

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

Toll-free: 1-800-635-5597 Fax: 1-800-447-2498 Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

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

Unum Life Insurance Company of America Provident Life and Accident Insurance Company

#### **OUR COMMITMENT TO YOU**

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

#### **INSTRUCTIONS**

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

Use this claim form to submit a critical illness/specified disease and/or cancer claim to Unum. This form should be used for the following types of claims only:

- · Voluntary Benefits Critical Illness/Specified Disease
- · Voluntary Benefits Cancer
- · Group Critical Illness/Specified Disease
- · Group Cancer

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 critical illness/specified disease and/or cancer benefits. Incomplete or illegible answers may result in a delay of benefit consideration. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- Insured/Patient Statement (pages 4-6): Please complete this section of the claim form and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above. If you are applying for Voluntary Benefits Cancer or Group Cancer benefits, please attach itemized bills indicating the ICD diagnosis code, the CPT-4 procedure code, and the dates of treatment, along with a copy of the pathology report. If you are applying for the Health Screening/Wellness Benefit only, please complete sections A, B, C, and G.
- 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 7): 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 1-800-447-2498. If you prefer, you may mail it to the address noted above.
- Attending Physician Statement (pages 8-9): 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 and ask him/her to complete Part II. Your physician or
  treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above. If you are applying for
  the Health Screening/Wellness Benefit, this statement is not required. Unum is not responsible for expenses associated with the
  completion of this form.
- Insured/Patient Authorization (last page): Please sign and date this form, provide a copy to your attending physician, and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above. This form authorizes the release of medical and other types of information needed to evaluate your claim.

#### Questions?

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



The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

#### 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 Alabama Residents

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

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents 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.

#### 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.



The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498 Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

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

#### 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.

#### 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 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,

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.



The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

																					$\overline{}$
A. Information About the Insured																					
Last Name						Sı	uffix		First	Nam	е										MI
Date of Birth (mm/dd/yy)			Social Se	curity N	lumbei	-						Ger	nder						1		
Line Address													/lale <sup>:</sup> emal	е							
Home Address																					T
City									_ ;	State		Zip									
Home Telephone Number		Ш	Cellular T	elephor	ne Nun	nber					 W	ork T	eleph	none	Num	ber					
		] [											Ť								
Policy Number(s)		Preferre	ed e-mail	addres	s						$\overline{}$		T		$\overline{}$	$\overline{}$					
Language Preference ☐ English ☐ Please check all types of coverage you	· ·	Ilnum																			
Short Term Disability	□ Long Ter		ility			□ Indiv	/idual	Disal	aility.					Life Ir	neur	ancc					
Policy #	Policy #	III DISAD	ility			Policy:		Disal	Jility					licv #		ance					
☐ Voluntary Benefits Disability	,		l Voluntar	v Bene				nce				⊒ Vol	untar	v Ber	nefits	Me	dSur	oport	Insu	rance	
Policy #			olicy#	•								Policy					·				
While there is no legal requirement for coverage you have with us for which policy or policies.	you may be e	eligible to	file a cla	im. Fail	ure to	provide			sted i												
B. Information About the Patient - 0	Check One I																				
	21100K 0110 1	LI Sell	⊔ Spou	se ப	Dome	stic Pai	rtner		hild												
Last Name	T I I	Li Seli	□ Spou	se ⊔	Dome		uffix			Nam	е				_						MI
						Sı				: Nam	е	0									MI
Last Name  Date of Birth (mm/dd/yy)			Social Se			Sı				: Nam	е	Ger	nder Male								MI
Date of Birth (mm/dd/yy)						Sı				Nam	е			le							MI
						Sı				Nam	e		Male	le						] [	MI
Date of Birth (mm/dd/yy)						Sı			First	Nam	e		Male	le							MI
Date of Birth (mm/dd/yy)  Home Address						Sı			First		e		Male	le							MI
Date of Birth (mm/dd/yy)  Home Address				curity N	lumber	Si Si			First		e		Male	le							MI
Date of Birth (mm/dd/yy)  Home Address  City	I No If no	, what w	Social Se	curity N	lumber	Si Si	uffix		First	State		Zip	Male Fema		nefit (	claim	-	nly, th	len g	) [	MI
Date of Birth (mm/dd/yy)  Home Address  City  Are you currently working?   Yes C	I No If no	what w	Social Se	curity N	lumber	Si Si	uffix		First	State		Zip	Male Fema		nefit (	claim	- as or	nly, th	l l l l l l l l l l l l l l l l l l l	) [	MI
Date of Birth (mm/dd/yy)  Home Address  City  Are you currently working? □ Yes □	I No If no creening/We de proof that his patient.	eliness E the test/ G H FF	Social Se	curity N  ast date  laim Co s perfor  liogram od Glu ssma Gl Post-Lo Hour F n A1C (gmoidos Stool Ar aphy	worke ompletomed.	d? e this set (FPG) sma	uffix		First	State	Cho nine Protitest ance ogrape F	Zip	Male Feman Temperature Tempera	s Ber est to DL ar DL ar DDL ar	nd LI nd LI resis	DL DL	- as or	hly, th	len g	o to	MI



