EDUCATOR DISABILITY CLAIM FORM

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

OUR COMMITMENT TO YOU

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

When should you use this claim form?

Use this claim form to submit a disability claim to Unum. This form should be used for the following types of claims only:

- Educator Select Income Protection Plan
- Educator Select Short Term Income Protection Plan
- If you have any of the following additional coverages, we may need to contact you or your employer for additional information.

  Short Term Disability • Long Term Disability • Individual Disability • Life Insurance Waiver of Premium • Voluntary Benefits Disability

If you are covered for more than one of these products, you only have to complete this one form.

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. Incomplete or illegible answers may result in a delay of benefit consideration. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- **Attending Physician Statement (page 4):** Please ask the physician or treating provider primarily responsible for your care to complete this statement. Your physician or treating provider should mail or fax the completed form to the address or fax number indicated above. Unum is not responsible for expenses associated with the completion of this form.
- **Employee Statement (pages 5-6):** Please complete this section of the claim form and mail or fax the completed form to the address or fax number indicated above.
- **Direct Deposit Request (page 7):** If your disability is expected to last more than 8 weeks, please complete this form if you wish to have your benefits deposited directly into your bank account.
- **Employer Statement (page 8):** Please ask your employer to complete this section of the claim form and to mail or fax the completed form to the address or fax number indicated above.
- **Employee Authorization:** Please sign and date this form and provide a copy to your attending physician and mail or fax the completed form to the address or fax number indicated above. This form authorizes the release of medical information needed to evaluate your claim.

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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A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number	Date of Birth	Social Security Number

Instructions: If this claim is related to normal pregnancy, complete the Normal Pregnancy section. For all other claims, including complicated pregnancy, complete the All Other Conditions section. **In all situations, you must complete the signature block at the bottom of this form.**

NORMAL PREGNANCY

Date of first visit for this pregnancy? When did symptoms first appear?

1. Expected Delivery Date: | If Delivered, Actual Delivery Date: | Type of Delivery ☐ Vaginal ☐ C-Section

2. Date First Unable to Work | Dates Hospitalized to

3. Has patient been released to work in her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No
If not, when should the patient be able to return to work? Full Time Part Time

ALL OTHER CONDITIONS

1. Diagnosis - Please include the primary diagnosis and list any secondary conditions.

Diagnosis (including any complications) include **ICD and/or DSM IV Multi Evaluation Nomenclature and Code Number**

2. Date First Unable to Work | Dates Hospitalized to

3. Has patient been released to work in his/her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No
If not, when should the patient be able to return to work? Full Time Part Time

4. Is this disability related to the patient's employment? ☐ Yes ☐ No ☐ Unknown

5. Has patient ever had the same or a similar condition? ☐ Yes ☐ No If yes, when?

6. Date of first visit for this illness or injury – When did symptoms first appear or accident happen?

7. Nature of treatment (including surgery and medications prescribed)	Name of Surgical Procedure	Date of Surgery

8. If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

RESTRICTIONS (What the patient should not do)

LIMITATIONS (What the patient cannot do)

Date restrictions and limitations began.

9. Referring physician or other treating physicians (names, addresses, telephone numbers):

Please include copies of all applicable office notes and test results.

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

Print or Type Name		Degree	Medical Specialty
Street Address			Telephone Number
City	State	ZIP Code	Fax
Signature of Physician			Date

SSN or Employer's ID Number: | Are you, the physician, related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

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B. EMPLOYEE'S STATEMENT (PLEASE PRINT)

1. Claimant's Name (as printed on your Social Security Card) | Home Telephone Number | Cell Telephone Number | Date of Birth | Social Security Number

☐ Male ☐ Female Height Weight

Home Address (Street, City, State, ZIP)

The state in which you work | Preferred e-mail address where you can be reached

Language Preference: ☐ English ☐ Spanish ☐ Other _____

2. Employer Name | Policy Number

3. Occupation | **4.** List the duties of your occupation at the time of your disability (grade taught, etc.)

5. How does your injury or sickness impede your ability to do your occupational duties?

6. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | If you are married, spouse's name | Spouse's Date of Birth | Is spouse employed? ☐ Yes ☐ No

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

For any accident related claim, describe the injury (what, how, where, when). | For Pregnancy, date of pregnancy test?

