UNUM®

BASIC GROUP LIFE CLAIM FORM

Please Fax to (412)963-0415 or Mail to:
Provident Agency, Inc.
P.O. Box 11588, Pittsburgh, PA 15238
Telephone 1-800-447-0360, Fax (412)963-0415

Please send the following documents to UnumProvident Corporation when submitting a claim:

For a Life Claim:

- A completed basic Group Life claim form
- A copy of the death certificate (a photocopy is acceptable)
- The original enrollment form and any beneficiary change form(s)
- Appropriate salary verification/documentation (see requirements below)
- When named beneficiary has predeceased the insured, a copy of the deceased beneficiary's death certificate and name of contingent beneficiary
- If the beneficiary is the Estate of the insured, a copy of the court appointment naming the Executor, Administrator or Personal Representative.

If this is an Accidental Death Claim, complete Parts 1-5 on Basic Group Life Claim Form (Notice of Death Claim) and A-2
If this is a Dismemberment Claim, complete Attachment A-1 and A-3.
For an Accelerated Benefit Claim, complete Attachments B-1 and B-2

Attention should be given to the following statements:
Claim Fraud Warning Statements

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

Fraud Warning

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

Fraud Warning for California Residents

For your protection, California law requires the following to appear:

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

Fraud Warning for Colorado Residents

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

Fraud Warning for District of Columbia, Maine and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

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

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

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

Fraud Statement for New York Residents

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

In order to accurately determine the Life Benefit payable, please provide the following:

Salary Verification/Documentation*

If Definition of Basic Monthly Earnings is:		**Required Documentation**
1	W-2	Include Previous Year's W-2 form
2	Salary and commissions	One month's payroll records (for month preceding date last worked) plus documentation of commissions earned/paid over the last 12 months
3	Salary, commissions and bonuses	One month's payroll records (for month preceding date last worked) plus documentation of commissions earned/paid and documentation of any bonuses earned/paid over the last 12 months

4 For Salary Only and flat benefit amounts, no verification/documentation is required.

Notice of Claim
Please Fax to (412)963-0415

1. INSURANCE INFORMATION (Complete for all claims)

Indicate the type of claim being filed:	☐ Life	☐ Supplemental	Did the deceased have other insurance?	Group Life Insurance	☐ Yes	☐ No	☑ Unknown
	☐ Dependent	☐ Accelerated		Individual Life Insurance	☐ Yes	☐ No	☑ Unknown
	☐ AD&D			Disability Insurance	☐ Yes	☐ No	☑ Unknown

2. EMPLOYER INFORMATION (Complete for all claims)

Company Name	If an affiliate, subsidiary, branch or employer member, give name

Address (Number/Street, City, State, Zip Code)	Telephone Number

Signature and Title of Authorized Representative	Date	Policy Number(s) and Division

THIS SECTION MUST BE COMPLETED IN FULL

1. Do you as the Employer pay any portion of the premium for this insurance? ☑ No ☐ Yes
2. Did you issue a summary plan description? ☑ No ☐ Yes
3. If you filed this as an ERISA program, please advise us of the plan number. Plan Number:

3. EMPLOYEE INFORMATION (Complete for all claims)

Full Name of Insured Employee	Social Security Number	Date of Birth

Address of Employee (Number/Street, City/Town, State, Zip Code)

Occupation	Salary/Rate of Pay* (See requirements on previous page)	Employment Status: ☐ Active ☐ Full-time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired ☐ Other Specify ☑ Medical Leave _____ *If part time:* hours per day _____ days per week _____

Amount of Unum Group Life Insurance: Basic Life $_____ Supplemental Life $_____ Basic AD&D $_____ Supplemental AD&D $_____	Date Employed	Effective Date of Unum Insurance

Date of Last Change in Amount of Insurance	Amount of Last Change			
	Basic Life	$_____	Increased	Decreased
	Supplemental	$_____	Increased	Decreased
	AD&D	$_____	Increased	Decreased

Date Last Worked	Reason for Ceasing Work	Date of Death and Age	Have premiums terminated? If yes, please give date.