The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

INSURED/PATIENT STA	ATEMENT (Con	tinued)																
Insured's Name (Last Name, Su	uffix, First Name, MI	)											Da	te of E	Birth (	mm/d	d/yy)	)
	$\Box$																	
D. Information About the Con-	dtion(s) Causing t	he Illness (	Complete	this	section	for C	itical	Illness/S	pecific	d Di	sease	e clair	ns only					
Please check the illness for which	ch you are filing this	claim.																
☐ Benign Brain Tumor	☐ Coma as t	the result of	severe T	raum	natic Br	ain Inj	ury	□М	ajor O	rgan	Failu	re						
☐ Blindness	☐ Coronary					•	•		ccupat	-								
☐ Cancer	□ Cystic Fib	rosis							erman	ent F	araly	sis as	the re	sult of	fa Co	vered	Acc	ident
☐ Carcinoma in Situ	□ Down Syn	drome						□S	pina B	ifida								
☐ Cerebral Palsy	□ End Stage	e Renal (kidr	ney) Failu	ıre				□ S	troke									
☐ Cleft Lip or Palate	☐ Heart Atta	ck (Myocard	lial Infarc	tion)	)													
Date of first treatment for this co	ondition (mm/dd/yy):																	
E. Information About Physicia	ans and Hospitals																	
	•	ourrant trac	tmont nr	ovid.	or(o) If		o boir	a traata	d by n	oro	thon	huo n	rovidor	o ploc	200 ok	oro th	o fo	llouina
Please provide the following info information for each provider on	n a separate sheet o	f paper and	include i	ovide t with	er(s). II n this fo	you ai rm.	e beli	ig treate	u by II	ше	man	two pi	ovidei	s, pież	ase si	iare ii	ie io	illowing
•	·										,		,					
1											(		)					
Primary Care Physician Name	e	Mailing A	ddress								T	eleph	one No	).				
											(		)					
Specialty		City				State		Zi	<u>р</u>		F	ax No	D.					
		•																
Date of First Visit (mm/dd/yy)		Date of N	Next Visit	(mm	n/dd/yy)	)												
2											(		)					
Treating Physician Name		Mailing A	ddress								T	eleph	one No	 ).				
											(		)					
Specialty		City				State		Zi	n		F	ax No	<u> </u>					
opeo.a,		0.1,				otato			P		•	۵, ۱۱						
Date of First Visit (mm/dd/yy)		Date of N	Next Visit	(mm	n/dd/yy)	)												
Please list any recent hospital v	/isits/admissions. If y	you have ha	d more th	nan t	wo rece	ent hos	spital v	visits/ad	missio	ns, p	lease	shar	e the fo	llowin	ng info	rmatio	on fo	or each
visit/admission on a separate sh	neet of paper and in	clude it with	this form	١.														
1																		
Hospital		Address									D	ate o	f Visit/	Admiss	sion (ı	mm/do	d/yy)	)
						<u> </u>												
Procedure		City			;	State		Zi	р		D	ate o	f Disch	arge (	mm/d	d/yy)		
2																		
Hospital		Address									D	ate o	f Visit/A	Admiss	sion (ı	mm/do	d/yy)	)
Procedure		City				State		Zi	<u>р</u>			ate o	f Disch	arge (	mm/d	d/vv)		
<del></del>		,									_	0		- 3- (		, , , /		