8. Date you first noted symptoms of your disability. _____

9. You have been unable to work because of this disability since what date? _____

10. Have you returned to work? If yes, when?
Part Time: _____
Full Time: _____

11. If you have not returned to work, when do you expect to return?
Part Time: _____ Full Time: _____

12. Number of Hours Worked on Date Last Worked

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

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

Have you filed for Sabbatical Leave? ☐ Yes ☐ No
Do you intend to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
Date Payment Began: _____
Payment Amount $ _____ wk/month

If you work in the state of Louisiana, have you filed for LA 90-day Extended Sick Leave? ☐ Yes ☐ No
If no, do you intend to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
If approved: Date Payment Began: _____
Payment Amount $ _____ month

Other Leave: ☐ Yes ☐ No What Type? Payment Amount $ _____ wk/month

	If yes				Date Benefits	
	Yes	No		WEEKLY / MONTHLY	Begin Date	Through Date
Social Security Retirement	☐	☐	$_____	☐ ☐	_____	_____
Social Security Disability	☐	☐	$_____	☐ ☐	_____	_____
State Disability	☐	☐	$_____	☐ ☐	_____	_____
Teacher's Retirement - Disability	☐	☐	$_____	☐ ☐	_____	_____
Teacher's Retirement	☐	☐	$_____	☐ ☐	_____	_____
Public Employee Retirement	☐	☐	$_____	☐ ☐	_____	_____
Public Employee Disability	☐	☐	$_____	☐ ☐	_____	_____
Pension/Disability	☐	☐	$_____	☐ ☐	_____	_____
Unemployment	☐	☐	$_____	☐ ☐	_____	_____

Other (Include Individual Disability or Group Disability Benefits) ☐ Yes ☐ No Payment Amount $ _____ wk/month.

14. Number of Regular Sick Days Accumulated _____

15. Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No
Do you intend filing a Workers' Compenation Claim? ☐ Yes ☐ No
If filed has it been approved? ☐ Yes ☐ No
Amount _____ Date Payment Began _____

16a. Have you ever been employed by any other school(s) or District(s)? ☐ Yes ☐ No

16b. Please list name(s) of school(s)/District(s) and years employed.

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17. Information about physicians and hospitals **NOTE: TO AVOID DELAY IN PROCESSING YOUR CLAIM, ADVISE YOUR DOCTOR(S) TO ATTACH COPIES OF MEDICAL RECORDS AND TEST RESULTS**

First medical attention for the current disability was given by (complete below):

Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to

List all other physicians and hospitals you have seen for this condition:

Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to
Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to
Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to

Hospital

Address (Street, City, State, Zip)	Dates of Confinement to

Have you ever had the same or a similar condition in the past?
☐ Yes ☐ No If yes, complete the following concerning your past treatment:

Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to

Hospital

Address (Street, City, State, Zip)	Dates of Confinement to

List your dependent children who are under age 25 (attach additional sheets if necessary).

Name	Date of Birth	Attending College?
		☐ Yes ☐ No
		☐ Yes ☐ No

Information about your income tax withholding:
If your request for benefits is approved, do you want the minimum $88.00 per month withheld from your check for Federal Income Tax purposes. ☐ Yes ☐ No
If you would like more than $88.00 withheld please state the dollar amount (to the nearest dollar only) you want withheld monthly. $ _____

I have read and understand the fraud notices listed on the instruction page of this form.

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

_____ _____
Signature Date

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Please provide the information requested below by completing sections A through C of this form. Once completed, sign and date the form, attach the appropriate documentation and mail or fax it to the address or fax number indicated above.

A. Information About You

Last Name | First Name | MI

Address

City | State | Zip

Social Security Number | Home Telephone Number

B. Information About How to Set-up or Change Your Direct Deposit

☐ Set-up Direct Deposit ☐ Change Direct Deposit Account

To Cancel your Direct Deposit, please contact the Direct Deposit Department at 1-800-413-7671.

Bank/Financial Institution Information

Name

City | State | Zip

Choose Type of Account – Note: We are only able to deposit benefit payments into one account only.

☐ Checking OR ☐ Savings

REQUIRED FOR CHECKING: Please provide either 1.) a voided check imprinted with your name; or 2.) the top portion of a bank statement or a letter from your bank, on bank letterhead, signed and dated by a bank representative. One of these items must be received to process your request.

