



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

## LONG TERM DISABILITY CLAIM FORM

Phone: 1-800-858-6843 Fax: 1-800-447-2498  
Monday through Friday 8 a.m. to 8 p.m. Eastern Time

Unum Life Insurance Company of America  
First Unum Life Insurance Company\*  
Unum Insurance Company  
Provident Life and Accident Insurance Company  
Provident Life and Casualty Insurance Company\*  
The Paul Revere Life Insurance Company\*

For use with policies issued by the above Unum Group ["Unum"] subsidiaries.

### When should you use this claim form?

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

- Long Term Disability, or any combination of the following: Long Term Disability, Individual Disability and Life Insurance Waiver of Premium. If you are covered for more than one of these products, this is the only form you need to complete.

## Instructions

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

This form should be completed by you (the employee), your employer and attending physician.

- **Employee/Individual Statement (pages 3-6):** Please complete this section of the claim form and fax it to 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- **Direct Deposit Request (page 7):** Please complete this form if you wish to have your Long Term Disability benefits deposited directly into your bank account. You may also sign up via your online account at [www.unum.com/claimant](http://www.unum.com/claimant).
- **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, child, sibling, friend, etc.), please sign and date this form and fax it to 1-800-447-2498. 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 1-800-447-2498 or mail it to the address noted above.
- **Employer Statement (pages 9-11):** 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 1-800-447-2498 or mail it to the address noted above.
- **Attending Physician Statement (pages 12-14):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to complete and fax the completed form to 1-800-447-2498. If s/he prefers, it may be mailed to the address noted above.

## Unum Online Services

Unum has developed a secure and easy way for you to submit and manage your claim online via our secure website at [www.unum.com/claimant](http://www.unum.com/claimant). Our secure web services allow you to access and make changes to your open claims, as well as view updates and available correspondence. Please contact your employer's human resource department to verify online filing is available to you.

Once you have submitted your claim, you may manage it with the Unum Customer App. The Unum Customer App is available for Apple and Android.

## 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.

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

\* Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.



---

## Claim Fraud Statements

---

**Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.**

**For your protection, state laws, including** Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this form.

**Fraud Warning:** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

### For your protection:

**Alabama law requires the following statement to appear on**

**this form:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**California law requires the following statement to appear on**

**this form:** Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado law requires the following statement to appear on**

**this form:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia law requires the following statement to**

**appear on this form:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida law requires the following statement to appear on this**

**form:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky law requires the following statement to appear on**

**this form:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Minnesota law requires the following statement to appear on**

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

**New Hampshire law requires the following statement to**

**appear on this form:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

**New Jersey law requires the following statement to appear on this form:**

Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, subject to criminal prosecution and civil penalties.

**New York law requires the following statement to appear on this form:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Pennsylvania law requires the following statement to appear on this form:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Puerto Rico law requires the following statement to appear on this form:**

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present; it may be reduced to a minimum of two (2) years.



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**EMPLOYEE/INDIVIDUAL STATEMENT (PLEASE PRINT)**

**A. Information About You**

Last Name	Suffix	First Name	MI
-----------	--------	------------	----

Date of Birth (mm/dd/yyyy)	Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	The state in which you work
----------------------------	------------------------	--	-----------------------------

Home Address

City	State	Zip
------	-------	-----

Telephone Number where you can be reached	Preferred e-mail address (for confirmation purposes only)
---	---

Employer Name

Language Preference  English  Spanish  Other

Please check all types of coverage you have with Unum.

Short Term Disability  Long Term Disability  Individual Disability  Life Insurance  Voluntary Benefits Disability

Voluntary Benefits Cancer/Critical Illness  Voluntary Benefits Accident  Voluntary Benefits MedSupport

Are you currently self-employed?  Yes  No Do you work for another employer?  Yes  No

If yes, employer name: \_\_\_\_\_ Telephone Number \_\_\_\_\_

**B. Information About Your Disability**

Date last worked (mm/dd/yyyy):	Number of hours worked on date last worked:	Date you were first unable to work due to this medical condition (mm/dd/yyyy):
--------------------------------	---	--

**C. Information About the Condition(s) Causing Your Disability**

1. For **illness**, answer the following questions then go to #4:

What is the name of your medical condition?	What were your first symptoms?
---	--------------------------------

Describe when you first noticed the symptoms.	Date you were first treated by a physician (mm/dd/yyyy):
---	--

2. For an **injury**, answer the following questions then go to #4:

What is the name of your medical condition?

