ACCIDENT CLAIM FORM

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

Toll-free: 1-800-635-5597 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

OUR COMMITMENT TO YOU

We understand an 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.

When should you use this claim form?

Use this claim form to submit a Voluntary Benefits Accident claim to Unum.

Who is responsible for completing this claim form?

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

- **Insured/Patient Statement** (pages 3-4)**:** Please complete this section of the claim form and mail or fax the completed form to the address or fax number indicated above.
- Please complete the name and date of birth fields at the top of every page for easy identification purposes in case the pages become separated.
- **Authorization to Share Information with Third Parties** (page 5)**:** 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 mail or fax it to the address or fax number indicated above.
- **Insured/Patient Authorization** (last page)**:** Please sign and date this form, provide a copy to your attending physician, and mail or fax the completed form to the address or fax number indicated above. This form authorizes the release of medical information needed to evaluate your claim.
- **Employer Statement** (page 6)**:** If you are applying for the Disability Rider benefit, 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 mail or fax the completed form to the address or fax number indicated above.
- **Attending Physician Statement** (pages 7-8)**:** If you are applying for the Disability Rider benefit or the Hospital Confinement/ Intensive Care benefit, please complete Part I of this statement. Once Part I is complete give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete Part II. Your physician or treating provider should mail or fax the completed form to the address or fax number indicated above. Unum is not responsible for expenses associated with the completion of this form.

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. Eastern Time, Monday through Friday.

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CLAIM FRAUD 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 on this claim 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.

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 Notice for District of Columbia Residents

For your protection, the District of Columbia requires the following to appear on this claim form:
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 Maine, Tennessee and Virginia Residents

For your protection, Maine, Tennessee and Virginia law requires the following to appear on this claim form:
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

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 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

For your protection, New Jersey, New Mexico and 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 Statement 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 Statement 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 (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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INSURED/PATIENT STATEMENT (PLEASE PRINT)

A. Type of Claim

Please check the type of claim you are filing:
☐ Accidental Injury ☐ Hospital Confinement/Intensive Care ☐ Total Disability

This claim is for: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent Child

B. Information About the Insured

Last Name | Suffix | First Name | MI

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

Home Address

City | State | Zip

Home Telephone Number | Cellular Telephone Number | Work Telephone Number

Accident Policy Number | Preferred e-mail address (for confirmation purposes only)

Language Preference ☐ English ☐ Spanish

Please check all types of coverage you have with Unum.

☐ Short Term Disability Policy #	☐ Long Term Disability Policy #	☐ Individual Disability Policy #	☐ Life Insurance Policy #
☐ Voluntary Benefits Disability Policy #	☐ Voluntary Benefits Cancer/Critical Illness Insurance Policy #	☐ Voluntary Benefits MedSupport Insurance 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.

C. Information About the Patient

Last Name | Suffix | First Name | MI

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

Home Address

City | State | Zip

D. Complete this section for HOSPITAL CONFINEMENT/INTENSIVE CARE claims.

Please attach an itemized copy of your hospital bill that includes the following information.
1. Diagnosis
2. Admission and discharge dates

If your hospital bill does not contain this information, please ask your doctor to complete the Attending Physician Statement (pages 7-8, Sections B & C of this form.)

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INSURED/PATIENT STATEMENT (Continued)

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

E. Complete this section for ACCIDENTAL INJURY CLAIMS

Date of Accident | Time of Accident ☐ a.m. ☐ p.m.

Were you at work at the time of your accident? ☐ Yes ☐ No

Please explain how your accident happened. (If you need more space, please attach a separate sheet of paper).

Please attach itemized copies of any bills related to this accident including doctor, emergency room, hospital, and motor vehicle incident/accident report. Bills should include diagnosis information (from your medical provider). Additional medical information may be requested to evaluate your claim.

F. Information About Physicians and Hospitals

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

1. Primary Care Physician 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. Treating Physician 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 hospital visits/admissions you have had in the last 12 months. If you have had more than two, please share the following information for each visit/admission on 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)

G. Tax Considerations

Benefit payments under this policy could be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Unum reports taxable income to you and the IRS as required on form 1099-MISC for Accident plan benefits and/or a W-2 for Accident Disability benefits. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.