Please verify the Transit Routing number with your bank.
A Routing Number beginning with the number 5 is not valid. (Ex: 502000027)

Bank Transit/Routing Number | Personal Account Number

C. Signature of Individual

X

Signature of Individual | Date

Frequently Asked Questions About Direct Deposit

- **What is Direct Deposit?**
  Unum will deposit your benefits directly into your checking or savings account on a weekly or monthly basis as per policy provisions.
- **Why use Direct Deposit?**
  It's a safe, convenient and reliable way to receive your benefits in a timely manner.
- **When can I expect the money to be in my account?**
  Because this can vary from person to person, please discuss the details with a Direct Deposit Specialist. Funds will be credited on the second business day after the date of release of funds with the exception of a Federal Reserve Bank Holiday.
- **What if I have questions?**
  Please call our toll-free Direct Deposit Customer Service line at 1-800-413-7671. Knowledgeable and courteous representatives are available to answer your questions, Monday through Friday, 8 a.m. to 4 p.m. Eastern Standard Time.

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D. EMPLOYER STATEMENT (PLEASE PRINT)

To be completed by Employer

1. Employer Name | Employer's Phone Number ( )

Employer Address (Street, City, State, ZIP)

Policy Numbers | Division Number

2. Employee's Name

Social Security Number | Date of Hire | Effective Date of LTD Insurance | Employee's Work Schedule at Time Last Worked _____Days per week _____Hours per day

Average monthly earnings in effect at last annual enrollment date $_____
Please refer to your contract for your earnings definition.
Has the employee's employment been terminated? ☐ Yes ☐ No If yes, please provide termination date

Please advise the following benefit selections applicable to this employee. Elimination Period _____ EE Benefit Election _____ Benefit Duration _____

Does the employee have the following types of coverage? Life Insurance ☐ Yes ☐ No Voluntary Benefits Disability ☐ Yes ☐ No

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

4. Job Title/Major Job Duties
Is the Employee also a Coach? ☐ Yes ☐ No

5. Date last worked prior to claim | **6.** Number of hours worked that day

7. Date paid through For ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick Pay

8. Does this employee contribute to FICA? ☐ Yes ☐ No Medicare SSDI? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No

9. Are you as the employer able to accommodate the employee's restrictions and limitations, if appropriate, for an early return to work? (i.e. job modification, part time, etc.) Please elaborate.

10. Employee's immediate supervisor: Name_____Title_____Telephone Number_____

11. How was the LTD premium paid for the plan year in which the disability occurred?
☐ Pre-tax _____ % paid by Employer
☐ Post-tax _____ % paid by Employee **Please call 1-800-845-2290 for tax related questions**

12. Is employee eligible for:

	Yes	No	If yes	WEEKLY	MONTHLY	Date Benefits Begin Date	Through Date
Unemployment	☐	☐	$_____	☐	☐	_____	_____
State Disability	☐	☐	$_____	☐	☐	_____	_____
Teacher's Retirement System-Disability	☐	☐	$_____	☐	☐	_____	_____
Teacher's Retirement	☐	☐	$_____	☐	☐	_____	_____
Social Security Retirement	☐	☐	$_____	☐	☐	_____	_____
Social Security Disability	☐	☐	$_____	☐	☐	_____	_____
Public Employee Retirement-Disability	☐	☐	$_____	☐	☐	_____	_____
Other Benefits	☐	☐	$_____	☐	☐	_____	_____
Workers' Compensation	☐	☐	$_____	☐	☐	_____	_____
Has Workers' Compensation claim been filed?	☐	☐	If Workers' Compensation Claim has been denied, please submit a copy of the denial with this claim.				

Has the employee filed for Sabbatical Leave? ☐ Yes ☐ No
Is employee eligible to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
Date Payment Began: _____

If the employee works in the state of Lousiana:
Is he/she eligible for LA Extended Sick Leave? ☐ Yes ☐ No
If yes, has he/she filed? ☐ Yes ☐ No
If no, does he/she intend to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
If approved: Date Payment Began: _____ Payment Amount $ _____ per month

Other Leave: ☐ Yes ☐ No What Type? Payment Amount $ _____ wk/month

13. Will (or has) the employee filed for disability benefits provided by any employer, employee, labor management, state disability or union welfare plant? ☐ Yes ☐ No | If yes, Weekly Amount $_____ Date _____

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

Name of Person Completing Form

Employer's Taxpayer ID Number (EIN) or Public Employer Social Security Number. If you have neither, please explain | Telephone Number ( )

Title of Person Completing Form | E-mail Address | Fax Number ( )

Signature | Date Signed

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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, Inc., 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, 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.

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, 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.