#### F. Tax Considerations

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



The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

INS	URE	D/I	PAT	IEN	IT S	TAT	ЕМ	EN	T (C	on	tinue	ed)																							
Insure	d's N	ame	(La	st Na	ame,	Suffi	x, Fii	rst N	ame,	MI)																			ate	of Bi	rth (m	ım/do	yy/L		
Frau	d V	Var	nir	ıg:	Fo	yo.	ur p	orot	ecti	ion	, Ari	zon	a la	ıw r	equ	uire	s th	ne i	ollo	ЭW	ing	to	apı	pea	ır c	n t	this	cla	mik	for	m:				
Any false for ir	or	fra	udu	ıler	it cl	aim	for	pa	aymo	ent	t of a	a lo	ss c	r b	ene	efit	or k	no	wir	ıgly	у рі	res	ent	s fa	als	e ir	nfor		•		•				'n
Frau	d V	Var	nir	ıg:	Fo	r yo	ur p	orot	ecti	ion	, Ne	w Y	′ork	lav	v re	qui	res	th	e fo	ollo	wir	ng '	to a	app	ea	r o	n th	nis	cla	im f	orm	:			
Any tion t mister and the	or i eadi sha	nsi ing II a	urai , in <sup>.</sup> Iso	nce forr be	or nat	sta ion	tem cor	nen nce	t of rnin	cla g a	im o any 1	cont fact	taini ma	ing teri	any ial t	/ m her	ate eto	ria , c	lly f	als mit	se i	nfo a fra	rm: aud	atic ule	n, nt	or ins	coi	nce anc	als e a	for ct, v	the whice	pu ch is	rpc s a	se crir	of ne,
G. Si	gnat	tur	e of	Ins	ure	d																													
I have paid to The a cons	or a bov	ny ⁄e s	rea: tate	son me	it is	my	obl	igat	ion t	to r	ерау	any	y su	ch c	ver	рау	mer	nt.													-				
X																																			
Sign	atur	e																					_	D	ate	•									
l sign or Co										у о	f the	do	cum	nent	t gra	anti	ng	aut	(in <b>hor</b>	dic i <b>ty</b>	ate	rel	atio	nsh	ip).	. If	Pov	ver	of A	Atto	orne	/, G	uar	diaı	n



The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

#### **OPTIONAL - DISCLOSING INFORMATION TO THIRD PARTIES**

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 and duly authorized relating to my claim w	ation or administration of my clai epresentatives ("Unum") to shar with the family members, friends,	m(s), I authorize Unum Group, its subsidiant personal health and financial information and/or other third parties listed below:	ries							
My Spouse:										
(Name)		(Telephone Number)								
Other Family Membe	r:									
	(Name / Relationship)	(Telephone Number)								
Other person:			-							
(Name / Relationship) (Telephone Number)										
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 follo	wing information about my claim	to be shared (leave blank if not applicable	):							
federal regulations go	overning the privacy of health info									
recipient of my inform	norization in writing at any time e lation has relied on it prior to rec ling written notice to the address	except to the extent Unum or the authorized eiving my notice of revocation. I may revok above.	this							
This authorization is a copy of the Authoriza	valid for the shorter of two (2) yeation and a copy shall be as valid	ars or the duration of my claim. I may reque as the original.	est a							
Insured/Patient Signa	ture	Date								
Printed Name		Social Security Number	-							
signed on behalf of the claimant as (indicate relationship). If Power										

document granting authority.

of Attorney Designee, Personal Representative, Guardian, or Conservator, please attach a copy of the



