



**CLAIM FOR SELECT INCOME PROTECTION BENEFITS**

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

Pacific Time Zone Toll-free: 1-877-851-7637 Fax: 1-877-851-7624  
All Other Time Zones Toll-free: 1-800-858-6843 Fax: 1-800-447-2498

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

Unum Life Insurance Company of America Provident Life and Accident Insurance Company  
The Paul Revere Life Insurance Company

**Please mail or fax this form to:**

The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158  
Pacific Time Zone Toll-free: 1-877-851-7637 Fax: 1-877-851-7624  
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This form should be used for the following types of claims only:

- Educator Select Income Protection Plan (Employees of any Educational Institution)
- Educator Select Short Term Income Protection Plan (Employees of any Educational Institution)
- Select Income Protection Plan
- Select Short Term Income Protection Plan

This form must be completed by the Attending Physician, the Employee, and the Employer, and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

Our centralized mail processing center, located in Columbia, SC, services our Benefits Centers located in:  
• Chattanooga, TN • Glendale, CA • Portland, ME

**The employee is responsible for completion of all portions of this form without expense to the Unum subsidiaries.**

**INSTRUCTIONS:**

- A. Attending Physician's Statement:** This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form. Advise your physician(s) to attach copies of medical records and test results.
- B. Employee's Statement:** This section must be completed by you, the employee. It includes a Physician/Medication page that must also be completed by you. If necessary, you may include additional information on the back of this page. To avoid delay in evaluating your claim, advise your physician(s) to attach copies of medical records and test results.
- C. Employer's Statement:** The employer must complete this form.

**Authorization:** Sign and date this form. Provide a copy of the signed and dated form to your attending physician.

**Please enclose any additional information that you feel will assist us in evaluating this claim.**



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**ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)**

Name of Patient	Home Telephone Number ( )	Date of Birth	Social Security Number
Employer Name/Address			Employer Telephone Number ( )

**Instructions:** The following sections must be completed and signed by the attending physician. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete the normal pregnancy section. **Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, you must complete the signature block at the bottom of this form.**

**NORMAL PREGNANCY**

a) Expected Delivery Date: \_\_\_\_\_ b) Actual Delivery Date: \_\_\_\_\_ c) Delivery Type:  Vaginal  C-Section

d) Date of first visit for this pregnancy: \_\_\_\_\_ e) LMP: \_\_\_\_\_

Date First Unable to Work \_\_\_\_\_ Date Hospitalized \_\_\_\_\_ through: \_\_\_\_\_

Has patient been released to return to work in her own occupation?  Yes  No In any occupation?  Yes  No

If not, when should patient be able to return to work? Full-time: \_\_\_\_\_ Part-time: \_\_\_\_\_

**ALL OTHER CONDITIONS**

**Patient Information**

a) Height \_\_\_\_\_ Weight \_\_\_\_\_ b) Date of first visit regarding current conditions? \_\_\_\_\_

c) Date patient ceased work because of condition? \_\_\_\_\_ d) Did you advise patient to cease work?  Yes  No If yes, when? \_\_\_\_\_

e) Has the patient been treated for the same/similar condition in the past?  Yes  No If yes, when? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

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

**Diagnosis and Treatment**

**Primary Diagnosis**

a) What is the primary diagnosis preventing your patient from working?  
Please include Primary ICD - 9 and/or DSM IV Multi-Axial Diagnoses and Codes \_\_\_\_\_

b) Date of last examination \_\_\_\_\_

c) Describe Reported Symptoms \_\_\_\_\_

d) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.) \_\_\_\_\_

**Other Conditions (Please attach additional information as necessary)**

Are there other conditions that prevent your patient from working? If so, please list with information as follows:

a) Secondary ICD-9s \_\_\_\_\_ Diagnosis \_\_\_\_\_

Secondary ICD-9s \_\_\_\_\_ Diagnosis \_\_\_\_\_

b) Describe Reported Symptoms \_\_\_\_\_

c) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.) \_\_\_\_\_

**Treatment**

a) Describe the patient's current treatment program: (include facilities name/address if applicable) \_\_\_\_\_

b) Medications (Please list all medications including dosage and frequency) \_\_\_\_\_

c) Has patient been hospitalized?  Yes  No Date Hospitalized \_\_\_\_\_ through \_\_\_\_\_

d) Was surgery performed? CPT 4 Code(s) \_\_\_\_\_ Date Surgery Performed: \_\_\_\_\_

