



DISABILITY STATUS UPDATE

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

Toll-free: 1-800-858-6843 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
The Paul Revere Life Insurance Company

Instructions for Completing this Form

The purpose of this form is to provide us with current information that will be used to evaluate your continued eligibility for disability benefits. It consists of three parts; please complete or have completed each part as described below.

- **Employee Information (pages 4-6):** Please complete all sections of this statement (even if you have provided the same information in the past) and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above. **Please be sure to sign and date this form at the bottom of page 6.**
- **Attending Physician Statement (pages 7-9):** Please ask the physician or treating provider primarily responsible for your care to complete this form. Your physician or treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above.
- **Employee Authorization (last page):** Please sign and date this form and provide a copy to your attending physician. You should fax the completed form to 1-800-447-2498 or mail it to the address noted above.

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



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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.



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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, 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.



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EMPLOYEE INFORMATION (PLEASE PRINT)

A. Information About You

Last Name		Suffix	First Name	MI
Date of Birth (mm/dd/yy)		Gender		
Home Address				
City			State	Zip
Home Telephone Number		Cellular Telephone Number		

Please provide a contact person name, address and telephone number, in the event we are unable to reach you.

B. Information About Income You Are Receiving

Are you receiving any other forms of payment such as salary, sick pay, commissions, bonuses, or business income whether working or not.

Yes No If yes, please explain:

Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please indicate the date:		Hours Per Week:
	Part Time (mm/dd/yy):	Full Time (mm/dd/yy):	
If yes, what is your income before taxes? \$ _____			
<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly (26 pay periods per year) <input type="checkbox"/> Bi-monthly (24 pay periods per year)			
Please provide copies of your pay stubs.			

C. Information About Your Training and Education

Have you received additional training or advanced your education since you stopped working? Yes No

If yes, please explain.

D. Information About Your Condition

Please describe your current day-to-day activities (for example, household chores, reading, computer use, caring for family members/children, etc.)

Does your current condition prevent you from caring for yourself? Yes No

Does someone provide you with assistance in your daily activities? Yes No

Do you use an assistive device(s) such as a cane, walker, hearing aid, etc.)? Yes No

If you answered yes to any of these questions, please provide details:

E. Information About Medications

Please list all current medications. If you are taking more than five, please share the following information on a separate sheet of paper and include it with this form.

Prescription Name	Dosage	Prescribing Physician	Pharmacy Name
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____



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EMPLOYEE INFORMATION (Continued)

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

Date of Birth (mm/dd/yy)

F. Information About Physicians and Hospitals

Please provide the following about any treatment providers you have seen since you last updated this information. If you are being treated by more than three providers, please share the following information on a separate sheet of paper and include it with this form.

1.	_____	_____	()
Provider Name	Mailing Address	Telephone No.	()
Specialty	City State Zip	Fax No.	
Date of Last Visit (mm/dd/yy)	Date of Next Visit for this Condition (mm/dd/yy)		()
2.	_____	_____	()
Provider Name	Mailing Address	Telephone No.	()
Specialty	City State Zip	Fax No.	
Date of Last Visit (mm/dd/yy)	Date of Next Visit for this Condition (mm/dd/yy)		()
3.	_____	_____	()
Provider Name	Mailing Address	Telephone No.	()
Specialty	City State Zip	Fax No.	
Date of Last Visit (mm/dd/yy)	Date of Next Visit for this Condition (mm/dd/yy)		()

Please list any hospital visits/admissions you have had since you last updated this information. If you have had more than two, provide the following information for each visit/admission on a separate sheet of paper and include it with this form.

1.	_____	_____	_____
Hospital/Facility Name	Address	Date of Visit/Admission (mm/dd/yy)	
Procedure	City State Zip	Date of Discharge (mm/dd/yy)	
2.	_____	_____	_____
Hospital/Facility Name	Address	Date of Visit/Admission (mm/dd/yy)	
Procedure	City State Zip	Date of Discharge (mm/dd/yy)	

G. Information About Your Family This information is important to assist us in determining if your family may be eligible for other benefits.

Status: Single Married Widowed Divorced Domestic Partner

Spouse/Domestic Partner's Name	Spouse/Partner's Date of Birth (mm/dd/yy)	Is he/she 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 (mm/dd/yy)	Attending School? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No



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EMPLOYEE INFORMATION (Continued)

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

Date of Birth (mm/dd/yy)

H. Information About Your Vocational, Work or Training History

Have you had any change in your vocational, work or educational training history since you last reported this information? Yes No If yes, please describe and provide applicable dates.

I. Information About Other Disability Income. This information is important to ensure the accuracy of your disability benefit calculation.

You may be receiving income from other sources that could impact your benefit from Unum. Please indicate what other income benefits you are receiving or are eligible to receive as a result of your disability.

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

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

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

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

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

J. Signature of Employee/Individual

I have read and understand the fraud notices listed above and on pages 2 and 3 of this form. I also acknowledge that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

X

Signature

Date

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



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ATTENDING PHYSICIAN INFORMATION (PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

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

Name of Patient (Last Name, Suffix, First Name, MI)

[Grid for patient name]

Social Security Number

[Grid for social security number]

Date of Birth (mm/dd/yy)

[Grid for date of birth]

Home Telephone Number

[Grid for home telephone number]

Employer Name

[Grid for employer name]

A. Patient Information

Height:

Weight:

Blood Pressure:

As of date (mm/dd/yy):

Diagnosis

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

Please include primary ICD Code.

DSM:

Date of last office visit (mm/dd/yy):

Date of next office visit (mm/dd/yy):

What are the symptoms currently reported by your patient?

What current diagnostic or clinical findings support your diagnosis?

Secondary Diagnosis

What are the other diagnoses that may impact your patient's functional capacity? N/A

Secondary Diagnosis:

Secondary ICD Code:

Secondary Diagnosis:

Secondary ICD Code:

B. Other Treating Providers, Facilities or Hospitals

Please provide complete name, specialty, city/state and date referred to any other treating physicians, facilities or hospitals.

Name	Specialty	City, State	Date Referred



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ATTENDING PHYSICIAN INFORMATION (Continued)

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

Date of Birth (mm/dd/yy)

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 E**.

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

Physical Restrictions and/or Limitations

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

Please provide the duration of these restrictions and limitations. From (mm/dd/yy): _____ To (mm/dd/yy): _____

Behavioral Health Restrictions and/or Limitations

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

Please provide the duration of these restrictions and limitations. From (mm/dd/yy): _____ To (mm/dd/yy): _____



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ATTENDING PHYSICIAN INFORMATION (Continued)

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

Date of Birth (mm/dd/yy)

D. Treatment

What is your treatment plan? Please include all medications

Has your patient undergone any medical procedure(s) or hospitalizations since you last reported this information? Yes No Unknown

If yes, please describe and provide dates.

Date procedure(s) performed (mm/dd/yy):

Are there any medical procedures anticipated in the next three months? Yes No Unknown

If yes, what is the procedure(s) and when will it be performed?

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

E. Signature of Attending Physician

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

Physician Name (Last Name, Suffix, First Name, MI) Please Print

Medical Specialty

Degree

Address

City

State

Zip

Telephone Number

Fax Number

Physician's Tax ID Number:

Are you related to this patient? Yes No If yes, what is the relationship?

X

Physician Signature

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 Advocate 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, 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, Provident Life and Accident 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.

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