GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM

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

Toll-free: 1-800-445-0402 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

OUR COMMITMENT

During this difficult time, we are committed to providing responsive, compassionate service.

INSTRUCTIONS

Who is responsible for completing this form?

- **Employer Statement (pages 4-7):** This section of the form should be completed by the employer who should fax it to 1-800-447-2498 or mail it to the address noted above. If available, the following information should also be provided:
  - A copy of the death certificate (a photocopy or fax is acceptable);
  - The original enrollment form and any other enrollment forms indicating any change in coverage; and
  - The most recent beneficiary designation form.
- **Accidental Death Statement (pages 8-10):** If the claim is related to an accidental death, this section of the form should be completed by the employee or beneficiary. The completed form should be faxed to 1-800-447-2498 or mailed to the address noted above.
- **Substitute W-9 Form (page 11):** This form should be completed, signed and dated by the beneficiary. If there are multiple beneficiaries, each beneficiary should complete, sign and date a form. The completed form(s) should be faxed to 1-800-447-2498 or mailed to the address noted above.
- **Authorization (last page):** This form should be signed and dated by the employee or beneficiary and faxed to 1-800-447-2498 or mailed to the address noted above.

Questions?

If you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center professionals are available from 8 a.m. to 8 p.m. Eastern Time 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.

Instructions (continued) / Claim Fraud Statements

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.

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

A. Information About the Type of Claim – Please check all that apply and provide the policy and division numbers.

Type of Coverage	Type of Claim Submitted	Policy Number	Division Number
☐ Life Insurance	☐ Employee Death ☐ Dependent Death		
☐ Accidental Death & Dismemberment	☐ Employee Death ☐ Dependent Death		

Is this claim also being submitted for Accidental Death & Dismemberment? ☐ Yes ☐ No

B. Information About the Employer

Employer Name

Employer Street Address

City State Zip -

Subsidiary/Affiliate/Branch Name Subsidiary Effective Date (mm/dd/yy)

C. Information About the Employee – The term "employee" refers to employees, members and/or retirees.

Employee Name (Last Name, Suffix, First Name, MI) Gender ☐ Male ☐ Female

Employee Street Address

City State Zip -

Date of Birth (mm/dd/yy) Social Security Number Original Date of Hire (mm/dd/yy) Date of Death (mm/dd/yy)

Home Telephone Number Cellular Telephone Number

Date Employee Entered Eligible Class (mm/dd/yy):	Termination & Rehire Dates (mm/dd/yy): Termination: Rehire:	Acquisition Date (mm/dd/yy):

If this employee is or has been known by another name(s) (such as a nickname, maiden name, etc.), please provide the name(s).

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Bargaining ☐ Non-Bargaining ☐ Union ☐ Non-Union	Hours Worked Per Week:
Salary/Rate of Pay: ☐ Hourly ☐ Salary ☐ Commission ☐ Non-Commission Amount: $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Semi-monthly	Job Title/Class:

Please provide the following salary verification/documentation. This information is necessary to accurately determine the amount of the life insurance benefit.

If the definition of annual earnings is:	**Then provide, as stated in your policy:**
W-2	A copy of the prior year W-2
Salary with commissions and/or bonus	• Payroll records • Documentation of commissions and/or bonuses

Last Date Physically at Work (mm/dd/yy):	Reason for Stopping Work:
Is the employee receiving any company sponsored retirement benefits? ☐ Yes ☐ No	If yes, when did the employee retire (mm/dd/yy)?

If yes, please describe the retirement benefits:

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EMPLOYER STATEMENT (Continued)

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

Amount of Insurance	Basic	Effective Date of Coverage (mm/dd/yy)	Supplemental	Effective Date of Coverage (mm/dd/yy)
Life Insurance	$ _____	_____	$ _____	_____
Accidental Death and Dismemberment	$ _____	_____	$ _____	_____

Changes to the Amount of Insurance	Amount of last change		Date of last change (mm/dd/yy)
Basic Life	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Life	$ _____	☐ Increase ☐ Decrease	_____
Basic Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____

Date of last premium payment for this employee (mm/dd/yy):

Was this employee terminated? ☐ Yes ☐ No
If yes, termination date (mm/dd/yy):

The Accidental Death and Dismemberment policy may provide an education benefit. Does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled in an institution of higher learning beyond the 12th grade? ☐ Yes ☐ No If yes, please provide the following information for each child:

Name: _____ Age:_____

Name: _____ Age: _____

Name: _____ Age: _____

D. Information About the Dependent – Please complete this section if the claim is for the death of the employee's dependent.

