**INDIVIDUAL DISABILITY CLAIM FORM**

The Benefits Center
P.O. Box 100262, Columbia, SC 29202-3262

Toll-free: 1-888-226-7959 Fax: 1-866-562-4794
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

For use with policies issued or administered 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

**OUR COMMITMENT TO YOU**

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

## INSTRUCTIONS

### When should you use this claim form?

Use this claim form to submit an Individual Disability claim to Unum.

### Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for disability benefits. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Please enclose any additional information you feel will assist us in the evaluation of your claim. During the evaluation of your claim, we may need to request additional information.

- **Individual Statement (pages 4-7):** Please complete this section of the claim form and fax it to 1-866-562-4794. If you prefer, it may be mailed to the address noted above.
- Please complete the name and date of birth fields at the top of every page for easy identification purposes in case the pages become separated.
- **Occupation Description Statement (pages 8-10):** Please complete this section of the claim form and fax it to 1-866-562-4794. If you prefer, it may be mailed to the address noted above.
- **Authorization to Disclose Information to Third Parties (page 11):** 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 1-866-562-4794. If you prefer, it may be mailed to the address noted above.
- **Individual Authorization (last page):** Please sign and date this form and provide a copy to your attending physician. Fax the completed form to 1-866-562-4794 or mail it to the address noted above.
- **Attending Physician Statement (pages 12-14):** 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 1-866-562-4794. If s/he prefers, it may be mailed to the address noted above.

### Questions?

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

**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.

**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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## INDIVIDUAL STATEMENT (PLEASE PRINT)

### A. Information About You

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female | Policy Number

Home Address

City | State | Zip

Home Telephone Number | Cellular Telephone Number

The state in which you work | Preferred e-mail address (for confirmation purposes only)

Employer Name

Employer Address

City | State | Zip

Employer Telephone Number | Employer e-mail address

Language Preference ☐ English ☐ Spanish

Please check all types of coverage you have with Unum.

☐ Short Term Disability Policy #: _____ ☐ Long Term Disability Policy #: _____ ☐ Life Insurance Policy #: _____

### B. Information About Your Disability Date

| Date you are claiming your disability began (mm/dd/yy): | Date last worked (mm/dd/yy): | Number of hours worked on date last worked: |
|---|---|---|

### C. Information About the Condition(s) Causing Your Disabililty

1. For **sickness**, answer the following questions then go to #4:

| What is the name of your medical condition? | What were your first symptoms? |
|---|---|

| When did you first notice the symptoms? | Date your illness began (mm/dd/yy): | Date you were first treated (mm/dd/yy): |
|---|---|---|

2. For an **injury/accident**, answer the following questions then go to #4:

| What is the name of your medical condition? | Date the injury/accident occurred (mm/dd/yy): |
|---|---|

Where and how did the injury/accident occur?

| What are the symptoms related to your injury/accident? | When did you first notice the symptoms? |
|---|---|
| Date you were first treated (mm/dd/yy): | If related to a motor vehicle accident, was an accident report filed? ☐ Yes ☐ No If yes, in what state was the report filed? |

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**INDIVIDUAL STATEMENT (Continued)** Please print your name and date of birth below for identification purposes

Individual's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

3. For **pregnancy**, answer the following questions then go to Section D:

What is your expected delivery date? (mm/dd/yy)

Were there any complications causing you to stop work prior to your expected delivery date? ☐ Yes ☐ No | If yes, please explain:

Have you already delivered? ☐ Yes ☐ No | If yes, what type of delivery? ☐ Vaginal ☐ C-Section | If yes, date of delivery (mm/dd/yy):

4. For **all medical conditions except pregnancy**, answer the following questions:

Is your condition related to your occupation? ☐ Yes ☐ No | If yes, please explain how:

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No | If no, do you intend to file a Workers' Compensation Claim? ☐ Yes ☐ No

Name of Workers' Compensation Carrier: | Telephone Number:

**D. Information About Your Day-to-Day Activities**

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

Please describe your current activities before your disability began:

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 Your Return to Work**

Have you returned to work? ☐ Yes ☐ No

If yes, in your previous occupation? ☐ Yes ☐ No
If no, when do you expect to return? (mm/dd/yy)

If yes, please indicate the date:
Part-Time (mm/dd/yy): Full-Time (mm/dd/yy): Hours Per Week:

What is your monthly income before taxes? $_____

What duties of your occupation are you able to perform and how long are you able to perform them?

What duties of your occuption are you unable to perform?

