SHORT 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

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.

OUR COMMITMENT TO YOU

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

Instructions:

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 Statement (pages 3-4):** 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.
- **Authorization to Share Information with Third Parties (page 5):** 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, it may be mailed to the address noted above.
- **Employee 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 6-7):** Please ask your employer to complete, sign and date the form and fax it to 1-800-447-2498 or mail it to the address noted above. If you are applying for Individual Short Term Disability benefits only, we do not require the Employer Statement.
- **Attending Physician Statement (pages 8-9):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to 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. 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 Phone number. Our Contact Center is staffed with experienced professionals who can be contacted from 8 a.m. to 8 p.m. Monday through Friday.

* 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 information to obtain or amend insurance coverage or to make a 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.

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EMPLOYEE STATEMENT (PLEASE PRINT)

A. Information About You

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)	Social Security Number	Gender ☐ Male ☐ Female	The state in which you work

Home Address

City	State	Zip

Home Telephone Number where we can reach you	Preferred e-mail address (for confirmation purposes only)

Employer Name

Language Preference ☐ English ☐ Spanish ☐ Somali ☐ French ☐ Arabic ☐ Other

Please check all types of coverage you have with Unum. ☐ Group Short Term Disability ☐ Individual Short Term Disability

Do you work for another employer? ☐ Yes ☐ No	If yes, employer name	Telephone Number

Are you currently self-employed? ☐ Yes ☐ No

B. Information About Your Family

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 ☐ No

C. Information About Your Disability

1. For **pregnancy**, answer the following questions under #1, skip questions #2 and #3, then go to #4:

What is your expected delivery date?	If you have delivered, what was your delivery date? (mm/dd/yyyy)	What type of delivery? ☐ Vaginal ☐ C-Section

Were there any complications causing you to stop work prior to your expected delivery date? ☐ Yes ☐ No

If yes, please explain:

2. For **other than pregnancy**, is your disability caused by ☐ Illness or ☐ Injury?

What is the name of your medical condition(s)?	Date you were first treated by a physician (mm/dd/yyyy)

3. Is your condition work related? ☐ Yes ☐ No If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

If yes, please explain how the work related injury/illness occurred:

4. Have you been hospitalized? ☐ Yes ☐ No If yes, date hospitalized (mm/dd/yyyy): through (mm/dd/yyyy):

5. Have you had a surgery due to your medical condition? ☐ Yes ☐ No Date of surgery (mm/dd/yyyy):

If yes, surgery type: Inpatient ☐ Outpatient ☐

6. If related to an injury, when, where and how did the injury occur?

7. Last day you were at work (mm/dd/yyyy)	Number of hours worked on date last worked	First date you missed work due to this medical condition (mm/dd/yyyy)

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EMPLOYEE STATEMENT (Continued)

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)

8. Have you returned to work? ☐ Yes ☐ No If yes, indicate date below.
Part Time (mm/dd/yyyy): Part-time hours per week: Full Time (mm/dd/yyyy):

If you have not returned to work, when do you expect to return?
Part Time (mm/dd/yyyy): Part-time hours per week: Full Time (mm/dd/yyyy): ☐ Unknown

D. Information About Your Medical Providers

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

Provider Name _____ Telephone No. _____ Fax No. _____

Date of first visit for this condition (mm/dd/yyyy) _____ Date of next visit for this condition (mm/dd/yyyy) _____

E. 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 directly above your signature:

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 directly above your signature:

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.

F. Signature of Employee/Individual

The above statements are true and complete to the best of my knowledge and belief. 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. **(Your signature is required for benefit consideration.)**

X _____ _____

Signature **Date**

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

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You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your 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.

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

A. Information About the Employer

Employer Name	Telephone Number

Employer Address

City	State	Zip

B. Information About the Employee

Last Name	Suffix	First Name	MI

Employee 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 provide the information requested.

Short Term Disability ☐ Yes ☐ No	Policy Number	Division Number (PEG No., if applicable)	Original Date of Coverage
Long Term Disability ☐ Yes ☐ No	Policy Number	Division Number (PEG No., if applicable)	Original Date of Coverage
Voluntary Benefits Disability ☐ Yes ☐ No	Policy Number	Division Number (PEG No., if applicable)	Original Date of Coverage
			Original Date of Coverage

Voluntary Benefits Disability Benefit Election Amount $_____

Is this employee: ☐ Full-time ☐ Part-time ☐ Exempt ☐ Non-exempt ☐ Bargaining ☐ Non-bargaining

Date Last Worked (mm/dd/yyyy) ☐ Actual date ☐ Expected date Number of hours worked on date last worked

Check off regular work days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat Hours scheduled to work per week:

Did this employee reduce his/her hours **prior** to his/her last day worked due to this medical condition? ☐ Yes ☐ No

If yes, please provide specific dates and hours worked.

