basic AD&D	$_____	Increased	Decreased
Supplemental	$_____	Increased	Decreased
Travel Accident	$_____	Increased	Decreased
Special Risk Basic	$_____	Increased	Decreased
Special Risk Supp	$_____	Increased	Decreased

Date of Last Premium Payment _____

If accidental claim being submitted, does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled in an institution of higher learning beyond the 12th grade? ☐ Yes ☐ No

Name of dependent child _____ Age _____

Name of dependent child _____ Age _____

Section 4. Dependent Information (for Dependent claim)

Full Name of Dependent _____ Relationship to Insured_____

Date of Birth _____ Effective Date of Insurance _____ Date of Death _____ Amount of Insurance _____

Dependent Social Security # _____

Was employee actively working at time of death of dependent? ☐ Yes ☐ No

Section 5. Beneficiary Information (Please attach additional sheet if necessary)

1. Name of Beneficiary _____ Relationship to Insured _____ Date of Birth _____

Address of Beneficiary _____

Telephone Number _____ Social Security # _____

2. Name of Beneficiary _____ Relationship to Insured _____ Date of Birth _____

Address of Beneficiary _____

Telephone Number _____ Social Security # _____

3. Name of Beneficiary _____ Relationship to Insured _____ Date of Birth _____

Address of Beneficiary _____

Telephone Number _____ Social Security # _____

4. Name of Beneficiary _____ Relationship to Insured _____ Date of Birth _____

Address of Beneficiary _____

Telephone Number _____ Social Security # _____

5. Name of Beneficiary _____ Relationship to Insured _____ Date of Birth _____

Address of Beneficiary _____

Telephone Number _____ Social Security # _____

6. Name of Beneficiary _____ Relationship to Insured _____ Date of Birth _____

Address of Beneficiary _____

Telephone Number _____ Social Security # _____

Section 6. Minor Beneficiary Information

If any of the above beneficiaries are minors, please complete the following information:

Full Name of Beneficiary _____

Full Name of Guardian/Custodian _____

(include Guardian/Custodian papers if applicable)

Mailing Address of Guardian/Custodian _____

Telephone Number _____

Section 7. Survivor Information (Complete for claims eligible for Survivor Financial Counseling)

Name of Survivor _____ Telephone Number _____

Address _____

Attachment A-1 – Accidental Death (1-800-445-0402)

TO BE COMPLETED BY BENEFICIARY OR AUTHORIZED REPRESENTATIVE
PLEASE ANSWER ALL QUESTIONS

Full Name of Deceased _____Social Security Number _____
When did accident happen? _____ Time? _____
Where did accident happen? _____
How did accident happen? _____
_____
What was the deceased doing at the time of the accident? _____

List all Physicians and Surgeons who attended deceased for these injuries

Name _____ Address _____
Name _____ Address _____
Name _____ Address _____
Advise if Autopsy or Inquest was held _____
(Note: attach summary of autopsy report or copy of inquest proceedings)

List all witnesses to the accident

Name _____ Address _____
Name _____ Address _____
Name _____ Address _____

List all investigating authorities

Investigating Officer Name _____ Telephone Number _____
Other – Name/Title _____ Telephone Number _____

List all physicians who have attended deceased during the last five years (State ailments involved)

Name and Address _____
Ailment _____
Name and Address _____
Ailment _____
Name and Address _____
Ailment _____
Name and Address _____
Ailment _____
Name and Address _____
Ailment _____

In what capacity are you acting to complete this form?

☐ Named Beneficiary ☐ Representative of Named Beneficiary ☐ Administrator of Estate
☐ Other (please specify) _____
Telephone Number _____
Named Beneficiary Social Security Number or Taxpayer I.D. Number _____

Attachment A-2 – Accidental Dismemberment (1-800-445-0402)

TO BE COMPLETED BY THE CLAIMANT

Full Name (Last, First, Middle) _____

Social Security Number _____ Telephone Number _____

Occupation _____

Date of Accident _____ Date of Loss _____

Name of physician who treated you for this accident _____

Address of Physician _____

Telephone Number of Physician _____

Name of Hospital where you received treatment for this accident _____

Address of Hospital _____

Telephone Number of Hospital _____

Please describe the loss for which benefits are being claimed. (Please attach an additional sheet if necessary)

Attachment A-3 – Physician's Statement for Accidental Death and Dismemberment (1-800-445-0402)

TO BE COMPLETED BY THE ATTENDING PHYSICIAN FOR ACCIDENTAL DISMEMBERMENT

Patient's Name _____ Social Security Number _____

Date of Accident Causing Loss _____ Date First Consulted _____

Has the patient ever had the same or similar symptoms? ☐ Yes ☐ No If Yes, Date _____

Diagnosis or Nature of Injury _____

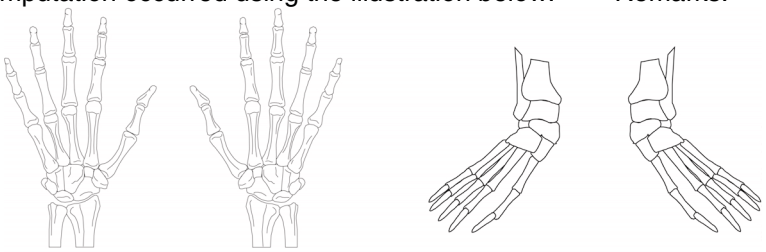
Describe Accident _____

When did symptoms first appear or accident happen? _____

Is condition arising out of employment? ☐ Yes ☐ No

If loss is extremity, where is amputation? _____

Please indicate where the amputation occurred using the illustration below: Remarks:



