DISABILITY STATUS UPDATE

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

Phone: 1-800-858-6843 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.

Instructions for Completing this Form

The purpose of this form is to provide us with current information that will be used to evaluate your continued eligibility for disability benefits. It consists of three parts; please complete or have completed each part as described below.

- **Employee Information (pages 3-7):** Please complete all sections of this statement (even if you have provided the same information in the past) and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above. **Please be sure to sign and date this form at the bottom of page 5.**

- **Attending Physician Statement (pages 7-9):** Please ask the physician or treating provider primarily responsible for your care to complete this form. Your physician or treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above.

- **Employee Authorization (last page):** Please sign and date this form and provide a copy to your attending physician. You should fax the completed form to 1-800-447-2498 or mail it to the address noted above.

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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* 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.

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EMPLOYEE INFORMATION (PLEASE PRINT)

A. Information About You

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)

Gender ☐ Male ☐ Female

Home Address

City	State	Zip

Home Telephone Number	Cellular Telephone Number

Please provide a contact person name, address and telephone number, in the event we are unable to reach you.

B. Information About Income You Are Receiving

Are you receiving any other forms of payment such as salary, sick pay, commissions, bonuses, or business income whether working or not.
☐ Yes ☐ No If yes, please explain:

Have you returned to work? ☐ Yes ☐ No If yes, please indicate the date:
Part Time (mm/dd/yyyy): Full Time (mm/dd/yyyy): Hours Per Week:

If yes, what is your income before taxes? $ ____________________ ☐ Hourly ☐ Weekly ☐ Monthly
☐ Bi-weekly (26 pay periods per year) ☐ Bi-monthly (24 pay periods per year)
Please provide copies of your pay stubs.

C. Information About Your Training and Education

Have you received additional training or advanced your education since you stopped working? ☐ Yes ☐ No

If yes, please explain.

D. Information About Your Condition

Please describe your current day-to-day activities (for example, household chores, reading, computer use, caring for family members/children, etc.)

Does your current condition prevent you from caring for yourself? ☐ Yes ☐ No
Does someone provide you with assistance in your daily activities? ☐ Yes ☐ No
Do you use an assistive device(s) such as a cane, walker, hearing aid, etc.)? ☐ Yes ☐ No
If you answered yes to any of these questions, please provide details:

E. Information About Medications

Please list all current medications. If you are taking more than five, please share the following information on a separate sheet of paper and include it with this form.

	Prescription Name	Dosage	Prescribing Physician	Pharmacy Name
1.				
2.				
3.				

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EMPLOYEE INFORMATION (Continued)

Last Name	Suffix	First Name	MI	Date of Birth (mm/dd/yyyy)

F. Information About Physicians and Hospitals

Please provide the following about any treatment providers you have seen since you last updated this information. If you are being treated by more than three providers, please share the following information 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 Last Visit (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 Last Visit (mm/dd/yyyy) | Date of Next Visit for this Condition (mm/dd/yyyy)

3. Provider Name | Mailing Address | Telephone No.
Specialty | City State Zip | Fax No.
Date of Last Visit (mm/dd/yyyy) | Date of Next Visit for this Condition (mm/dd/yyyy)

Please list any hospital visits/admissions you have had since you last updated this information. If you have had more than two, 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)

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

G. Information About Your Family

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

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner

Spouse/Domestic Partner's Name	Spouse/Partner's Date of Birth (mm/dd/yyyy)	Is he/she employed? ☐ Yes ☐ No

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

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

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EMPLOYEE INFORMATION (Continued)

Last Name	Suffix	First Name	MI	Date of Birth (mm/dd/yyyy)

H. Information About Your Vocational, Work or Training History

Have you had any change in your vocational, work or educational training history since you last reported this information? ☐ Yes ☐ No If yes, please describe and provide applicable dates.

I. 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 impact your benefit from Unum. Please indicate what other income benefits you are receiving or are eligible to receive as a result of your disability.

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

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.

J. Signature of Employee/Individual

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

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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 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.

____ ____________________

Claimant 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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ATTENDING PHYSICIAN INFORMATION (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 E.

Last Name	Suffix	First Name	MI	Date of Birth (mm/dd/yyyy)

Social Security Number	Telephone Number

Employer Name

A. Patient Information

Height:	Weight:	Blood Pressure: As of date (mm/dd/yyyy):

Diagnosis

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

Please include primary ICD Code.

DSM:

Date of last office visit (mm/dd/yyyy):	Date of next office visit (mm/dd/yyyy):

What are the symptoms currently reported by your patient?

What current diagnostic or clinical findings support your diagnosis?

Secondary Diagnosis

What are the other diagnoses that may impact your patient's functional capacity? ☐ N/A

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

B. Other Treating Providers, Facilities or Hospitals

Please provide complete name, specialty, city/state and date referred to any other treating physicians, facilities or hospitals.

Name	Specialty	City, State	Date Referred

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ATTENDING PHYSICIAN INFORMATION (Continued)

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

C. 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 E.***

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/yyyy): ______________ To (mm/dd/yyyy): ________________

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/yyyy): ______________ To (mm/dd/yyyy): ________________

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ATTENDING PHYSICIAN INFORMATION (Continued)

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

D. Treatment

What is your treatment plan? Please include all medications

Has your patient undergone any medical procedure(s) or hospitalizations since you last reported this information? ☐ Yes ☐ No ☐ Unknown

If yes, please describe and provide dates. Date procedure(s) performed (mm/dd/yyyy):

Are there any medical procedures anticipated in the next three months? ☐ Yes ☐ No ☐ Unknown

If yes, what is the procedure(s) and when will it be performed?

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 portion of the claim form.

E. Signature of Attending Physician

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

Physician Name (Last Name, Suffix, First Name, MI) 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?

X

Physician Signature **Date**

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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, 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.

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