Describe where and how the injury occurred.

Date the injury occurred (mm/dd/yyyy):	If related to a motor vehicle accident, was an accident report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date you were first treated by a physician (mm/dd/yyyy):
--	--	--

3. For **pregnancy**, answer the following questions then go to #4:

What is your expected delivery date?

Were there any complications causing you to stop work prior to your expected delivery date? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
--	-------------------------



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**EMPLOYEE/INDIVIDUAL STATEMENT (Continued)**

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

Date of Birth (mm/dd/yyyy)

Have you already delivered?  Yes  No If yes, what type of delivery?  Vaginal  C-Section If yes, date of delivery:

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?

Have you been treated for this condition(s) in the past? If yes, when and by whom?

Yes  No

Is your condition related to your occupation? If yes, please explain:

Yes  No If no, go to Section C.

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

**D. Information About Physicians, Hospitals and Medications:** This information will assist us in the evaluation of your claim.

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 two, please use a separate sheet of paper and include it with this form.

1. \_\_\_\_\_

Provider Name	Mailing Address	Telephone No.
Specialty	City State Zip	Fax No.
Date of First Visit (mm/dd/yyyy)	Date of Next Visit (mm/dd/yyyy)	

2. \_\_\_\_\_

Provider Name	Mailing Address	Telephone No.
Specialty	City State Zip	Fax No.
Date of First Visit (mm/dd/yyyy)	Date of Next Visit (mm/dd/yyyy)	

Please list any recent (within the last 12 months) hospital visits/admissions. If you have had more than two, use a separate sheet of paper and include it with this form.

1. \_\_\_\_\_

Hospital	Address	Date of Visit/Admission (mm/dd/yyyy)
Procedure	City State Zip	Date of Discharge (mm/dd/yyyy)

2. \_\_\_\_\_

Hospital	Address	Date of Visit/Admission (mm/dd/yyyy)
Procedure	City State Zip	Date of Discharge (mm/dd/yyyy)

**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**EMPLOYEE/INDIVIDUAL STATEMENT (Continued)**

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

Date of Birth (mm/dd/yyyy)

Please list all current medications. If you have more than five, use a separate sheet of paper and include it with this form.

Prescription Name	Dosage/Frequency	Prescribing Physician	Pharmacy Name
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

**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 are eligible to receive or are receiving as a result of your disability and complete the information requested.

Other Source of Income	Eligible to Receive	Receiving	Amount	Benefit Begin Date
Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
State Disability Plan (CA, HI, NJ, NY, PR, RI)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Workers' Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Motor Vehicle Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Third Party Settlement/Income	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Social Security/Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Social Security/Family	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Social Security/Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Pension/Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Pension/Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Canada Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Public Employee Retirement System	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
State Teachers Retirement System	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

**F. Information About Your Return-to-Work**Have you returned to work?  Yes  No If yes, indicate information below.

Part Time (mm/dd/yyyy):

Full Time (mm/dd/yyyy):

Hours per week:

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

Part Time (mm/dd/yyyy):

Full Time (mm/dd/yyyy):

 Unknown**G. Information About Your Family:** This information is important to assist us in determining if your family may be eligible for other benefits.Marital Status:  Single  Married  Widowed  Divorced  Domestic Partner  Separated

Spouse/Partner's Name

Spouse/Partner's Date of Birth  
(mm/dd/yyyy)Is he/she employed?  
 Yes  NoList your dependent children who are under age 25 (include additional sheets if necessary).  
Name

Date of Birth (mm/dd/yyyy)

Attending School?

 Yes  No Yes  No Yes  No



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**EMPLOYEE/INDIVIDUAL STATEMENT (Continued)**

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

Date of Birth (mm/dd/yyyy)

**H. Information About Income Tax Withholding:** Unum will not withhold Federal and State Income Tax if your benefit is not taxable.

**TAX INFORMATION**

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

- **For Fully-Insured Plans** – If your claim is approved and your employer tells us your benefit is taxable, we are required by law to withhold FICA taxes. Do you want Unum to also withhold Federal and/or State Income Taxes from your taxable benefit checks?