**F. 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/yy) | Is he/she employed? ☐ Yes ☐ No

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**INDIVIDUAL STATEMENT (Continued)** Please print your name and date of birth below for identification purposes

Individual's Name (Last Name, Suffix, First Name, MI) Date of Birth (mm/dd/yy)

**G. 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 eligible to receive or are receiving as a result of your disability.

| Source of Income: | Name of Insurance Carrier (if applicable) | Policy or ID No. | Benefit Amount Weekly/Monthly | Date claim was filed | Date payments began | Date payments ended |
|---|---|---|---|---|---|---|
| Other Disability Insurance | | | | | | |
| Social Security/Disability | | | | | | |
| Social Security/Other | | | | | | |
| Unemployment | | | | | | |
| Workers' Compensation | | | | | | |
| State Disability Plan (CA, HI, NJ, NY, PR, RI) | | | | | | |

**H. Information About Physicians, Hospitals and Medications**

Please provide the following information about all your current medical treatment providers (physicians, hospitals, physical therapists, etc.). If you are being treated by more than three, please share the following information for each provider 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 emergency room visits/admissions you have had in the last 12 months. If you have had more than two, provide the following information for each emergency room 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)

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## INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

Please list all current medications. If you are taking more than five, provide this information for each prescription on a separate sheet of paper and include it with this form.

| | Prescription Name | Dosage | Prescribing Physician | Pharmacy Name |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

**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.

### I. 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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**OCCUPATION DESCRIPTION** Please provide the following information about your occupation.

**A. Information About You**

Individual's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

**B. Information About Your Occupation**

| Job Title: | Nature of Business: | |
|---|---|---|
| Years with current employer: | Years in Occupation: | Annual Income: |

Please advise the name, title, and telephone number of the person we should contact for additional information about your occupational duties.

| Name: | Title: | Telephone Number |
|---|---|---|
| Are you currently self-employed? ☐ Yes ☐ No | If yes, employer name: | Telephone Number |
| Do you work for another employer? ☐ Yes ☐ No | If yes, employer name: | Telephone Number |

**C. Information About Premium Funding for the Policy Year of Disability.** The following information will ensure your benefit is taxed appropriately according to Federal and State regulations

What percent of the Individual Disability benefit is taxable? _____%

Are you an owner of the above business? ☐ Yes ☐ No

If yes, which tax form do you file:
- ☐ Form Schedule C
- ☐ Form 1065 (ownership % ___)
- ☐ Form 1120 (ownership % ___)
- ☐ Form 1120S (ownership % ___)

Answers to these questions may impact taxability of benefits received.

**List and describe your occupational duties.**

**Duty** | Hours Spent Each Week:

Description:

**Duty** | Hours Spent Each Week:

Description:

**Duty** | Hours Spent Each Week:

Description:

Does your occupation require travel (other than to and from work)? ☐ Yes ☐ No If yes, how many hours do you travel per week?

Do you supervise others? ☐ Yes ☐ No If yes, how many people do you supervise?

How has your medical condition impacted your ability to perform these occupational duties?

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**OCCUPATION DESCRIPTION (Continued)** Please print your name and date of birth below for information purposes

Individual's Name (Last Name, Suffix, First Name, MI) Date of Birth (mm/dd/yy)

**In an 8 hour workday the job requires:**

**Physical Requirements:**

| (% of time performed) | Never | Occasionally (1 - 33%) | Frequently (34 - 66%) | Constantly ( 67 - 100%) | Item | Weight |
|---|---|---|---|---|---|---|
| Sitting | ☐ | ☐ | ☐ | ☐ | | |
| Standing | ☐ | ☐ | ☐ | ☐ | | |
| Walking | ☐ | ☐ | ☐ | ☐ | | |
| Climbing | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Balancing | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Bending/Stooping | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Kneeling | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Squatting/Crouching | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Crawling | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Reaching | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Using Foot Controls | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Twisting | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Carrying | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Pushing/Pulling | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Lifting | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| Hand Use -Simple Grasping | ☐ | ☐ Right ☐ Left | ☐ Right ☐ Left | ☐ Right ☐ Left | | |
| Hand Use -Fine Manipulation | ☐ | ☐ Right ☐ Left | ☐ Right ☐ Left | ☐ Right ☐ Left | | |
| Hand Use- Repetitive Motion | ☐ | ☐ Right ☐ Left | ☐ Right ☐ Left | ☐ Right ☐ Left | | |

Dominant Hand ☐ Right ☐ Left

Are there any other physical requirements of your occupation that you are unable to do as a result of your medical condition? ☐ Yes ☐ No
If yes, please explain:

Does your occupation require the performance of repetitive tasks? ☐ Yes ☐ No If yes, please describe:

**Cognitive Requirements:** Does the job require (check all that apply):
☐ working under emergency, critical or dangerous situations.
☐ meeting deadlines.
☐ attention to detail.
☐ day-to-day contact with others (co-workers and/or the public).
☐ making independent decisions.