Name/Address of facility \_\_\_\_\_

e) Is the patient still under your care?  Yes  No Final Date of Treatment \_\_\_\_\_





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**B. EMPLOYEE'S STATEMENT (PLEASE PRINT)**

1. Employee's Name (as printed on your Social Security Card)	Home Telephone Number ( )	Date of Birth	Social Security Number	
	Cell Telephone Number ( )		<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:      Weight:

Home Address (Street, City, State, ZIP)

The state in which you work:	Preferred e-mail address where you can be reached:	Policy Number
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2. Employer Name	Policy Number
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Occupation:	If you have returned to work, list the duties of the occupation you are performing.	# of weekly hours spent at duty
Have you returned to work? If yes, when?		
Part Time:                      Full Time:		
Hours per week:		
If you have not returned to work, when do you expect to return?		
Part Time:                      Full Time:		

What specific job duties are you unable to do as a result of your sickness/injury?

**In order to expedite your claim, please provide medical records to support your inability to perform your occupational duties.**

3. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	If you are married, spouse's name:	Spouse's Date of Birth	Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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List your dependent children who are under age 25 (attach additional sheets if necessary).

Name	Date of Birth	Attending School?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Is this disability due to:  Motor Vehicle Accident  Other Accident  Sickness  Work-related Injury/Sickness  Pregnancy

Please describe your medical condition(s) or injury that is resulting in your disability. Advise when the symptoms first appeared. If related to an injury, advise when, where and how the injury occurred.

5. Date Last Worked:	Number of Hours Worked on Date Last Worked:
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6. Number of Regular Sick Days Accumulated:

7. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.

**If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.**

Social Security/Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No
Canada Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No	No-Fault Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Employee Retirement/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Third Party Settlement/Income <input type="checkbox"/> Yes <input type="checkbox"/> No	
Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	- Ins. Co. Name and Policy #	
Any other insurance coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	- Ins. Co. Name and Policy #	

8. Have you filed a Worker's Compensation claim?  Yes  No

Do you intend filing a Workers' Compensation claim?  Yes  No

If filed has it been approved?  Yes  No

Payment Amount \_\_\_\_\_ week/month      Date Payment Began \_\_\_\_\_

9. If your request for benefits is approved, do you want Federal Income Tax withheld from your check?  Yes  No

If yes, please indicate dollar amount \$ \_\_\_\_\_ week/month      (Note: Minimum withholding is \$20.00 per week for weekly benefits and \$88.00 per month for monthly benefits)

Do you want State Income Tax withheld from your check?  Yes  No

If yes, please indicate dollar amount \$ \_\_\_\_\_ week/month      (Note: The amount indicated must be a whole dollar increment)

Employee Name: \_\_\_\_\_

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

10. Are you currently employed by another employer?  Yes  No If yes, please advise the name and telephone number of that employer.

If you work for an educational institution (school, college, university, etc.) , please complete questions #11 through #13. If not, continue to the signature block.

11. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.

If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

Have you filed for Sabbatical Leave?  Yes  No Date Payment Began: \_\_\_\_\_

Do you intend to file?  Yes  No Payment Amount \$ \_\_\_\_\_ week/month

If filed, has it been approved?  Yes  No

Other Leave:  Yes  No What Type? \_\_\_\_\_

If yes, date benefits began: \_\_\_\_\_ Payment Amount \$ \_\_\_\_\_ week/month

Have you filed for:		PAYMENT AMOUNT	WEEKLY	MONTHLY	Begin Date	Through Date
Teachers' Retirement - Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teachers' Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
If no, do you intend to file?	<input type="checkbox"/> Yes <input type="checkbox"/> No					

12a. Have you ever been employed by any other school(s) or District(s)?  Yes  No

12b. Please list name(s) of school(s)/District(s) and years employed.