Was the death considered a homicide/accident? ☐ No ☐ Yes (If yes, please attach a copy of the police report)

If dismemberment, indicate if Employee is still at work.

4. DEPENDENT CLAIM FORM (Complete for Dependent Life & AD&D Claims only)

Full Name of Deceased Dependent	Relationship to Insured Employee	Date of Birth

Effective Date of Unum Dependent Life Insurance	Amount of Insurance	Date of Last Change in Amount of Insurance	Date of Death and Age

5. BENEFICIARY INFORMATION (Complete for all claims)

Total Number of Beneficiaries: If more than two beneficiaries, attach a separate sheet.

Name of Beneficiary	Relationship to Employee	Beneficiary's Date of Birth
Address (Number/Street, City, State, Zip Code)	Beneficiary's Telephone Number	Beneficiary's Social Security No.
Name of Beneficiary	Relationship to Employee	Beneficiary's Date of Birth
Address (Number/Street, City, State, Zip Code)	Beneficiary's Telephone Number	Beneficiary's Social Security No.

6. SURVIVOR INFORMATION (Complete for employee claims eligible for SurvivorSupport®)

Name of Survivor (This individual may be different than the beneficiary) and Relationship	Telephone Number

Address (Number/Street, City, State, Zip Code)

Attachment A-1 – Accidental Dismemberment

Please Fax to (412)963-0415

TO BE COMPLETED BY THE EMPLOYEE

To avoid delay, please answer all questions - please print.

Have the Attending Physician's Statement Completed

Full Name (Last, First, Middle)	Social Security Number	Telephone Number
Date of Accident	**Date of Loss**	**Occupation**
__ __ /__ __ /__ __ __ __	__ __ /__ __ /__ __ __ __	

Name, Address and Telephone Number of the Physician who treated you for this accident

Name and Address of the Hospital where you received treatment for this accident

Full account of the accident (Please attach an additional sheet, if necessary)

DISCLOSURE INFORMATION

I authorize any doctor, hospital, practitioner, pharmacist, clinic, other medical facility, or provider of health care, banking or financial institution, insurer or reinsurer, consumer reporting agency, governmental agency, including the Social Security Administration, Medical Information Bureau, Employers and other persons or institutions; to provide Unum Life Insurance Company of America and its representatives who are employed to assist in the evaluation of my claim any information, data or records you may have regarding me, my employment, medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and, but not limited to, information regarding my HIV status and test results, and any disability I may now have or have had) and income.

I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to any agency, insurance support organization or person employed by Unum to assist with this purpose. This authorization is valid during the pendency of my claim. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photostatic copy of this form will be valid as the original.

__ __ /__ __ /__ __ __ __

Signature of Insured — Date Signed

TO BE COMPLETED BY BENEFICIARY OR AUTHORIZED REPRESENTATIVE
PLEASE ANSWER ALL QUESTIONS

Full Name of Deceased	Social Security Number

When did accident happen (month, day, year)	Time	Where did accident happen? (if city or town, show street no.)
__ __ /__ __ /__ __ __ __	☐ a.m. ☐ p.m.	

How did accident happen? (Describe fully)

What was deceased doing at the time of the accident?

List all Physicians and Surgeons who attended deceased for these injuries

Name	Name	Name
Address	Address	Address

Advise if Autopsy or Inquest was held (Note: attach summary of autopsy or copy of inquest verdict)

List all witnesses to the accident

Name	Name	Name
Address	Address	Address

List all investigating authorities: (Please include Addresses)

Investigating Officer Telephone Number ( )

List all physicians who have attended deceased during the last five years. (State ailments involved)

Name and Address	Ailment
Name and Address	Ailment

In what capacity are you acting to complete this form?

