VOLUNTARY BENEFITS DISABILITY CLAIM FORM

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

Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday 8 a.m. to 8 p.m. Eastern Time

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

For use with policies issued by the above Unum Group ["Unum"] subsidiaries.

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 apply for disability benefits with Unum. This form should be used for the following types of claims only:

- Voluntary Benefits Disability
- Voluntary Benefits Life Insurance Wavier of Premium; or
- A combination of the two

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 neatly printed 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 Statement (pages 3-5):** Please complete this section of the claim form and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above.
- Please complete the name and date of birth fields at the top of every page for easy identification in case the pages become separated.
- **Attending Physician Statement (pages 6-8):** 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 1-800-447-2498 or mail it to the address noted above. Unum is not responsible for expenses associated with the completion of this form.
- **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, son, daughter, 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 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.

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.

*Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this form.

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.

For your protection:

Alabama law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado law requires the following statement to appear on this 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.

District of Columbia law requires the following statement to appear on this form: 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.

Florida law requires the following statement to appear on this form: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky law requires the following statement to appear on this 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.

Minnesota law requires the following statement to appear on this form: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire law requires the following statement to appear on this 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.

New Jersey law requires the following statement to appear on this 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, subject to criminal prosecution and civil penalties.

New York law requires the following statement to appear on this 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 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.

Pennsylvania law requires the following statement to appear on this 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.

Puerto Rico law requires the following statement to appear on this 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 (5,000) dollars and not more than ten thousand (10,000) dollars, 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.

VOLUNTARY BENEFITS DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

EMPLOYEE STATEMENT (PLEASE PRINT)

A. Information About You

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)	Social Security Number	Gender ☐ Male ☐ Female

Home Address

City	State	Zip

Home Telephone Number	Cellular Telephone Number	Work Telephone Number

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
Policy #	Policy #	Policy #	Policy #

☐ Voluntary Accident	☐ Voluntary Benefits Cancer/Critical Illness	☐ Voluntary Benefits MedSupport
Policy #	Policy #	Policy #

While there is no legal requirement for you to provide information regarding other policies you may have with Unum, this information will help us identify any other coverage you have with us for which you may be eligible to file a claim. Failure to provide the requested information may delay claim initiation under the additional policy or policies.

B. Information About Your Disability

Date Last Worked (mm/dd/yyyy)	Number of Hours Worked on Date Last Worked	Date you were first unable to work due to this medical condition (mm/dd/yyyy)

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

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

What is your medical condition?	What were your first symptoms?
When did you first notice the symptoms?	Date you were first treated by a physician (mm/dd/yyyy)

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

What is your medical condition?

Where and how did the injury occur?

Date the injury occurred (mm/dd/yyyy)	Date you were first treated by a physician (mm/dd/yyyy)

VOLUNTARY BENEFITS DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

EMPLOYEE STATEMENT (Continued)

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

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

What is your expected delivery date? (mm/dd/yyyy)

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

Have you already delivered? ☐ Yes ☐ No	If yes, date of delivery (mm/dd/yyyy):	If yes, what type of delivery? ☐ Vaginal ☐ C-Section

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

What is your job title?

What are the physical requirements of your job?

On average, how many hours a day are spent walking or standing at your job?

On average, how many pounds do you lift, carry, push or pull at your job?

Does your job require you to bend, twist, squat, kneel or climb on a daily basis? ☐ Yes ☐ No

Is this a work related injury or accident? ☐ Yes ☐ No	If yes, please explain how:

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

If no, do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No	If no, please explain why you are not filing a Workers' Compensation claim.

D. Information About Physicians and Hospitals

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 share the following information for each provider on 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 for this condition (mm/dd/yyyy) _____ Date of next visit for this condition (mm/dd/yyyy) _____

2. Provider Name _____ Mailing Address _____ Telephone No. _____

Specialty _____ City _____ State _____ Zip _____ Fax No. _____

Date of first visit for this condition (mm/dd/yyyy) _____ Date of next visit for this condition (mm/dd/yyyy) _____

Please list any hospital visits/admissions you have had in the last 12 months. If you have had more than one, provide the following information for each visit/admission on a separate sheet of paper and include it with this form.

1. Hospital/Facility Name _____ Address _____ Date of Visit/Admission (mm/dd/yyyy) _____

Procedure _____ City _____ State _____ Zip _____ Date of Discharge (mm/dd/yyyy) _____

VOLUNTARY BENEFITS DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

EMPLOYEE STATEMENT (Continued)

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

E. Information About Your Return-to-Work

Have you returned to work? ☐ Yes ☐ No | If yes, indicate date (mm/dd/yyyy):

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

Expected return to work date (mm/dd/yyyy):

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.