H. Signature of Insured

I have read and understand the fraud notices listed on page 2 of this form. I also understand 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**

I signed on behalf of the insured, as _____ (Indicate relationship). **If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.**

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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)

Other Family Member: _____
(Name / Relationship)

Other person: _____
(Name / Relationship)

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.

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

A. Information About the Employer

Employer Name

Employer's Telephone Number

Employer Address

City

State

Zip

B. Information About the Employee

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

Employee Address

City

State

Zip

Employee Telephone Number

Social Security Number

Date of Hire (mm/dd/yy)

Date Last Worked (mm/dd/yy)

Number of hours worked on date last worked

C. Information About the Employee/Individual's Job

Job Title (please attach a copy of the employee's job description)

Dates this employee has been unable to work: From (mm/dd/yy) ☐ am ☐ pm to (mm/dd/yy) ☐ am ☐ pm

Did the employee/individual's occupational duties and/or hours change prior to his/her last day worked due to disability? ☐ Yes ☐ No If yes, please explain.

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

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

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 Employer and Attending Physician portions 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

X

Signature **Date**

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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY INSURED/PATIENT

Insured Name (Last Name, Suffix, First Name, MI)

Insured Social Security Number

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

Patient Social Security Number

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child

Patient Date of Birth (mm/dd/yy)

Patient Gender: ☐ Male ☐ Female

PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN OR TREATING PROVIDER

Instructions: If the patient is submitting a claim for Disability Rider benefits, complete Section A and Section C. If the patient is submitting a claim for Hospital Confinement/Intensive Care Rider benefits, complete Section B and Section C.

A. Complete this section for DISABILITY claims.

Diagnosis	ICD-9 Code	Date first unable to work (mm/dd/yy)	Is this condition the result of an accidental injury? ☐ Yes ☐ No

If this claim is related to normal pregnancy, please provide the following:

Expected Delivery Date: (mm/dd/yy)	Actual Delivery Date: (mm/dd/yy)	Delivery Type: ☐ Vaginal ☐ C-Section

If related to a fracture or dislocation, please indicate:
☐ Closed ☐ Open ☐ Unknown Name of bone fractured:

If related to a laceration, please indicate the length:

If related to a burn, please indicate the degree: ☐ First ☐ Second-percent of body burned _____ % ☐ Third-square inches of body surface burned _____

Is the patient's condition related to his/her employment? ☐ Yes ☐ No ☐ Unknown

Has the patient been treated for the same or a similar condition by another physician in the past? ☐ Yes ☐ No ☐ Unknown
If yes, please list the diagnosis and treatment dates (mm/dd/yy).

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

Facility Name

Address

City	State	Zip

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

Is the patient still under your care? ☐ Yes ☐ No	If no, final date of treatment (mm/dd/yy):

Have you advised the patient to return to work? ☐ Yes ☐ No	If yes, expected return to work date (mm/dd/yy): ☐ 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)

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ATTENDING PHYSICIAN STATEMENT (Continued)

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

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

Is the patient permanently disabled? ☐ Yes ☐ No | If yes, what is the recommended frequency of treatment?

Does the patient have permanent restrictions and limitations? ☐ Yes ☐ No | If yes, please list the permanent restrictions and limitations.

B. Complete this section for HOSPITAL CONFINEMENT/INTENSIVE CARE BENEFIT claims

Diagnosis: | ICD-9 Code:

Dates of Inpatient Hospital Confinement: From (mm/dd/yy) To (mm/dd/yy)

Dates of Confinement in Intensive Care, including Coronary Care Unit: From (mm/dd/yy) To (mm/dd/yy)

Hospital Name | Telephone Number

Hospital Address

Date of Surgery (mm/dd/yy) ☐ Inpatient ☐ Outpatient (choose one)

Surgical Procedure | CPT 4 Code:

Date of follow up visit following confinement or outpatient surgery

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?

X

Physician Signature **Date**

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INSURED/PATIENT AUTHORIZATION

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; professional licensing body; and employer that has information about my health, financial or credit history, professional license, earnings, employment history, or other insurance claims and benefits, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum, its insurance subsidiaries* and duly authorized representatives ("Unum"), and, where applicable, to persons or entities that may assist me with or provide services related to my claim(s) for Social Security or other government-sponsored benefits. Information about my health 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 Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. 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 my claim, whichever 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 Unum 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 this authorization, Unum 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.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____
(Patient/Guardian Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

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

* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.