13. If you work in the state of Louisiana:

Have you filed for LA 90-day Extended Sick Leave?  Yes  No Date Payment Began: \_\_\_\_\_

Do you intend to file?  Yes  No Payment Amount \$ \_\_\_\_\_ week/month

If filed, has it been approved?  Yes  No

### Employee Signature Required

I have read and understand the fraud notices listed below.

The above statements and the information provided on the Physician/Medication list (if applicable) are true and complete to the best of my knowledge and belief.

(Your signature is required for benefit consideration.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### 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, Tennessee 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 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 Statement for Puerto Rico Residents

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 — Physician/Medication List (PLEASE PRINT)**

To avoid delay please answer all questions as completely as possible. Please attach additional pages if needed.

Claimant's Full Name	Policy No.
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**Please list ALL treatment providers with whom you are currently treating.**

1) _____ Provider Name	_____ Mailing Address	_____ ( ) Telephone No.
_____ Specialty	_____ City State Zip	_____ ( ) Fax No.
_____ Frequency of Treatment	_____ Date of Last Visit	_____ ( )
2) _____ Provider Name	_____ Mailing Address	_____ ( ) Telephone No.
_____ Specialty	_____ City State Zip	_____ ( ) Fax No.
_____ Frequency of Treatment	_____ Date of Last Visit	_____ ( )
3) _____ Provider Name	_____ Mailing Address	_____ ( ) Telephone No.
_____ Specialty	_____ City State Zip	_____ ( ) Fax No.
_____ Frequency of Treatment	_____ Date of Last Visit	

**Please list any recent hospital confinements.**

1) _____ Hospital	_____ Address	_____ Dates of Confinement
_____ Procedure	_____ City State Zip	
2) _____ Hospital	_____ Address	_____ Dates of Confinement
_____ Procedure	_____ City State Zip	

**Please list all current medications.**

Prescription Name	Dosage	Prescribing Physician
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____



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C. EMPLOYER'S STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

- Short Term Disability, Long Term Disability, Individual Disability, Waiver of Premium (Life Insurance), Voluntary Workplace Benefits, Select Income Protection, Select Short Term Income Protection, Educator Select Income Protection, Educator Select Short Term Income Protection

1. Employer Name, Employer's Phone Number

Employer Address (Street, City, State, ZIP)

Policy Numbers, Division Number / Class Number, Division Description / Class Description

2. Employee's Name, Employee's Phone Number, Social Security Number

Employee's Address (Street, City, State, ZIP)

Date of Hire, Effective Date of STD or Select Short Term Income Protection Insurance, Effective Date of LTD or Select Income Protection Insurance

Effective Date of ID Insurance, Effective Date of Life Insurance, Effective Date of Voluntary Workplace Benefits, Date Last Worked

Please attach a copy of current year and prior year enrollment forms.

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

Has the employee's employment been terminated? Yes, No. If yes, please provide termination date

3. Has employee returned to work? Yes, No. If yes, date, Full Time, Part Time, Hours Per Week

4. Job Title/Major Job Duties (Please attach a copy of employee's job description)

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

5. How was the STD or Select Short Term Income Protection premium paid for the plan year in which the disability occurred?