The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

ATTENDING PHYSICIAN S	TATEMENT (PLEASE PRINT)		
PART I: TO BE COMPLETED BY IN	SURED/PATIENT		
Insured Name (Last Name, Suffix, Fi	rst Name, MI)  Self  Spouse  Domestic Partner  C	hild	Insured Social Security Number  Patient Social Security Number  Patient Date of Birth (mm/dd/yy)
Patient Gender:   Male Fema	lie		
			h as office notes, medical records, consultations, and/or
Complete these questions for all n	nedical conditions		
Diagnosis Information			
Diagnosis:			ICD Code:
Date of Diagnosis:			Date you were first consulted for this condition (mm/dd/yy):
Please check the condition(s) that ap as required for the condition(s) indicate		s, operative reports	s, pathology reports, and/or your detailed medical statement
Condition	Medical Documentation	Other Pertinent	Information
☐ Benign Brain Tumor	Tissue Biopsy		
Blindness	Metric Acuity or Snellen/E-Chart Acuity Measurements	Visual Acuity after	er correction L R triction L R
☐ Cancer	Pathology Report and/or Clinical Diagnosis	Stage:	_ Grade:
☐ Carcinoma in Situ	Pathology Report and/or Clinical Diagnosis		
☐ Cerebral Palsy	Clinical Diagnosis		
☐ Cleft Lip or Palate	Clinical Diagnosis		
☐ Coma (resulting from severe traumatic brain injury)	Clinical Diagnosis	more consecutive	erienced a continuous state of unconsciousness for 14 or e days?   Yes   No re intubation?   Yes   No
☐ Coronary Artery Bypass Surgery	Surgical report		
☐ Cystic Fibrosis	Clinical Diagnosis		
☐ Down Syndrome	Clinical Diagnosis		
☐ End Stage Renal Failure	Clinical Diagnosis		ve chronic irreversible function of both kidneys? ☐ Yes ☐ No purier regular hemodialysis or peritoneal dialysis? ☐ Yes ☐ No
☐ Heart Attack	Any of the following: Electrocardiograph (EKG), cardiac enzymes, thallium scans, MUGA scans, stress echocardiogram		
☐ Major Organ Transplant/Failure	Surgical Report	Is the patient on If yes, date adde	the UNOS list?  Yes  No ed to UNOS list:
☐ Occupational HIV	Clinical Diagnosis		·
☐ Permanent Paralysis	Clinical Diagnosis		
☐ Spina Bifida	Clinical Diagnosis		
Stroke	Documented neurological deficits and/or neuroimaging studies		
Return to Work Assessment			
Did you advise the patient to stop wor  ☐ Yes ☐ No	rk? If yes, when (mm/dd/yy)? Have you adv	rised patient to retu	ırn to work?
If yes, please indicate any chaoing re	estrictions and limitations in the space provided	on the next rage	

If yes, please indicate any ongoing restrictions and limitations in the space provided on the next page. If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided on the next page.