☐ Named Beneficiary ☐ Representative of Named Beneficiary ☐ Administrator of Estate ☐ Other _____

Telephone Number ( ) _____ Named Beneficiary's Social Security Number or Taxpayer I.D. Number_____

DISCLOSURE INFORMATION

I authorize any doctor, hospital, practitioner, pharmacist, clinic, other medical facility, or provider of health care, banking or financial institution, insurer or reinsurer, consumer reporting agency, governmental agency, including the Social Security Administration, Medical Information Bureau, Employers and other persons or institutions; to provide Unum Life Insurance Company of America and its representatives data or records you may have regarding the employment, medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and, but not limited to, information regarding HIV status and test results) and income of the deceased.

I understand that any information obtained pursuant to this authorization will be used to evaluate the claim and may be transferred to any agency, insurance support organization or person employed by Unum, to assist with this purpose. This authorization is valid during the pendency of the claim. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photostatic copy of this form will be valid as the original.

Beneficiary or Authorized Person's Signature __ __ /__ __ /__ __ __ __ Date Signed

Attachment A-3 — Physician's Statement for AD&D

Please Fax to (412) 963-0415

TO BE COMPLETED BY THE ATTENDING PHYSICIAN FOR ACCIDENTAL DEATH OR DISMEMBERMENT

Patient's Name	Social Security Number	Date of Birth

Date of Accident causing present loss	Date first consulted you for this condition	Has patient ever had same or similar Symptoms? ☐ Yes ☐ No If yes, Date:

Diagnosis or nature of injury _____

When did symptoms first appear or accident happen?_____

Patient ceased work due to disability? _____

Is condition arising out of employment? ☐ Yes ☐ No

When do you think patient will be able to resume work?
Approximate Date _____
Indefinite ☐
Never ☐

If loss is extremity, where is amputation? Use diagram below.

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No

If no, speech at this time_____

If loss of hearing, is loss in both ears? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, hearing at this time? _____

If loss of vision please provide the following: (Snellen Notation)

		Mo. / Day / Yr.	Uncorrected	Corrected
a	Give date of first eye examination	_____	O.D._____	O.D. _____
b	Give date of last examination	_____	O.S._____	O.S. _____

c If the injury necessitated removal of either or both eyes, give date of removal:

d Vision can be restored in whole or in part by ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

e If by operation, do you recommend it? ☐ Yes ☐ No

f Date corrected vision was irrecoverably reduced to 20/200 or less (Snellen Notation)

In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

In your opinion was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, list dates you provided treatment for this illness: _____ (MM DD YYYY) _____ (MM DD YYYY)

List names of any other physician who treated insured for a contributory condition:

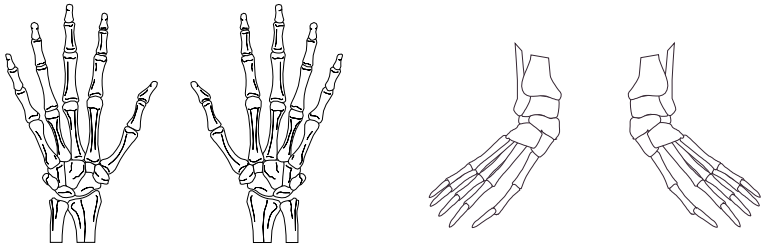
Name of Physicians Address

(1) _____

(2) _____

Please indicate where the injury occurred using the illustration below:

Remarks:



RIGHT LEFT RIGHT LEFT

PLEASE ATTACH COPIES OF OFFICE NOTES RELATED TO THIS INJURY

Name (Attending Physician) — Please print	Degree/Professional Designation	Telephone Number ( )

Physician's Address (Number and Street, City/Town, State, Zip Code)

Signature	Date

TO BE COMPLETED BY THE CLAIMANT:

Date of accident or date you first noticed symptoms of your illness.	Describe how and where accident occurred or describe the first symptoms of your illness and nature of illness.
Is your accident or illness related to your occupation? ☐ Yes ☐ No	If yes, explain.

Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No

If no, do you intend to? ☐ Yes ☐ No

Date you were first treated for your illness or injury.	Treated By:	Name	Street Address	City	State	Zip Code
If More Than One Hospital/Doctor Attach a Separate Listing	Hospital:					
	Doctor:					
			Street Address	City	State	Zip Code

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No	Treated By:	Name	Street Address	City	State	Zip Code
If More Than One Hospital/Doctor Attach a Separate Listing	Hospital:					
	Doctor:					
			Street Address	City	State	Zip Code

Disclosure Information

I authorize any doctor, hospital, practitioner, pharmacist, clinic, other medical facility, or provider of health care, banking or financial institution, insurer or reinsurer, consumer reporting agency, governmental agency, including the Social Security Administration, Medical Information Bureau, Employers and other persons or institutions; to provide Unum Life Insurance Company of America and its representatives who are employed to assist in the evaluation of my claim any information, data or records you may have regarding me, my employment, medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and, but not limited to, information regarding my HIV status and test results, and any disability I may now have or have had) and income.

I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to any agency, insurance support organization or person employed by UNUM, to assist with this purpose. This authorization is valid during the pendency of my claim. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photostatic copy of this form will be valid as the original.

Special Notice To Minnesota Claimants:
This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, fire-fighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care and or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who qualify under the good Samaritan law.

_____ _____

Signature of Insured Date Signed

Please have your Attending Physician Complete Reverse Side

Attachment B-2 — Accelerated Benefit Claim — Attending Physician's Statement

Please Fax to (412) 963-0415

Name of Patient	Date of Birth	Social Security No.
		Group/Policy No.

History

When did symptoms first appear or accident happen?	Has patient ever had same or similar condition? ☐ Yes ☐ No	If "Yes" state when and describe.

Names and addresses of other treating physicians

DIAGNOSIS

Date of Diagnosis	Diagnosis (including any complications)

Subjective symptoms	Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)

Secondary diagnosis(es)	Date of Diagnosis(es)

Subjective symptoms	Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)

TREATMENT

Date of first visit	Frequency ☐ Daily ☐ Weekly ☐ Monthly ☐ Other (specify)	Date of last examination

PROGNOSIS

During last 6 months, has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Is Patient ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

Has Patient been hospital confined? ☐ Yes ☐ No	If "Yes" give name and address of hospital.	Dates of hospital admission(s)

What is the estimated life expectancy? ☐ less than 6 months ☐ 6-12 months ☐ 12-24 months ☐ greater than 24 months

Cardiac (If Applicable)

Functional Capacity (American Heart Assn.)
☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

Therapeutic Class (Activity)
☐ A. (no restric.) ☐ C. (moderate restric.)
☐ B. (slight restric.) ☐ D. (marked restric.)
☐ E. (complete restric.)

Blood pressure last visit _____ Systolic/Diastolic

Cancer (If Applicable)

If Diagnosis is Cancer, Indicate Stage _____

Physical Impairment
(*As defined in federal dictionary of occupational titles)
☐ Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)
☐ Class 2 - Medium manual activity* (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)
Remarks:

Mental Impairment (If Applicable)

In your opinion, is this individual competent to make decisions? ☐ Yes ☐ No	Remarks:

Restrictions

Does this patient currently have limitations/restrictions?				Describe specific limitations and restrictions
	Patient's Occupation	☐ Yes	☐ No	
	Any Other Work	☐ Yes	☐ No	

PLEASE INCLUDE COPIES OF MEDICAL RECORDS FOR THIS CONDITION, INCLUDING BUT NOT NECESSARILY LIMITED TO:
• Treatment Notes • Consultation to/by Other Physicians
• Diagnostic Tests and Results • Hospital Records

Name of Attending Physician – Please Print		Degree	Telephone
Medical Specialty			
Street Address	City or Town	State or Province	Zip Code
Signature		Date	

Claimant Please Complete Reverse Side