



## DISABILITY CLAIM FORM

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  
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  
The Paul Revere Life Insurance Company

### OUR COMMITMENT TO YOU

We understand that a disabling illness or injury creates emotional, physical and financial challenges and we want to do whatever we can to help you. You have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during the claim process.

### INSTRUCTIONS

#### When should you use this claim form?

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

- Short Term Disability
- Voluntary Benefits Disability
- Any combination of the following: Short Term Disability, Long Term Disability, Individual Disability, Life Insurance Waiver of Premium, and Voluntary Benefits Disability

If you are covered for more than one of these products, you only have to complete this one form.

#### Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for disability benefits. Please provide complete and 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.

- **Employee/Individual Statement (pages 4-7):** Please complete this section of the claim form and fax it to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If you prefer, it may be mailed to the address noted 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 8):** If you wish to give us permission to share the details of your claim with a third party (such as your spouse, son, daughter, friend, etc.), please sign and date this form and fax it to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If you prefer, it may be mailed to the address noted above.
- **Employee/Individual Authorization (last page):** Please sign and date this form and provide a copy to your attending physician. Fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones) or mail it to the address noted above.
- **Employer Statement (pages 9-11):** If you are applying for Short Term Disability, Long Term Disability, Individual Disability or Life Insurance Waiver of Premium, 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 fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones) or mail it to the address noted above. If you are applying for Voluntary Disability Benefits only, we do not require the Employer Statement.
- **Attending Physician Statement (pages 12-14):** Please complete Part I of this statement, then give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to complete Part II and fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If s/he prefers, it may be mailed to the address noted above.

#### Questions?

If, at any time, you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center is staffed with experienced professionals who can be contacted from 8 a.m. to 8 p.m. Monday through Friday.



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**Instructions (continued) / Claim Fraud Statements**

**Fraud Warning**

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, New Mexico, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, Washington, and West Virginia require the following statement 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 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 Warning for District of Columbia Residents**

For your protection, the District of Columbia requires the following to appear on this claim form:

**WARNING:** 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.

**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 insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**Fraud Warning for Kentucky Residents**

For your protection, Kentucky 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 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.

**Fraud Warning for Minnesota Residents**

For your protection, Minnesota law requires the following to appear on this claim form:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Fraud Warning for New Hampshire Residents**

For your protection, New Hampshire law requires the following to appear on this claim 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.

**Fraud Warning for New Jersey Residents**

For your protection, New Jersey law requires the following to appear on this claim 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, which is a crime, subject to criminal prosecution and civil penalties.



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**Instructions (continued) / Claim Fraud Statements**

**Fraud Warning 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 Warning for Oregon Residents**

For your protection, Oregon law requires the following to appear on this claim form:

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**Fraud Warning for Pennsylvania Residents**

For your protection, 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 Warning 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 dollars (\$5,000) and not more than ten thousand dollars (\$10,000), 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/INDIVIDUAL STATEMENT (Continued)**

Employee/Individual's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for name entry

Grid for date of birth entry

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

What specific duties of your occupation are you unable to perform due to your medical condition?

Is your condition related to your occupation?  Yes  No

If yes, please explain how:

Have you filed a Workers' Compensation claim?  Yes  No

If no, do you intend to file a Workers' Compensation claim?  Yes  No

If no, please explain why you are not filing a Workers' Compensation claim.

**C. Information About Your Disability**

Date Last Worked (mm/dd/yy)

Number of Hours Worked on Date Last Worked

Date you were first unable to work due to this medical condition (mm/dd/yy)

**D. Information About Physicians and Hospitals**

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

Form for providing information about medical treatment providers (1-3 providers)

Please list any hospital visits/admissions you have had in the last 12 months. 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.

Form for providing information about hospital visits/admissions (1-2 visits)



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**EMPLOYEE/INDIVIDUAL STATEMENT (Continued)**

Employee/Individual's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for name entry: 26 columns

Grid for date of birth entry: 6 columns

**E. 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 reduce your benefit from Unum. Please indicate what other income benefits you may be eligible to receive or are receiving as a result of your disability and complete the information requested.

Table with 3 columns: Other Source of Income, May Be Eligible to Receive, Receiving. Rows include State Disability Plan, Workers' Compensation, Motor Vehicle Insurance, etc.

Other Short Term Disability Coverage  Yes  No If yes, please list the insurance company name.

**F. Information About Your Return-to-Work**

Have you returned to work?  Yes  No If yes, indicate date below.

Part Time (mm/dd/yy): Full Time (mm/dd/yy): Hours per week:

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

Part Time (mm/dd/yy): Full Time (mm/dd/yy):  Unknown

**G. Information About Income Tax Withholding.** The following information will ensure your benefit is taxed appropriately according to Federal and State regulations.

