CLAIM FOR INCOME PROTECTION BENEFITS

The Benefits Center, P.O. Box 100158
Columbia, SC 29202-3158
Pacific Time Zone Toll-free: 1-877-851-7637 Fax: 1-877-851-7624
All Other Time Zones Toll-free: 1-800-858-6843 Fax: 1-800-447-2498

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

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

Please mail or fax this form to:
The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158
Pacific Time Zone Toll-free: 1-877-851-7637 Fax: 1-877-851-7624
All Other Time Zones Toll-free: 1-800-858-6843 Fax: 1-800-447-2498

This form should be used for the following types of claims only:
- Short Term Disability (STD)
- Voluntary Workplace Benefits (VWB)
- Integrated STD, Long Term Disability (LTD) and/or Individual Disability (ID) and/or Life Insurance Waiver of Premium and/or VWB

This form must be completed by the Attending Physician, the Employee, and the Employer, and be returned promptly 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 return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

Our centralized mail processing center, located in Columbia, SC, services our Benefits Centers located in:
• Chattanooga, TN • Glendale, CA • Portland, ME

The employee is responsible for completion of all portions of this form without expense to the Unum subsidiaries.

INSTRUCTIONS:

A. **Attending Physician's Statement:** This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form.

B. **Claimant's Statement:** This section must be completed by you, the employee. It includes a Physician/Medication page that must also be completed by you. If necessary, you may include additional information on the back of this page. To avoid delay in evaluating your claim, advise your physician(s) to attach copies of medical records and test results.

C. **Employment Statement:** The employer must complete this form for all claims other than VWB claims; for VWB claims, the employee may decide whether to submit the Employment Statement to the Employer for completion.

Authorization: Sign and date this form. Provide a copy of the signed and dated form to your attending physician.

Please enclose any additional information that you feel will assist us in evaluating this claim.

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 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

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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A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number ( )	Date of Birth	Social Security Number

Employer Name/Address	Employer Telephone Number
Town of Atlantic Beach	(252) 726-2121

Instructions: The following sections must be completed and signed by the attending physician. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete the normal pregnancy section. **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, you must complete the signature block at the bottom of this form.**

NORMAL PREGNANCY

a) Expected Delivery Date: b) Actual Delivery Date: c) Delivery Type: ☐ Vaginal ☐ C-Section

Date First Unable to Work: Date Hospitalized:

ALL OTHER CONDITIONS

Patient Information

a) Height: Weight: b) Date of first visit regarding current conditions?

c) Date patient ceased work because of condition? d) Did you advise patient to cease work? ☐ Yes ☐ No If yes, when?

e) Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No If yes, when?

If yes, please describe:

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

Diagnosis and Treatment
Primary Diagnosis

a) What is the primary diagnosis preventing your patient from working?

Please include Primary ICD-9 and/or DSM IV Multi-Axial Diagnoses and Codes

b) Date of last examination:

c) Describe Reported Symptoms:

d) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.):

Other Conditions **(Please attach additional information as necessary)**

Are there other conditions that prevent your patient from working? If so, please list with information as follows:

a) Secondary ICD-9s: Diagnosis:

Secondary ICD-9s: Diagnosis:

b) Describe Reported Symptoms:

c) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.):

Treatment

a) Describe the patient's current treatment program (include facilities name/address if applicable):

b) Medications (Please list all medications including dosage and frequency):

c) Has patient been hospitalized? ☐ Yes ☐ No Date Hospitalized: through:

d) Was surgery performed? CPT 4 Code(s): Date Surgery Performed:

Name/Address of facility:

e) Is the patient still under your care? ☐ Yes ☐ No Final Date of Treatment:

Claimant Name: Social Security Number:

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	To

Physical Capabilities

a) Patient's ability to: *(Please Check Number of Hours Per Workday and How Often)*

	Number of Hours									How Often	
Sit	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently
Stand	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently
Walk	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently

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

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

c) 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.	☐	☐	☐	☐

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

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

Dominant Hand ☐ Right ☐ Left

Psychological Features

Are there any cognitive deficits or psychiatric conditions that interfere with the patient's ability to perform his/her occupation? If so, please describe specifically how any identified condition prevents the patient from performing his/her occupation.

Return to Work

a) When do you expect improvement in the patient's capabilities?

b) Have you advised patient to return to work? ☐ Yes ☐ No Expected Return to Work Date: ☐ Full Time ☐ Part Time
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.

c) RESTRICTIONS (activities patient should not do)

d) LIMITATIONS (activities patient cannot do)

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.

Print or Type Name		Degree	Medical Specialty
Street Address			Telephone Number ( )
City	State	ZIP Code	Fax ( )
Signature of Physician			Date
SSN or Employer's ID Number:		Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship?	