**Federal Income Tax:**  Yes  No If yes, how much do you want withheld from each check? (whole dollar amount) \$ \_\_\_\_\_

Minimum Withholding: \$20/week for Short Term Disability.

**State Income Tax:**  Yes  No If yes, how much do you want withheld from each check? (whole dollar amount) \$ \_\_\_\_\_

- **For Self-Insured Plans** – Attach a copy of your completed W-4 for accurate calculation of Federal and State Income Taxes. **Note:** If not provided, we are required by law to withhold 25% of your taxable benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.

- **If your benefits are not taxable, Federal and State Income Taxes will not be withheld.**

**Fraud Warning:** For your protection, Arizona law requires the following to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Fraud Warning:** For your protection, New York law requires the following to appear on this claim form:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**I. Signature of Employee/Individual**

I have read and understand the fraud notices listed above and on page 2 of this form. I also acknowledge that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

**X**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Reminder:** Please sign and date the Authorization (last page of this claim form).





The Benefits Center  
 P.O. Box 100158  
 Columbia, SC 29202-3158  
 Phone: 1-800-858-6843 Fax: 1-800-447-2498

You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

**Optional Authorization to Disclose Information to Third Parties**

To assist in the evaluation or administration of any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) with the family members, friends, and/or other third parties listed below:

My Spouse: \_\_\_\_\_  
 (Name) (Telephone Number)

Other Family Member: \_\_\_\_\_  
 (Name / Relationship) (Telephone Number)

Other person: \_\_\_\_\_  
 (Name / Relationship) (Telephone Number)

I understand that information about my claim(s) and/or leave(s) may include information about my health and that such information about my health may be related to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I do not wish the following information about my claim(s) and/or leave(s) to be shared (leave blank if not applicable):

\_\_\_\_\_ I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

I may revoke this authorization in writing at any time except to the extent Unum or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of any of my claim(s) and/or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

\_\_\_\_\_  
 Claimant Signature

\_\_\_\_\_  
 Date

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

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

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

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



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

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

**A. Information About the Employer**

Employer Name	Employer's Phone Number
---------------	-------------------------

Employer Address

City	State	Zip
------	-------	-----

Prior LTD Carrier Name	Prior LTD Carrier Employee Effective Date	Prior LTD Carrier Policy Termination Date
------------------------	---	---

**B. Information About the Employee**

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

Employee's Address

City	State	Zip
------	-------	-----

Employee Telephone Number	Social Security Number	Date of Hire (mm/dd/yyyy)
---------------------------	------------------------	---------------------------

Please check all types of coverage this employee has with Unum and indicate the effective date of his/her coverage.

Short Term Disability \_\_\_\_\_  Long Term Disability \_\_\_\_\_  Individual Disability \_\_\_\_\_  
 Life Insurance \_\_\_\_\_ Premium paid thru date \_\_\_\_\_  Voluntary Benefits Disability \_\_\_\_\_  
 Voluntary Benefits Cancer/Critical Illness \_\_\_\_\_  Voluntary Benefits MedSupport \_\_\_\_\_

Short Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description
-------------------------------------	-----------------	--------------	--

Long Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description
------------------------------------	-----------------	--------------	--

Individual Disability Policy Number	Division Number	Class Number	Division Description / Class Description
-------------------------------------	-----------------	--------------	--

Life Insurance Policy Number	Division Number	Class Number	Division Description / Class Description	Basic Life Amount	Supplemental Life Amount
------------------------------	-----------------	--------------	--	-------------------	--------------------------

Date Last Worked (mm/dd/yyyy):	Number of hours worked on date last worked:	Regular Work Schedule
	Days/Week _____ Hours/Day _____	Hours/Week _____

Check off regular work days:  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

If this is a Section 125/Cafeteria plan, indicate which option of coverage this employee has chosen.  
 Previous Plan Year \_\_\_\_\_ Current Plan Year \_\_\_\_\_

Date of Open Enrollment (mm/dd/yyyy) \_\_\_\_\_ Option \_\_\_\_\_ Date of Open Enrollment (mm/dd/yyyy) \_\_\_\_\_ Option \_\_\_\_\_

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

Occupation Title (please include a copy of the employee's job description):

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

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

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

Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date (mm/dd/yyyy):	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Hours Per Week:
---	----------------------------	---	-----------------

Has the employee's employment been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, termination date (mm/dd/yyyy):
---	--



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**EMPLOYER STATEMENT (Continued)**

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

Date of Birth (mm/dd/yyyy)

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

How was the employee paid prior to date last worked? Please check all that apply and indicate the amount paid.