Are there any other cognitive requirements of your occupation that you are unable to do as a result of your medical condition? ☐ Yes ☐ No
If yes, please explain:

**Equipment:** Describe all equipment used to perform your occupation:

**Environmental Conditions:** Please check the amount of time you are exposed to the following elements:

| | Never | Occasionally (1 - 33%) | Frequently (34 - 66%) | Constantly ( 67 - 100%) | |
|---|---|---|---|---|---|
| Heat | ☐ | ☐ | ☐ | ☐ | Temperature: _____ |
| Cold | ☐ | ☐ | ☐ | ☐ | Temperature: _____ |
| Dust, Fumes, Gases | ☐ | ☐ | ☐ | ☐ | |
| Vibrations | ☐ | ☐ | ☐ | ☐ | |
| Any Other | ☐ | ☐ | ☐ | ☐ | Description: _____ |

Noise Intensity ☐ Quiet ☐ Moderate ☐ Loud

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**OCCUPATION DESCRIPTION (Continued)** Please print your name and date of birth below for information purposes

Individual's Name (Last Name, Suffix, First Name, MI) Date of Birth (mm/dd/yy)

**D. Information About Your Previous Work Experience**

Please list any previous employment including any other positions held with your current employer.

| Occupational Title | Employer Name | Dates Employed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**E. Information About Your Education and Licenses**

Please check highest level of education completed.

☐ Post Graduate – Years completed _____

☐ College – Years completed _____

☐ Trade/Vocational School – Years completed _____

☐ GED – Date received _____

☐ High School – Years completed _____

Please list all degrees, diplomas, certificates and licenses obtained. License holders should indicate the states of licensure and the expiration date of the licenses.

| **Degrees, diplomas, certificates and licenses.** | **State of Licensure** | **Expiration Date of License** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**F. Signature of Individual**

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

**X**

**Signature** **Date**

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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 claim, we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

## Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of my claim(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health and financial information in verbal or written format relating to my claim 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 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 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 my claim. 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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## ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

**BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER**

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

Social Security Number

Date of Birth (mm/dd/yy)

Home Telephone Number

**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 F.

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

| Expected Delivery Date (mm/dd/yy): | Actual Delivery Date (mm/dd/yy): | Delivery Type: ☐ Vaginal ☐ C-Section | Date First Unable to Work (mm/dd/yy): | Date Hospitalized (mm/dd/yy): |
|---|---|---|---|---|
| Diagnosis Code | ICD Code: | Height: | Weight: | Blood Pressure: |

**B. Complete this section for all conditions except normal pregnancy**

| Date of first visit for this current condition(s) (mm/dd/yy): | Date of last office visit (mm/dd/yy): | Date of next office visit (mm/dd/yy): | Did you advise your patient to stop working? ☐ Yes If yes, effective when? (mm/dd/yy): ☐ No |
|---|---|---|---|

Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yy): From Through

Is the patient's condition work related? ☐ Yes ☐ No ☐ Unknown | Patient's Height: | Patient's Weight

Is the patient's condition due to a sickness or accident? Sickness ☐ Yes ☐ No Accident ☐ Yes ☐ No

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

ICD Code:

Please provide data which supports current DSM Diagnoses.

What are the other diagnoses that may impact your patient's functional capacity? ☐ NA

| Secondary Diagnosis: | ICD Code: |
|---|---|
| Secondary Diagnosis: | ICD Code: |

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

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

**INDIVIDUAL DISABILITY CLAIM FORM**
The Benefits Center
P.O. Box 100262, Columbia, SC 29202-3262
Toll-free: 1-888-226-7959 Fax: 1-866-562-4794
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

## ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name | 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 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.

### Physical Restrictions

If your patient has CURRENT PHYSICAL RESTRICTIONS (activities patient should not 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): _____

### Physical Limitations

If your patient has CURRENT 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

If your patient has CURRENT BEHAVIORAL HEALTH RESTRICTIONS (activities patient should not 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): _____

### Behavioral Health Limitations

If your patient has CURRENT 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 STATEMENT (Continued)

Patient's Name | Date of Birth (mm/dd/yy)

What diagnostic or clinical findings support your patient's restrictions and/or limitations as noted above?

What is your treatment plan? Please include all medications.

### D. Prognosis

Do you expect improvement in the patient's functional abilities? ☐ Yes ☐ No

If yes, when do you expect improvement (mm/dd/yy)?

### E. Other Treating Providers, Facilities, Hospitals or Recent Referrals

Please provide complete name, contact information and specialty of any other treating physicians, facilities or hospitals.

| Name | Specialty | Address |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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.

### F. 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

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?

**Signature of Physician** | **Date**

**X**

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Columbia, SC 29202
Toll-free: 1-888-226-7959 Fax: 1-866-562-4794

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 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.