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B. CLAIMANT'S STATEMENT (PLEASE PRINT)

1. Claimant's Name (as printed on your Social Security Card)	Home Telephone Number ( )	Date of Birth	Social Security Number
	Cell Telephone Number ( )	☐ Male ☐ Female	

Home Address (Street, City, State, ZIP)

The state in which you work:	Preferred e-mail address where you can be reached

2. Employer Name	Policy Number
Town of Atlantic Beach	

	If you have returned to work, list the duties of the occupation you are performing.	# of weekly hours spent at duty
Have you returned to work? If yes, when?		
Part Time: Full Time:		
Hours per week:		
If you have not returned to work, when do you expect to return?		
Part Time: Full Time:		

What specific job duties are you unable to do as a result of your sickness/injury?

In order to expedite your claim, please provide medical records to support your inability to perform your occupational duties.

3. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	If you are married, spouse's name	Spouse's Date of Birth	Is spouse employed? ☐ Yes ☐ No

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

Name	Date of Birth	Attending School?
		☐ Yes ☐ No
		☐ Yes ☐ No

4. Is this disability due to ☐ Motor Vehicle Accident ☐ Other Accident ☐ Sickness ☐ Work-related Injury/Sickness ☐ Pregnancy

Please describe your medical condition(s) or injury that is resulting in your disability. Advise when the symptoms first appeared. If related to an injury, advise when, where and how the injury occurred.

5. Date Last Worked	Number of Hours Worked on Date Last Worked

6. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.
If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

Social Security/Retirement	☐ Yes ☐ No	Social Security/Disability	☐ Yes ☐ No	Dependent Social Security	☐ Yes ☐ No
Canada Pension Plan	☐ Yes ☐ No	State Disability	☐ Yes ☐ No	Third Party Settlement/Income	☐ Yes ☐ No
Worker's Compensation	☐ Yes ☐ No	Pension/Retirement	☐ Yes ☐ No	Pension/Disability	☐ Yes ☐ No
Unemployment	☐ Yes ☐ No	No-Fault Insurance	☐ Yes ☐ No		

Short Term Disability ☐ Yes ☐ No – Ins. Co. Name and Policy #

Any other insurance coverage ☐ Yes ☐ No – Ins. Co. Name and Policy #

7. For Fully-Insured Plans – If your request for benefits is approved, do you want Federal Income Tax withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ _____ (Note: Minimum withholding is $20.00 per week for Short Term Disability and $88.00 per month for Long Term Disability)
Do you want State Income Tax withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ _____ (Note: The amount indicated must be a whole dollar increment)
For Self-Insured Plans – Attach a copy of your completed W-4 for accurate calculation of Federal and State income taxes. If not provided, we will withhold 25% of your benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.
If you do not know if you are covered under a fully-insured or self-insured plan, please contact your employer for assistance.

8. Are you currently employed by another employer? ☐ Yes ☐ No If yes, please advise the name and telephone number of that employer.

I have read and understand the fraud notices listed on the instruction page of this form.
The above statements and the information provided on the Physician/Medication list (if applicable) are true and complete to the best of my knowledge and belief.
(Your signature is required for benefit consideration.)

_____ _____
Signature Date

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B. CLAIMANT'S — Physician/Medication List (PLEASE PRINT)

To avoid delay please answer all questions as completely as possible. Please attach additional pages if needed.

Claimant's Full Name | Policy No.

Please list ALL treatment providers with whom you are currently treating.

1) Provider Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | Fax No.
Frequency of Treatment | Date of Last Visit

2) Provider Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | Fax No.
Frequency of Treatment | Date of Last Visit

3) Provider Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | Fax No.
Frequency of Treatment | Date of Last Visit

Please list any recent hospital confinements.

1) Hospital | Address | Dates of Confinement
Procedure | City | State | Zip

2) Hospital | Address | Dates of Confinement
Procedure | City | State | Zip

Please list all current medications.

	Prescription Name	Dosage	Prescribing Physician
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			

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C. EMPLOYMENT STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

☑ **Short Term Disability** ☐ **Long Term Disability** ☐ **Individual Disability** ☐ **Waiver of Premium (Life Insurance)** ☐ **Voluntary Workplace Benefits**

1. Employer Name	Employer's Phone Number
Town of Atlantic Beach	(252) 726-2121

Employer Address (Street, City, State, ZIP)
PO Box 10, Atlantic Beach, NC 28512

Policy Numbers	Division Number / Class Number	Division Description / Class Description

2. Claimant's Name	Claimant Phone Number	Social Security Number
	( )	

Claimant's Address (Street, City, State, ZIP)

Date of Hire	Effective Date of STD Insurance	Effective Date of LTD Insurance	Effective Date of ID Insurance	Date Last Worked

Claimant's Work Status: ☐ Full-time ☐ Part-time ☐ Exempt ☐ Non-exempt ☐ Bargaining ☐ Non-bargaining