RIGHT LEFT RIGHT LEFT

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No (Attach records)

If loss is hearing, is loss in both ears? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No (Please attach audiograms and office notes)

If loss is vision please provide the following:

Date of first eye examination _____

Date of last eye examination _____ and visual acuity (Using Snellen Notation – See Below)

Uncorrected	**Corrected**
O.D. _____	O.D. _____
O.S. _____	O.S. _____

If the injury necessitated removal of either or both eyes, give date of removal _____

Vision can be restored in whole or in part by: ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

If by operation, do you recommend it? ☐ Yes ☐ No

Date corrected vision was irrecoverably reduced to 20/200 or less _____

In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

In your opinion, was the loss caused in any way by illness or disease? ☐ Yes ☐ No

List dates you provided treatment for this illness or injury: _____ _____

List names of other physicians who treated insured for this or a contributory condition:

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

PLEASE ATTACH COPIES OF OFFICE NOTES RELATED TO THIS INJURY

Name (Attending Physician – Please print) _____

Degree/Professional Designation _____ Telephone Number_____

Physician's Address (Number and Street, City/Town, State, Zip Code)_____

_____

Physician's Signature _____ Date _____

Attachment B-1 – Accelerated Benefit Claimant Statement (1-800-445-0402)

TO BE COMPLETED BY THE CLAIMANT

Date of injury or date you first noticed symptoms of your illness _____

Describe how and where injury occurred or describe the first symptoms of your illness and nature of illness.

_____

Is your injury or illness related to your occupation? ☐ Yes ☐ No If yes, explain _____

_____

Date you were first treated for your illness or injury _____
List all those that treated you for your illness or injury

Physician Name _____

Physician Address _____

Physician Telephone Number _____

Hospital Name _____

Hospital Address _____

Hospital Telephone Number _____

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No
(If yes, please attach Physician/Hospital information)

Special Notice to Minnesota Claimants:

Your authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term “emergency medical personnel” includes individuals employed to provide pre-hospital emergency services; licensed police officers, fire-fighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care and or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who qualify under the good Samaritan law.

Attachment B-2 – Accelerated Benefit – Attending Physician's Statement (1-800-445-0402)

Name of Patient _____

Date of Birth _____ Social Security # _____

When did symptoms first appear or injury happen? _____

Has patient ever had same or similar condition? ☐ Yes ☐ No

If "Yes" state when and describe _____

Names and addresses of other treating physicians:

Name _____ Address _____

Name _____ Address _____

Date of Diagnosis _____

Diagnosis _____
(Including any complications)

If Cancer, indicate Stage _____

Date of Distant Metastases _____ Location of Metastasis _____

Hospice Referral? ☐ Yes ☐ No If yes, Date _____

Date of First Visit _____ Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other
If "Other" please specify _____

Date of Last Examination _____

During last 6 months, has patient: ☐ Recovered ☐ Improved ☐ Retrogressed ☐ Unchanged

Is patient: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

Has Patient been Hospital Confined? ☐ Yes ☐ No Dates: _____

If "Yes" give name and address of hospital _____

Functional Capacity (American Heart Association)

☐ Class 1 (no limitation)
☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation)
☐ Class 4 (complete limitation)

Therapeutic Class (Activity)

☐ A. (No restrictions)
☐ B. (slight restrictions)
☐ C. (moderate restrictions)
☐ D. (marked restrictions)
☐ E. (complete restrictions)

What is the estimated life expectancy?

☐ Less than 6 months
☐ 6 – 12 months
☐ 12 – 24 months
☐ Greater than 24 months

Name of Attending Physician – Please Print _____

Degree _____ Medical Specialty _____

Telephone Number _____

Street Address _____

City/Town _____ State _____ Zip Code _____

Signature of Physician _____ Date _____

UnumProvident, Group Life Customer Care Center
P.O. Box 9061, Portland, Maine 04104-5046
Telephone: 1-800-445-0402

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to the address above.

AUTHORIZATION
For Life or Accidental Death Claim

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy, emergency medical service agency, or other medically related facility or service; medical examiner's office; coroner's office; health plan; rehabilitation professional; vocational evaluator; insurer; reinsurer; insurance service provider; third party administrator; producer; government organization; law enforcement agency; consumer reporting agency; and employer that has (1) information about the health, death, financial or credit history, earnings, employment history, or other insurance claims and benefits, or (2) blood, urine or other specimens of _____(print name of deceased) to disclose any and all of this information and specimens to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). Information about the deceased may include, but is not limited to, autopsy reports and findings, laboratory test results and findings, toxicology results, police reports, accident reports, or incident reports of any kind. Health information about the deceased 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 the claim(s). 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 the 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, alter, or do not sign 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.

_____ _____
Signature of Claimant (or Other Person Authorized to Act on Behalf of Deceased) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I, _____, signed on behalf of the claimant as the claimant's personal representative. 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: First Unum Life Insurance Company, Provident Life and Casualty Insurance Company, and The Paul Revere Life Insurance Company.

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AUTHORIZATION
For Accidental Dismemberment or Accelerated Benefit Claim

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy, emergency medical service agency, or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurer; reinsurer; insurance service provider; third party administrator; producer; government organization; law enforcement agency; consumer reporting agency; and employer that has (1) information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits, or (2) my blood, urine or other specimens to disclose any and all of this information and specimens to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). Information may include, but is not limited to, laboratory test results and findings, toxicology results, police reports, accident reports, or incident reports of any kind. Health information 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.

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_____ _____
Signature of Claimant (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I, _____, signed on behalf of the claimant as the claimant's personal representative. If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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