



CLAIM FOR INCOME PROTECTION BENEFITS

Glendale Customer Care Center, 655 North Central Ave., Suite 800,
Glendale, CA 91203
Phone: 877.851.7637 Fax: 877.851.7624

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

Mail to: Glendale Customer Care Center, 655 North Central Ave., Suite 800, Glendale, CA 91203
Toll free: 877.851.7637 Fax: 877.851.7624

This form should be used for the following types of claims only:

- Long Term Disability (LTD)
- Individual Income Protection (IIP)
- Integrated LTD/IIP/Life Insurance Waiver of Premium

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.

The employee is responsible for completion of all portions of this form without expense to the UnumProvident Corporation 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. To avoid delay in evaluating your claim, advise your physician(s) to attach copies of medical records and test results.
- C. Direct Deposit Request:** This section must be completed by you, the employee, if you wish to have your Long Term Disability and/or your Individual Disability benefits deposited directly into your bank account.
- D. Employment Statement:** The employer must complete this form.

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 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.



INCOME PROTECTION CLAIM

Mail to: Glendale Customer Care Center, 655 North Central Ave., Suite 800, Glendale, CA 91203

Claim Questions: 877.851.7637 Fax To: 877.851.7624

A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number	Date of Birth	Social Security Number
Employer Name			Employer Telephone Number

Instructions: If this claim is related to normal pregnancy, complete the Normal Pregnancy section. For all other claims, including complicated pregnancy, complete the All Other Conditions section. **In all situations, you must complete the signature block at the bottom of this form.**

Normal Pregnancy

1. Expected Delivery Date:	If Delivered, Actual Delivery Date:	Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
2. Date First Unable to Work	Date Hospitalized	
3. Has patient been released to work in her own occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No In any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If not, when should the patient be able to return to work? Full Time		Part Time

All Other Conditions

1. **Diagnosis** - Please include the primary diagnosis and list any secondary conditions.

Diagnosis (including any complications) include **ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number**

2. Date First Unable to Work	Date Hospitalized			
3. Has patient been released to work in his/her own occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No In any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If not, when should the patient be able to return to work? Full Time Part Time				
4. Is this disability related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
5. If complicated pregnancy	Expected Delivery Date:	If Delivered, Actual Delivery Date:	Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	
6. Date of first visit for this illness or injury				
7. Nature of treatment (including surgery and medications prescribed)			Date of Surgical Procedure	CPT Code

8. If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

RESTRICTIONS (What the patient should not do)

LIMITATIONS (What the patient cannot do)

Date restrictions and limitations began.

9. Referring physician or other treating physicians (names, addresses, telephone numbers):

Please include copies of all applicable office notes and test results.

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?



INCOME PROTECTION CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED)
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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
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Home Address (Street, City, State, ZIP)

The state in which you work	Preferred e-mail address where you can be reached
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2. Employer Name	Policy Number
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	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 <input type="checkbox"/> Full Time <input type="checkbox"/>		
Hours per week		
If you have not returned to work, when do you expect to return?		
Part Time <input type="checkbox"/> Full Time <input type="checkbox"/>		

How does your injury or sickness impede your ability to do your occupational duties?

3. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	If you are married, spouse's name	Spouse's Date of Birth	Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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List your dependent children who are under age 25 (attach additional sheets if necessary).

Name	Date of Birth	Attending School?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

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

For any accident related claim, describe the injury (what, how, where, when).

5. Date Last Worked	Number of Hours Worked on Date Last Worked
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Canada Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No
No-Fault Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No – Ins. Co. Name and Policy #		
Other (Include Individual Disability or Group Disability Benefits) <input type="checkbox"/> Yes <input type="checkbox"/> 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 \$87.00 per month)

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.

8. If benefits are approved, do you want these benefits to be automatically deposited into your bank account? Yes No If yes, please completed the Direct Deposit Request of this form and return it to us along with this completed claim form. Note: This service is not available for self-insured group plans.

I have read and understand the fraud notices listed on the instruction page of this form.

The above statements 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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C. DIRECT DEPOSIT REQUEST

We are pleased to offer you the security and convenience of having your monthly benefit check deposited electronically to your bank account. Direct Deposit means no more mail delays or trips to the bank to cash your check.

● **How does direct deposit work?**

Each month, our bank will transfer your benefit payment directly into your bank account. We recommend this payment option because it is predictable, safe and convenient. This is the same system enjoyed by over 15 million Social Security recipients.

● **How do I sign up?**

Complete the below section of this form and forward to us. Be sure to print the information clearly. You may want to verify your account and transit/routing numbers with your bank to avoid delays.

● **How soon can my direct deposits begin?**

To ensure accuracy, your Direct Deposit will begin within 30 days of our notification to your bank. This means you may still receive checks by mail after you send in your request. Once Direct Deposit processing begins, your funds will be deposited into your bank account on the second business day after the day your benefit payment is processed.

● **What if I have questions?**

Call our Customer Service Line at 1-800-413-7671. This toll-free number is available Monday through Friday from 8:00 A.M. to 4:00 P.M. EST.

● **What happens if I am out of town when the benefit payment is due?**

Your deposit is in your account. You may access it anytime after it is deposited.

● **What if I change banks?**

Simply call and we will send a request form for your completion or you can provide us with the new bank information in writing. You may receive a paper check in the mail for one payment while we process your change request.

● **Can I change my mind?**

Yes. You can start or stop Direct Deposit at any time. Just write and tell us.

● **Now what?**

Sit back and relax. We will transfer your benefits directly to your bank every month. No more waiting for the mailman, standing in line at the bank, or remembering to send us a change of address each time you establish a temporary residence.

Social Security Number: _____

Name: _____

Address: _____

Tel #: () _____

I authorize UnumProvident to deposit my Benefit payments to the bank shown here.

Signed _____ Date: _____

Name of Bank _____

City _____ State _____ Zip _____

Phone () _____

Type of Account Checking Savings

Account Number _____

Transit/Routing Number*

*Checking (Attach a Voided Check)

*Savings (Contact Bank/Credit Union for Transit/Routing Number)



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D. EMPLOYMENT STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY) Long Term Disability Individual Disability Waiver of Premium (Life Insurance)

1. Employer Name	Employer's Phone Number ()
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Employer Address (Street, City, State, ZIP)

Policy Numbers	Division Number / Class Number	Division Description / Class Description
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2. Claimant's Name

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

Social Security Number	Date of Hire	Effective Date of LTD Insurance	Effective Date of ID Insurance	Date Last Worked
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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 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

6. 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

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

8. 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 2 periods 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.).

9. 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

10. 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 _____

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

12. Is claimant eligible for:	Yes	No	
Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	If yes, name and address of Carrier
Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please provide the amount of coverage: \$

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

Do you have a pension plan? If yes, what type?
 Yes No Defined benefit Defined contribution 401(k)/403(b) Profit Sharing Other: (specify)

Is claimant eligible for your pension plan?	If eligible, does the claimant participate?	What % does claimant contribute?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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

Name of Person Completing Form	Telephone Number ()
Title of Person Completing Form	E-mail Address
Signature	Fax Number ()
	Date Signed



INCOME PROTECTION CLAIM EMPLOYEE'S AUTHORIZATION

Mail to: Glendale Customer Care Center, 655 North Central Ave., Suite 800,
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FOR EMPLOYEE TO COMPLETE

NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization to the Customer Care 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; 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 to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). 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 UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning 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 period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident 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 UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.