Percentage paid by Employer, Was the premium amount paid by the employer included in the employee's W-2? Pre-tax, Post-tax

6. How was the LTD or Select Income Protection premium paid for the plan year in which the disability occurred?

Percentage paid by Employer, Was the premium amount paid by the employer included in the employee's W-2? Pre-tax, Post-tax

7. How was the ID premium paid for the plan year in which the disability occurred?

Percentage paid by Employer, Was the premium amount paid by the employer included in the employee's W-2? Pre-tax, Post-tax

8. Year to Date Earnings (for FICA % Deductions) \$

9. Does this employee contribute to FICA? Medicare SSDI: Medicare:

10. How was the employee paid? (please check all that apply)

- Hourly, Salary, Overtime, Bonus, Commissions, Other

Salary/Wage prior to date last worked (refer to Earnings definition in your contract).

Hourly, Weekly, Bi-Weekly, Semi-Monthly, Bonuses (per week), Commissions (per week)

11. Required for LTD, ID and Select Income Protection: Financial Documentation (please refer to your contract for your Earnings definition and attach the appropriate documentation).

Salary Only/Current Earnings definition: Attach copy of payroll records or paystubs for 3 months just prior to disability.

Bonus/Commissions Included: Attach copy of payroll records for the 12 or 24 months (see definition) just prior to disability.

Other Earnings definitions: Attach referenced document per Earnings definition (W-2, K-1s, Schedule Cs, teacher's contract, etc.).

Employee Name:

Social Security Number:

12. Employee Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability

401(k)/403(b) %; Pre-tax medical and other insurance \$ /week; Flexible spending account \$ /week

13. Date of last Salary/Wage Increase Work Schedule at time last worked: Days/Week Hours/Day Hours/Week

Check off regular work days: Sun Mon Tues Wed Thurs Fri Sat Number of hours on date last worked:

Date paid through: For: Salary Continuation Vacation Pay Accrued Sick pay Other

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

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

Type of business entity? Regular Corporation S Corporation Partnership Sole Proprietorship

15. Prior LTD Carrier Name and Address Effective Date: Termination Date:

Table with 7 columns: 16. Is employee eligible for: Yes No, If yes, weekly or monthly amount, Weekly, Monthly, When do benefits begin?, When do benefits end?. Rows include Salary Continuation, State Disability, Other Disability Benefits, Social Security, Public Employee Retirement, Health Insurance, Life Insurance, Workers' Compensation.

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

If so, has a Workers' Compensation claim been filed? If yes, Name and Address of Carrier

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

17. Information about your pension plan

Do you have a pension plan? If yes, what type? Defined benefit Defined contribution 401(k)/403(b) Profit Sharing Other: (specify)

Is employee eligible for your pension plan? If eligible, does the employee participate? What % does employee contribute?

If the employee is participating, when is he or she eligible for benefits under the plan?

18. If the employee is released to return to work with restrictions and limitations, are you willing to accommodate?

Educational Institution Employers (schools, colleges, universities, etc.) complete question #19

19. Has the employee filed for: Sabbatical Leave? Is the employee eligible to file? If filed, has it been approved? If yes, date payment began: Amount of payment: Has the employee filed for: Teachers' Retirement Teachers' Retirement Disability Is the employee eligible to file? If filed, has it been approved? If yes, date payment began: Amount of payment:

Louisiana Educational Employers Only

Is the employee eligible for LA 90-day Extended Sick Leave? Yes No If yes, does he/she intend to file? Yes No If filed, has it been approved? Yes No If yes, date payment began: Amount of payment: Number of regular sick days accumulated:

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

Name of Person Completing Form (please print) Telephone Number ( ) Title of Person Completing Form E-mail Address Fax Number ( ) Signature Date Signed



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**NOTE:** This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

**Authorization**

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; professional licensing body; and employer that has information about my health, financial or credit history, professional license, earnings, employment history, or other insurance claims and benefits, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum, its insurance subsidiaries\* and duly authorized representatives ("Unum"), and, where applicable, to persons or entities that may assist me with or provide services related to my claim(s) for Social Security or other government-sponsored benefits. Information about my health may relate 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 understand that any information Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. 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.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

\_\_\_\_\_  
(Claimant Signature)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Social Security Number)

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

\* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.

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