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

Has the employee's employment been terminated? ☐ Yes ☐ No If yes, termination date (mm/dd/yyyy):

How was the employee paid? (please check all that apply)
☐ Hourly ☐ Salary ☐ Overtime ☐ Bonus ☐ Commissions ☐ Shift Differential ☐ Other

If the policy defines earnings as prior year W-2, please include a copy of W-2 and year end pay stub.

Salary/Wage prior to date last worked
☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
$ _____

Bonuses (per week) ☐ Yes ☐ No $ _____
Commissions (per week) ☐ Yes ☐ No $ _____

Employee Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability so that earnings will be calculated as defined by the policy.
401(k)/403(b) Pre-tax medical and other insurance Flexible spending account
_____% $ _____/week $ _____/week

Date paid through (mm/dd/yyyy): For: ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick pay ☐ Other

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 ☐ Non-Profit

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

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EMPLOYER STATEMENT (Continued)

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)

Complete only for New York Disability Benefits Law Temporary Disability Benefits Salary Information

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 this policy provides New York Disability Benefits Law coverage, please provide the earnings for the 8 weeks prior to disability. (For Disability Benefits Law - include the week in which disability began).

	Week Ending						Week Ending					
	Mo.	Day	Yr.	No. Days Worked	Amount		Mo.	Day	Yr.	No. Days Worked	Amount
1						5					
2						6					
3						7					
4						8					

Complete only for New Jersey Temporary Disability Benefits Salary Information

If this policy provides New Jersey Temporary Disability Benefits coverage, please provide the following earnings, so we may calculate the average weekly wage. In 2020, a "base week" is any week an employee earns $200. Based on the "base week" definition, do not include weeks or the income from any week where the employee received $200 or less.

Previously Completed Quarters	Time Frame Covered	Total Earnings	Number of Base Weeks
Quarter 5 (most recently completed)			
Quarter 4			
Quarter 3			
Quarter 2			
Quarter 1			

C. Information Needed for Calculation of FICA

What percentage of the Short Term Disability benefit is taxable? _____% We will assume the benefit is 100% taxable if this information is not provided. [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.]

D. Statutory Disability/Paid Medical Leave

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

E. Information About Your 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, who should we contact to discuss a return-to-work plan?

Name _____ Telephone Number _____

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

F. 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

Telephone Number	Fax Number	E-mail Address

Signature

X

Date Signed

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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Last Name	Suffix	First Name	MI

Patient Address

City	State	Zip

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

Employer Name

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

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

Diagnosis:	ICD Code:	Did you advise your patient to stop working? ☐ Yes ☐ No If yes, on what date (mm/dd/yyyy)?

Were there any complications causing your patient to stop working prior to her expected delivery date? ☐ Yes ☐ No
If yes, please explain:

B. Complete this section for all conditions except pregnancy, then go to Section C

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? ☐ Yes ☐ No If yes, on what date (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? ☐ Yes ☐ No ☐ Unknown	Patient's Height:	Patient's Weight:

Primary Diagnosis:	Primary ICD Code:

Secondary Diagnosis:	Secondary ICD Code:

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

Was surgery performed? ☐ Yes ☐ No If yes, what procedure was performed?	CPT Code:	Date Surgery Performed (mm/dd/yyyy):

What is your treatment plan? Please include all medications.

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ATTENDING PHYSICIAN STATEMENT (Continued)

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)

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

Name	Specialty	Address	Phone #

Have you advised the patient to return to work? ☐ Yes ☐ No

Expected return to work date (mm/dd/yyyy): ☐ Full Time ☐ Part Time

Part-time hours per day

C. 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.

Restrictions and/or Limitations

If your patient has CURRENT RESTRICTIONS (activities patient should not do) and/or 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): _____

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

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	Degree/Specialty

Address

City	State	Zip

Telephone Number:	Fax Number:	Physician Tax ID Number:	Are you related to this patient? ☐ Yes ☐ No If yes, what is the relationship?

Signature of Physician

X

Date

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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 Advocator 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.

*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.