F. Signature of Employee/Individual

I have read and understand the fraud notices listed above and on page 2 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).

VOLUNTARY BENEFITS DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT

Name of Patient (Last Name, Suffix, First Name, MI)		Social Security Number
Date of Birth (mm/dd/yyyy)	Home Telephone Number	Cellular Telephone Number

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete, sign and date this statement. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete Section A. Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, please complete the signature block at the bottom of this form.

A. Complete this section for normal pregnancy, then go to section C. DON'T COMPLETE THIS SECTION IF NOT A NORMAL PREGNANCY.

Expected Delivery Date (mm/dd/yyyy):	Actual Delivery Date (mm/dd/yyyy):	Delivery Type: ☐ Vaginal ☐ C-Section	Date of first visit for this pregnancy (mm/dd/yyyy):
Date Hospitalized (mm/dd/yyyy):	Did you advise your patient to stop working? ☐ Yes ☐ No		If yes, on what date (mm/dd/yyyy)?

B. Complete this section for all conditions except normal pregnancy

Patient Information

Date of first visit for this current condition(s) (mm/dd/yyyy):	Did you advise your patient to stop working? ☐ Yes ☐ No If yes, on what date (mm/dd/yyyy)?

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

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

Is this condition the result of an accidental injury? ☐ Yes ☐ No If yes, please provide the following:

- the date of the accident (mm/dd/yyyy):
- the description of the accident:

Is the patient's condition due to injury or sickness involving the patient's employment? ☐ Yes ☐ No ☐ Unknown

Diagnosis

What is the primary diagnosis preventing the patient from working?

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 conditions that prevent the patient from working? ☐ NA

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

Are there any cognitive deficits or psychiatric conditions that impact function? ☐ Yes ☐ No
If yes, please provide restrictions and limitations:

Date of last examination (mm/dd/yyyy):	Date of next examination (mm/dd/yyyy):

What symptoms is your patient reporting about his/her condition?

What diagnostic or clinical findings support your diagnosis?

What diagnostic or clinical findings support your patient's work restrictions and limitations?

VOLUNTARY BENEFITS DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name (Last Name, Suffix, First Name, MI)	Date of Birth (mm/dd/yyyy)

Treatment

What is your treatment plan?

Medications (Please attach medication log)

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

Facility Name

Address

City	State	Zip

Was surgery performed? ☐ Yes ☐ No	If yes, what procedure was performed?	Date Surgery Performed (mm/dd/yyyy):

Is the patient still under your care? ☐ Yes ☐ No	If no, final date of treatment:

Other Providers: Was the patient referred to you or have you referred your patient to other treating providers? If yes, please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #

Functional Capacity This is your estimate of your patient's functional capacity based on your knowledge of the patient. This information is important to assess your patient's eligibility for disability benefits.

Patient's ability to: *(Please check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐

Patient's ability to perform: *(Please Check)*

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
Fine Finger movements	☐	☐	☐	☐	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☐ Right ☐ Left

Patient's ability to perform: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☐	☐	☐	☐
Twist/bend/stoop	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate heavy machinery	☐	☐	☐	☐

Patient's ability to lift/carry: (Please Check)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐

VOLUNTARY BENEFITS DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name (Last Name, Suffix, First Name, MI)	Date of Birth (mm/dd/yyyy)

Return to Work Assessment

Have you advised the patient to return to work? ☐ Yes ☐ No	If yes, expected return to work date (mm/dd/yyyy): ☐ Full Time ☐ Part Time	Hours per day

If yes, please indicate any ongoing restrictions and limitations in the space provided below.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below.

CURRENT RESTRICTIONS (activities patient should not do)

CURRENT LIMITATIONS (activities patient cannot do)

Do you support your patient's return to work within the restrictions and limitations you provided? ☐ Yes ☐ No	If yes, as of (mm/dd/yyyy):

If no, when do you expect improvement in the patient's functional capacity?

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 Attending Physician portions of the claim form.

C. 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	

The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498

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 leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), 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 any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) 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 understand that information about my claim(s) and/or leave(s) 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(s) and/or leave(s) 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 any of my claim(s) and/or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

_____ _____

Policyholder 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.

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-635-5597 Fax: 1-800-447-2498

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, Brown & Brown Absence Services 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, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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, First Unum Life Insurance Company*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty 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 (to include any subsequent financial management and/or benefit recovery review), 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.

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.

*Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.