The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

ATT	ΕN	1DI	N	G F	'H	YSI	CI	AN	I S	TAT	Έ	ME	N	Т (С	ont	in	ue	d)																					_						
Insured	's l	Nam	ne	(Las	st N	ame	, F	irst	Nar	me,	MI	, Su	ffix	()																						D	ate	of E	3irtl	ı (m	m/c	ld/yy	/)		
				Т							T					П			Т							Τ			Τ																
Patient'	⊥L s N	lam	L e (	L Las	t Na	ı ame.	F	irst	Nan	ne. N	Ц ИI,	Suf	l ffix	)		_						_	_		_			_						<u> </u>		D	ate	of E	_ 3irt∤	L n (m	_I_ m/c	 ld/yy	/)		
	T		T	Т			Τ			Ť	Ť					Т		Т	Т			Т	Т		Г	Т		Г	Т							Γ			٦	Ù	Т	T)	Ĺ	Т	
							L				_														<u> </u>			<u> </u>								L			丄						
CURRE	EN <sup>-</sup>	ΓRE	ES <sup>*</sup>	ΓRI	CTI	ONS	S (8	activ	/ities	s pa	tie	nt sl	hou	ıld no	ot do	) P	lea	se b	e sp	oec	ific.																								
CURRE	EN <sup>-</sup>	ΓLIN	MΙ	ГАТ	ION	IS (a	cti	ivitie	es pa	atier	nt o	cann	ot	do) F	Pleas	se k	e s	spec	ific.																										
Hospita	aliz	atio	ons	an	ıd C	Othe	r T	rea	ting	Pro	ovi	der	s																																
Has the	pa	atier	nt k	eer	n tre	eated	d fo	or th	ne sa	ame	or	sim	nila	r con	ditio	n b	y a	noth	ner p	hy	sicia	n ir	n th	e p	ast?	• [	ΞY	es/		No		_ ι	Inkr	now	n	If y	es,	list	bel	OW.					
Other F	_																_		_	_				_												_									
										•																		Π	•					Ť							Т	reat	me	ent	
Name								Spe	ecial	lty					Ad	dre	ess											Ph	on	e #				F	ax :	#				F	rom			То	
													_																																
Has pat	as patient been hospitalized?   Yes   No If yes, date hospitalized (mm/dd/yy): through (mm/dd/yy):																																												
Facility	Ns	me																																											
acility	INC	IIIC																																											
Address	S																																												
City																													Sta	ite		2	Zip												
						•		,			Ι.,			DT 4														15							_	,		.,							
Was su	rge	ery p	er	rorn	nea	? L	_ \	res		No	II	yes	s, C	P14	coa	e(s	5):											Da	ate	Sur	gei	′у ⊦	'erf	orm	ea	(mr	n/do	l/yy	):						
Is the p	atie	ent s	stil	un	der	your	C	are′	? [	Ye	S		No	If n	o, fir	nal	dat	e of	trea	atm	ent	(mn	n/d	d/y	/):			<u>'                                    </u>																	
	11	7 /	10	\Т		<del></del> -	۸ .						<u></u>				داء	, £:	ادما	_		-+-			-+ -	٠.	ماد		_		-+-			~ 4	اما				.:.		ناد				
FRAU inform form.	na	atic	on.	is	SU	⊏: Æ ubje	4r 20	ny et t	pe o c	rsc crin	ni nii	wi nal	nc a	nd	ow civ	in il p	giy	y II na	Itie	s a	Sta	ate nis	em in	icli	nt d	or es	CI A	ain	n c	din	nta g	air Pł	nys	g 1 sic	iai	se n p	or	m tio	กร	ea s o	f th	ng ne	cla	aim	1
Signatu		of	ΔΗ	one	line	ı Ph	vs	icia	n				_			_	_			_		_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_		_		
The ab										con	nn	lete	to	the l	nest	οf	mv	kn	owl	edo	ne ai	nd I	hel	ief															_						
Physicia											_						_				jo ui		-	-																					
Medical	I S <sub>l</sub>	oeci	alt	y																		De	egre	ee																					
Address	S																																												
City																													Sta	ite			Zip												
Telepho	ne	Nu	mb	er													F	ax N	luml	ber								-				+	P	hys	icia	an's	Тах	ID	Nu	mbe	er:				
Are you	ı re	late	d t	o th	is p	atier	nt?	? [	] Ye	es		No	I1	yes,	wha	at is	th	e re	latio	nsl	nip?																								
X																																													
Physi	ci	an	Si	an	atı	ire																								Ī	Da	te													



The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

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

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, consumer reporting agencies including credit bureaus, the MIB Group, Inc., The Advocator Group and other Social Security advocacy vendor, 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 ("My Information");

**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");

For the purposes of evaluating and administering claims, including assistance with return to work. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim for benefits, whichever is shorter.

I also authorize Unum to disclose My Information to any insurance broker; employee benefit plan sponsored by my employer; my employer; any person providing services to, or insurance benefits on behalf of my employer, any such plan, or any benefit offered by Unum; or the Social Security Administration, 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. 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, this authorization is valid for one year or for the length of time otherwise permitted by law.

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, except as otherwise specified, 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 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.

Insured's Signature	Date Signed
Printed Name	Social Security Number
I signed on behalf of the Insured as Designee, Guardian, or Conservator, please atta	(Relationship). If Power of Attorney ach a copy of the document granting authority.
CL-1018-AUTH (01/13)	