Dependent Name (Last Name, Suffix, First Name, MI)

Relationship to Employee
☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

Dependent Date of Birth (mm/dd/yy) | Dependent Date of Death (mm/dd/yy)

Dependent Social Security Number

Dependent Gender
☐ Male ☐ Female

Dependent Effective Date of Coverage (mm/dd/yy)

Amount of Insurance	Basic	Effective Date of Coverage (mm/dd/yy)	Supplemental	Effective Date of Coverage (mm/dd/yy)
Life Insurance	$ _____	_____	$ _____	_____
Accidental Death and Dismemberment	$ _____	_____	$ _____	_____

Changes to the Amount of Dependent Insurance	Amount of last change		Date of last change (mm/dd/yy)
Basic Life	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Life	$ _____	☐ Increase ☐ Decrease	_____
Basic Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____

Date of last premium payment for this dependent (mm/dd/yy):

Was the employee in active employment at the time of the dependent's death?
☐ Yes ☐ No

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EMPLOYER STATEMENT (Continued)

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

E. Information About the Employee's Beneficiary(ies) – If the claim is for the death of the employee, please complete this section. If there are more than three, please provide the following information for each additional beneficiary on a separate sheet of paper and include it with this form. **The first beneficiary listed will receive the Life Planning Resources, if the services are provided by this policy.**

Name, Address & Telephone Number	Relationship	Social Security Number	Date of Birth	Percentage
Name				
Street				
City, State, Zip Telephone #				
Name				
Street				
City, State Zip Telephone #				
Name				
Street				
City, State, Zip Telephone #				
				Total Must Equal 100%

A copy of the most recent beneficiary designation form is enclosed. ☐ Yes ☐ No If no, please explain:

F. Information About Minor Beneficiary – If any of the above beneficiaries are minor children, please complete this section. If there is more than one, please provide the following information for each additional minor beneficiary on a separate sheet of paper and include it with this form.

Name of Minor Child (Last Name, Suffix, First Name, MI):

Adult Representative of Minor Child (Last Name, Suffix, First Name, MI):

Mailing Address of Adult Representative:

City: State: Zip: Telephone Number of Adult Representative:

G. Information About Payment – Advise the beneficiary that if the claim is approved the benefit will be paid by check if it is less than $10,000. The benefit will be paid through a Unum Retained Asset Account if it is $10,000 or more and the group policy calls for this method of payment. If the group policy does not call for this method of payment, the benefit will be paid by check. The beneficiary may request the benefit be paid by check regardless of the amount of the benefit by contacting The Benefits Center at the telephone number listed on this form. More information about the Unum Retained Asset Account can be found in section H.

EMPLOYER STATEMENT (Continued)

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

H. Information About Unum Retained Asset Accounts – By placing the funds in a Unum Retained Asset Account the beneficiary will have the time needed to decide how to best manage the insurance proceeds so as not to put his/her investment decisions at risk. Here's how it works:

- When the claim is approved, a personalized book of bank drafts and an opening account statement will be mailed to the beneficiary.
- He/She will have unlimited access to the balance in the account.
- The entire account balance can be accessed by the use of one draft.
- Drafts can be written for a minimum of $250 up to the full account balance at any time. There is no limit on the number of withdrawals that can be made from the account.
- No charges will be made to the Unum Retained Asset Account for writing drafts or ordering a new supply of drafts.
- The following charges will be made to the Unum Retained Asset Account for any request for:
  - A copy of a draft or statement ($5);
  - A stop payment of a draft ($15);
  - A draft returned as unpaid, requests for additional statements, and requests for additional copies of IRS Form 1099-INT ($10); and
  - Draft book rush orders ($25).
- A quarterly statement is provided, detailing the account balance, interest rate, accrued interest and account transactions for the statement period.
- Funds in the Unum Retained Asset Account are fully guaranteed by Unum Group. The funds are not protected by the FDIC, but are protected by state Guaranty Associations. To learn more about the protections provided by these associations, the beneficiary may contact the National Organization of Life and Health Insurance Guaranty Associations at nolhga.com or 703-481-5206.
- The beneficiary may leave the money in the Unum Retained Asset Account for as long as he/she wishes. If there is no account activity or any contact with the beneficiary for two years, we will attempt to contact him/her. If we are unable to contact the beneficiary, we could be required to surrender the account balance to the state of his/her last known residence.

Unum will retain the funds and invest them in its general account for as long as they remain in the Unum Retained Asset Account. Unum guarantees the account balance and will pay a competitive interest rate regardless of the investment performance of Unum's general account. Unum may derive income from the total gains received on the investment of the balance of the funds in the retained asset account.