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

Has the claimant's employment been terminated? ☐ Yes ☐ No If yes, please provide termination date:

3. Has claimant returned to work? ☐ Yes ☐ No If yes, date: ☐ Full Time ☐ Part Time Hours Per Week:

4. Job Title/Major Job Duties **(Please attach a copy of claimant's job description)**

5. How was the STD premium paid for the plan year in which the disability occurred?
Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No
Percentage paid by Employee _____ ☐ Pre-tax ☐ Post-tax

6. How was the LTD premium paid for the plan year in which the disability occurred?
Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No
Percentage paid by Employee _____ ☐ Pre-tax ☐ Post-tax

7. How was the ID premium paid for the plan year in which the disability occurred?
Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No
Percentage paid by Employee _____ ☐ Pre-tax ☐ Post-tax

8. Year to Date Earnings (for FICA % Deductions) $

9. How was the claimaint paid? (please check all that apply)
☐ Hourly ☐ Salary ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other

What is the earnings figure you use to compute premium payments for this claimant on an annual basis? $

Salary/Wage prior to date last worked ***(refer to Earnings definition in your contract).***

☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	Bonuses (per week)	Commissions (per week)
$	$	$

If this policy provides New York DBL or New Jersey TDB coverage, please provide the earnings for the 8 weeks prior to disability (For DBL - including the week in which disability began. For TDB - the **8 full** weeks of income just prior to date disability began.)

	Week Ending						Week Ending					
	Mo.	Day	Yr.	No. Days Worked	Amount		Mo.	Day	Yr.	No. Days Worked	Amount
1						5					
2						6					
3						7					
4						8					

Claimant Name: Social Security Number:

10. Required for LTD and ID: Financial Documentation (please refer to your contract for your Earnings definition and attach the appropriate documentation).

Salary Only/Current Earnings definition: **Attach copy of payroll records or paystubs for 3 months just prior to disability.**

Bonus/Commissions Included: **Attach copy of payroll records for the 12 or 24 months (see definition) just prior to disability.**

Other Earnings definitions: **Attach referenced document per Earnings definition (W-2, K-1s, Schedule Cs, teacher's contract, etc.).**

11. Claimant Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability

401(k)/403(b) %; Pre-tax medical and other insurance $ /week; Flexible spending account $ /week

12. Date of last Salary/Wage Increase	Work Schedule at time last worked: Days/Week	Hours/Day	Hours/Week
Check off regular work days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	Number of hours on date last worked:		
Date paid through:	For: ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick pay ☐ Other		

Paid Time Off/Sick Leave balance as of last day worked:

13. Does the claimant have an ownership interest in this business? ☐ Yes ☐ No If yes, what is the % of ownership? %

Type of business entity? ☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship

14. If this is a Flexible Benefits Plan, indicate which option of coverage this claimant has chosen.

Previous Plan Year - Date of Open Enrollment _____Option _____ Current Plan Year - Date of Open Enrollment _____Option _____

15. Prior LTD Carrier Name	Effective Date
Address (Street, City, State, ZIP)	Termination Date

16. Is claimant eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	When do benefits begin?	When do benefits end?
Salary Continuation	☐	☐	$	☐	☐		
State Disability	☐	☐	$	☐	☐		
Other Disability Benefits	☐	☐	$	☐	☐		
Social Security	☐	☐	$	☐	☐		
Worker's Compensation	☐	☐	$	☐	☐		

Is the claim the result of a work related injury or sickness? ☐ Yes ☐ No

If so has Workers' Compensation claim been filed?	☐	☐	If yes, Name and Address of Carrier
Health Insurance	☐	☐	If yes, Name and Address of Carrier
Life Insurance	☐	☐	If yes, please provide the amount of coverage: $

If Workers' Compensation claim has been denied, please submit a copy of denial with this claim.

17. Information about your pension plan (Please send copy of Plan Summary) (Do not complete for maternity claim)

Do you have a pension plan? ☐ Yes ☐ No	If yes, what type? ☐ Defined benefit ☐ Defined contribution ☐ 401(k)/403(b) ☐ Profit Sharing ☐ Other: (specify)	
Is claimant eligible for your pension plan? ☐ Yes ☐ No	If eligible, does the claimant participate? ☐ Yes ☐ No	What % does claimant contribute?

If the claimant is participating, when is he or she eligible for benefits under the plan?

18. If the claimant is released to return to work with restrictions and limitations, are you willing to accommodate?

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

Name of Person Completing Form		Telephone Number (252) 726-2121
Title of Person Completing Form: Admin Services Supervisor	E-mail Address: tab@atlanticbeach-nc.com	Fax Number (252) 726-5115
Signature		Date Signed

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FOR EMPLOYEE TO COMPLETE

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; and employer that has information about my health, financial or credit history, 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"). 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).

_____ _____
(Claimant 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.