**TAX INFORMATION**

If you do not know if you are covered under a fully-insured or self-funded plan, please contact your employer for assistance.

- For Fully-Insured Plans - If your request for benefits is approved, should Unum withhold Federal and/or State Income Taxes from your benefit checks? Federal Income Tax: State Income Tax: For Self-Funded Plans - Attach a copy of your completed W-4 for accurate calculation of Federal and State income taxes.





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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.

\_\_\_\_\_  
Employee/Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Social Security Number

I signed on behalf of the employee/individual as \_\_\_\_\_ (indicate relationship). If Power of Attorney Designee, Personal Representative, Guardian, or Conservator, please attach a copy of the document granting authority.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.



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

**A. Information About the Employer**

Employer Name [grid] Employer's Telephone Number [grid]
Employer Address [grid]
City [grid] State [grid] Zip [grid]

**B. Information About the Employee**

Employee/Individual's Name (Last Name, Suffix, First Name, MI) [grid]
Employee/Individual's Address [grid]
City [grid] State [grid] Zip [grid]
Employee/Individual Telephone Number [grid] Social Security Number [grid] Date of Hire (mm/dd/yy) [grid]
Date Last Worked (mm/dd/yy) [grid] Number of hours worked on date last worked [grid]

If this is a Section 125/Cafeteria plan, indicate which option of coverage this employee/individual has chosen.

Previous Plan Year [grid] Current Plan Year [grid]
Date of Open Enrollment (mm/dd/yy): [grid] Option: [grid] Date of Open Enrollment (mm/dd/yy): [grid] Option: [grid]

Please check all types of coverage this employee has with Unum.

- Short Term Disability Long Term Disability Individual Disability Life Insurance Waiver of Premium Voluntary Benefits Disability
Voluntary Benefits Cancer/Critical Illness Voluntary Benefits Accident Voluntary Benefits MedSupport

Table with 4 columns: Policy Number, Division Number, Class Number, Division Description / Class Description. Rows include Short Term Disability, Long Term Disability, Life Insurance, and Voluntary Benefits Disability.

Effective Date of Short Term Disability Coverage (mm/dd/yy) [grid]
Effective Date of Long Term Disability Coverage (mm/dd/yy) [grid]
Effective Date of Individual Disability Coverage (mm/dd/yy) [grid]

**C. Information About the Employee/Individual's Occupation**

Occupation Title (please attach a copy of the employee's job description) [grid]

Primary duties of the employee's occupation on date last worked: [grid]

Employee/Individual's Pre-Disability Work Status: Full-time Part-time Exempt Non-exempt Bargaining Non-bargaining

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 the employee/individual's employment been terminated? Yes No If yes, termination date (mm/dd/yy): [grid]

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



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**EMPLOYER STATEMENT (Continued)**

Employee/Individual's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for name and date of birth input

**D. Information About the Employee's Salary**

How was the employee/individual paid? (please check all that apply)

- Hourly  Salary  Overtime  Bonus  Commissions  Other

Salary/Wage prior to date last worked

- Hourly  Weekly  Bi-Weekly  Semi-Monthly

Bonuses (per week)

Commissions (per week)

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Employee/Individual Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability so that earnings will be calculated as defined by the policy.

401(k)/403(b)

Pre-tax medical and other insurance

Flexible spending account

\_\_\_\_\_ %

\$ \_\_\_\_\_ /week

\$ \_\_\_\_\_ /week

Date of last salary/wage increase (mm/dd/yy)

Work schedule at time last worked: Days/Week Hours/Day Hours/Week

Check off regular work days:  Sun  Mon  Tues  Wed  Thurs  Fri  Sat

Date paid through (mm/dd/yy):

- For:  Salary Continuation  Vacation Pay  Accrued Sick pay  Other

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

**New York Disability Benefits Law or New Jersey Temporary Disability Benefits Salary Information**

If this policy provides New York Disability Benefits Law or New Jersey Temporary Disability Benefits coverage, please provide the earnings for the 8 weeks prior to disability. (For Disability Benefits Law - include the week in which disability began. For Temporary Disability Benefits - include the 8 full weeks of income just prior to date disability began.)

Table with 2 main sections for 'Week Ending' data, each with columns for Mo., Day, Yr., No. Days Worked, and Amount.

**E. Information Needed for Calculation of FICA**

What percent of the Short Term Disability benefit is taxable? \_\_\_\_\_ %

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

What percent of the Long Term Disability benefit is taxable? \_\_\_\_\_ %

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

What percent of the Individual Disability benefit is taxable? \_\_\_\_\_ %

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

Year to Date Earnings (from January 1 to the present for FICA Deductions) \$ \_\_\_\_\_



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**EMPLOYER STATEMENT (Continued)**

Employee/Individual's Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Grid for name and date of birth input

**F. Information About Other Disability Income**

Table with columns: Is employee/individual eligible for, Yes/No, If yes, weekly or monthly amount, Weekly/Monthly, When do benefits begin?, When do benefits end?