The interest rate is determined by monitoring rates of interest offered on similar types of accounts (i.e. checking, savings and money market accounts). Any changes to the interest rate will be disclosed via a quarterly account statement.

The interest earned on the Unum Retained Asset Account may be taxable. The beneficiary should consult a tax advisor, an investment advisor, or another financial advisor with any questions. For further information, the beneficiary should contact his/her state insurance department.

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

I. Information About and Signature of Benefit Administrator (Please Print)

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

Name of Person Completing Form

Title of Person Completing Form	Telephone Number	Fax Number

Signature
X

Date Signed

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ACCIDENTAL DEATH STATEMENT (PLEASE PRINT)

To be completed by:
- **the beneficiary or next of kin, if the claim is related to the accidental death of the employee**
- **the employee, if the claim is related to the accidental death of a dependent**

Please attach copies of any police and/or emergency medical services reports.

A. Information About the Employee

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

Date of Birth (mm/dd/yy)

Employer Name

Employer Telephone Number

B. Information About the Deceased

Deceased Name (Last Name, Suffix, First Name, MI)

Deceased Social Security Number

Deceased Date of Birth (mm/dd/yy)

Date of Death (mm/dd/yy)

Relationship to the Employee ☐ Self ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

C. Information About the Accident

Date of the accident (mm/dd/yy):	Time of the accident:

Where did the accident happen?

Describe how the accident happened.

D. Information About the Witnesses to the Accident

Please provide the following information about all witnesses to the accident. If there were more than three, please share the following information for each additional witness on a separate sheet of paper and include it with this form.

Witness Name	Mailing Address	Telephone Number

E. Information About the Investigating Authorities

Name/Title of Investigating Officer:	Telephone Number
Other: Name/Title	Telephone Number

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ACCIDENTAL DEATH STATEMENT (Continued)

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

F. Information About Physicians/Hospitals

Please provide the following information about all the physicians/hospitals who attended the deceased for injuries sustained in this accident. If there were more than three, please share the following information for each additional physician/hospital on a separate sheet of paper and include it with this form.

Physician/Hospital Name	Mailing Address	Telephone Number

G. Information About Previous Medical Conditions

Please provide the following information about all physicians who treated the deceased for any medical condition in the last five years. If there were more than five, please share the following information for each additional physician on a separate sheet of paper and include it with this form.

Physician Name, Specialty, Address and Telephone Number	Medical Condition Treated

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ACCIDENTAL DEATH STATEMENT (Continued)

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

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.

H. Signature

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

Language Preference: ☐ English ☐ Spanish

Print Name	Telephone Number
Signature **X**	**Date Signed**

Substitute Form (Rev. December 2011)

W-9

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Exempt payee

☐ Other (see instructions) ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the IRS instructions. For other entities, it is your employer identification number (EIN).

For further instructions, see http//www.irs.gov/pub/irs-pdf/fw9.pdf.

Social security number

			–			-				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

For further instructions, see http//www.irs.gov/pub/irs-pdf/fw9.pdf.

Sign Here	**Signature of U.S. person** ▶	**Date** ▶

Please complete the below fields and return this completed W-9 form as soon as possible to the address below; otherwise, the IRS may require us to withhold taxes from the interest we pay you, to ensure that the tax will be collected. For more information on withholdings, please refer to the IRS website at http://www.ins.gov.

Insured Name:	Insured Social Security Number:
Dependent Name (if the deceased):	Dependent Social Security Number:

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

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Please sign and return this authorization to The Benefits Center at the address above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are entitled to receive a copy of this authorization.

Authorization – Life or Accidental Death Claim

I authorize health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies, and all other medical or medically related providers, facilities or services, medical examiner's offices, coroner's offices, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, law enforcement agencies, consumer reporting agencies, 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 the deceased's 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, death, earnings, financial or credit history, professional licenses, employment history, autopsy reports and findings, laboratory test results and findings, toxicology results, police reports, accident reports, or incident reports of any kind, photographs, blood, urine, or other specimens, insurance claims and benefits, and all other claims and benefits of _____ (print name of deceased):

To the following persons: 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"), employee benefit plans sponsored by the deceased's employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, the deceased's employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about the deceased to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to the deceased's benefit plans.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate 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 is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

_____ _____
Signature of Beneficiary or Personal Representative Date Signed

_____ _____
Printed Name Social Security Number

I signed on behalf of the Beneficiary or Personal Representative as _____(print relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.