- Hourly \$ \_\_\_\_\_
- Weekly \$ \_\_\_\_\_
- Bi-Weekly \$ \_\_\_\_\_
- Semi-Monthly \$ \_\_\_\_\_
- Bonuses \$ \_\_\_\_\_
- Commissions \$ \_\_\_\_\_

Date paid through for (mm/dd/yyyy):

- Salary Continuation \_\_\_\_\_
- Vacation Pay \_\_\_\_\_
- Accrued Sick pay \_\_\_\_\_
- Other \_\_\_\_\_

Paid Time Off balance as of last day worked:

Sick Leave balance as of last day worked:

Does the employee have an ownership interest in this business?  Yes  No If yes, what is the % of ownership? \_\_\_\_\_ %

Type of business:  Regular Corporation  S Corporation  Partnership  Sole Proprietorship

Other than payments under this policy, will the employee be receiving any other income from you, such as K-1 earnings, bonuses, commissions, salary continuation, PTO?  Yes  No

**Financial Documentation:** We are requesting this information so we can accurately calculate your employee's benefit. Please refer to the definition of earnings in your policy and provide us with the appropriate payroll information.

If your earnings definition is:	Then we need:
Salary Only/Current Earnings	Payroll records or paystubs for the 3 months just prior to disability
Bonus/Commissions Included	Payroll records for either 12 or 24 months (per your definition of earnings) just prior to disability
Other	Payroll documentation referenced in your definition of earnings (e.g. W-2, K-1, Schedule C, teacher contract, etc.)

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

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) \$ \_\_\_\_\_

**F. Statutory Disability/Paid Medical Leave**

Do you participate in a state PFML plan or state disability plan for this EE? \_\_\_\_\_ Which state? \_\_\_\_\_

**G. Information About Other Disability Income**

Is employee eligible for:	Yes No		If yes, weekly or monthly amount	Weekly Monthly		Date benefits begin	Date benefits end
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
Salary Continuation	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Other Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Social Security Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**EMPLOYER STATEMENT (Continued)**

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

Date of Birth (mm/dd/yyyy)

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

If yes, has a Workers' Compensation claim been filed?  Yes  No

If yes, name of Workers' Compensation carrier

Telephone Number

Address of Carrier

Fax Number

City

State

Zip

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

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

Do you have a pension plan?  Yes  No If yes, what type?  PERS/STRS \$\_\_\_\_\_  Defined benefit

Cash Balance  401(k)/403(b)  Profit Sharing  Money Purchase Plan/401A  Other: (specify)

Is the employee eligible for your pension plan?  Yes  No

What percentage does the employee contribute?

If eligible, does the employee participate?  Yes  No

\_\_\_\_\_ %

If yes, what is the earliest age or date the employee is eligible to withdraw?

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

If the employee is released to return to work in restricted duty, are you willing to discuss accommodations?  Yes  No

If yes, whom 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 the Employer portion of the claim form.

**J. 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

**Signature**

**X**

**Date**



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)**

**TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER**

**Instructions:** Please complete, sign and date this form. The purpose of this form is to assist us in making a disability determination. Please complete all questions on this form and provide copies of supporting reports, such as office notes, medical records, medication logs, consultations and/or testing. Be sure to sign and date this form in Section D.