Is the claim the result of a work related injury or sickness? Yes No If yes, has a Workers' Compensation claim been filed? Yes No

Form fields for Workers' Compensation carrier details: name, telephone number, address, fax number, city, state, zip

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

**G. Information About Your Pension Plan.** This information is necessary to ensure your benefit is calculated accurately. (Do not complete for a maternity claim).

Form fields for Pension Plan: Do you have a pension plan? If yes, what type? Is employee/individual eligible for your pension plan? What % does employee/individual contribute?

**H. Information About Your Rehire or Return-to-Work Program**

Form fields for Rehire/Return-to-Work Program: If the employee/individual is released to return-to-work in restricted duty, are you willing to discuss accommodations? If yes, who should we contact to discuss a return-to-work plan? Name, Title, Telephone Number

**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 portions of the claim form.

**I. Signature of Benefit Administrator (Please Print)**

Form fields for Benefit Administrator: 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

Signature and Date Signed fields



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**ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)**

**PART I: TO BE COMPLETED BY PATIENT**

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

Grid for patient name input

Social Security Number

Grid for social security number input

Date of Birth (mm/dd/yy)

Grid for date of birth input

Home Telephone Number

Grid for home telephone number input

Employer Telephone Number

Grid for employer telephone number input

Employer Name

Grid for employer name input

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

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

**A. Complete this section for normal pregnancy, then go to section C**

Expected Delivery Date (mm/dd/yy): Actual Delivery Date (mm/dd/yy): Delivery Type: [ ] Vaginal [ ] C-Section Date of first visit for this pregnancy (mm/dd/yy): Date Hospitalized (mm/dd/yy):

Did you advise your patient to stop working? [ ] Yes [ ] No If yes, on what date (mm/dd/yy)?

Diagnosis: ICD9 Diagnosis Code: Height: Weight: Blood Pressure: As of date (mm/dd/yy):

**B. Complete this section for all conditions except normal pregnancy**

**Patient Information**

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

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

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

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

**Diagnosis**

What is the primary diagnosis preventing the patient from working?

Please include primary ICD-9 or DSM IV Multi-Axial diagnoses codes ICD9: DSMIV: I II III IV V

What other conditions prevent the patient from working? [ ] NA

Secondary ICD-9s: Diagnosis: Secondary ICD-9s: Diagnosis:

Are there any cognitive deficits or psychiatric conditions that impact function? [ ] Yes [ ] No

If yes, please provide restrictions and limitations:

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

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

What diagnostic or clinical findings support your diagnosis?

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



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**ATTENDING PHYSICIAN STATEMENT (Continued)**

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

Date of Birth (mm/dd/yy)

Grid for patient name input

Grid for date of birth input

**Treatment**

What is your treatment plan?

When do you expect the patient to improve to return to work?

Medications (Please attach medication log)

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:

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

Table with 4 columns: Name, Specialty, Address, Phone #

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

Form for functional capacity assessment including: Patient's ability to: (Please check) and Patient's ability to perform: (Please Check)

Form for functional capacity assessment including: Patient's ability to: (Please Check) and Patient's ability to lift/carry: (Please Check)



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**ATTENDING PHYSICIAN STATEMENT (Continued)**

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

Date of Birth (mm/dd/yy)

Grid for patient name input

Grid for date of birth input

**Return to Work Assessment**

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)

Do you support your patient's return to work within the restrictions and limitations you provided?  Yes  No

If yes, as of (mm/dd/yy):

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

**FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.**

**C. Signature of Attending Physician**

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

Physician Name (Last Name, First Name, MI, Suffix) Please Print

Medical Specialty

Degree

Address

City

State

Zip

Telephone Number

Fax Number

Physician's Tax ID Number:

Are you related to this patient?  Yes  No

If yes, what is the relationship?

**Signature of Physician**

**Date**

**X**



**DISABILITY CLAIM FORM**

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

Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

**EMPLOYEE/INDIVIDUAL AUTHORIZATION – FOR EMPLOYEE TO COMPLETE**

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**

**I authorize** 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, credit bureaus, the MIB Group, Inc., GENEX Services, Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), 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, 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;

**To the following persons:** Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies (“Unum”), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration (“Authorized Recipients”);

**For the purposes of evaluating and administering claims, including assistance with return to work.** Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

**Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.**

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate 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 is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

\_\_\_\_\_  
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.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

CL-1008-AUTH (04/10)