Name of Patient (Last Name, Suffix, First Name, MI)	Social Security Number
---	------------------------

Patient Address
-----------------

City	State	Zip
------	-------	-----

Date of Birth (mm/dd/yyyy)	Patient Telephone Number
----------------------------	--------------------------

Employer Name
---------------

**A. Patient Information**

Date of first visit for this current condition(s) (mm/dd/yyyy):	Date of last office visit (mm/dd/yyyy):	Date of next office visit (mm/dd/yyyy):	Did you advise your patient to stop working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective when? (mm/dd/yyyy):
---	---	---	---

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

If yes, please provide treatment dates (mm/dd/yyyy): From \_\_\_\_\_ Through \_\_\_\_\_

Is the patient's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Patient's Height:	Patient's Weight
--	-------------------	------------------

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

Please include primary ICD or DSM codes	ICD Code:
	DSM:

What are the other diagnoses that may impact your patient's functional capacity?  NA

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

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

Has the patient been hospitalized?  Yes  No If yes, date hospitalized (mm/dd/yyyy): \_\_\_\_\_ through: \_\_\_\_\_

Was surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what procedure was performed?	CPT Code:	Date Surgery Performed (mm/dd/yyyy):
---	-----------	--------------------------------------



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**ATTENDING PHYSICIAN STATEMENT (Continued)**

Patient's Name

Date of Birth (mm/dd/yyyy)

**B. Functional Capacity**

If your patient **does not** have physical and/or behavioral health RESTRICTIONS (activities patient should not do) and/or LIMITATIONS (activities patient cannot do), please initial here \_\_\_\_\_ and go to **SECTION D**.

**Please note:** When considering a standard 8 hour workday with breaks (approximately every two hours) please quantify terms that may not be uniformly understood such as "prolonged", "repetitive", "light-duty", "heavy lifting", or "stressful situations". In addition, never means not at all, occasional means more than never but less than 33% of the time; frequent means 34-66% of the time, and constant means 67-100% of the time.

**Physical Restrictions and/or Limitations**

If your patient has CURRENT PHYSICAL RESTRICTIONS (activities patient should not do) and/or PHYSICAL LIMITATIONS (activities patient cannot do) list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yyyy): \_\_\_\_\_ To (mm/dd/yyyy): \_\_\_\_\_

**Behavioral Health Restrictions and/or Limitations**

If your patient has CURRENT BEHAVIORAL HEALTH RESTRICTIONS (activities patient should not do) and/or BEHAVIORAL HEALTH LIMITATIONS (activities patient cannot do) please list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yyyy): \_\_\_\_\_ To (mm/dd/yyyy): \_\_\_\_\_

What diagnostic or clinical findings support your patient's restrictions and/or limitations as noted above?

What is your treatment plan? Please include all medications.



**LONG TERM DISABILITY CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498

Monday through Friday 8 a.m. to 8 p.m. Eastern Time

**ATTENDING PHYSICIAN STATEMENT (Continued)**

Patient's Name	Date of Birth (mm/dd/yyyy)
----------------	----------------------------

**C. Other Treating Providers, Facilities or Hospitals**

Please provide complete name, contact information and specialty of any other treating physicians, facilities or hospitals.

Name	Specialty	City, State

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

**D. 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?

<b>Signature of Physician</b> <b>X</b>	<b>Date</b>
---	-------------



The Benefits Center  
P.O. Box 100158  
Columbia, SC 29202-3158  
Phone: 1-800-858-6843 Fax: 1-800-447-2498  
www.unum.com

Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

**Authorization to Collect and Disclose Information**  
*(Not for FMLA Requests)*

**I authorize the following persons:** health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocate Group, Brown & Brown Absence Services Group and other Social Security advocacy vendors, professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

**To disclose information,** whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits ("My Information");

**To Unum Group and its subsidiaries,** Unum Life Insurance Company of America, First Unum Life Insurance Company\*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company\*, The Paul Revere Life Insurance Company\* and persons who evaluate claims for any of those companies ("Unum");

**So that Unum may evaluate and administer my claims, including providing assistance with return to work.** For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits (to include any subsequent financial management and/or benefit recovery review), whichever is shorter. I understand that once My Information is disclosed to Unum, any privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum may then disclose My Information only as permitted by law, including, state fraud reporting laws or as authorized by me.

**I also authorize Unum to disclose My Information to the following persons** (for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum; or, the Social Security Administration. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purposes of these disclosures by Unum, this authorization is valid for one year or for the length of time otherwise permitted by law.

If I do not sign this authorization or if I alter or revoke it, except as specified above, Unum may not be able to evaluate or administer my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that Unum requests or discloses prior to Unum receiving my revocation request.

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Date Signed

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

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

I signed on behalf of the Insured as \_\_\_\_\_ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.