CLAIM FOR SELECT INCOME PROTECTION BENEFITS
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 ["Unum"] subsidiaries:

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

Please mail or fax this form to:
The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498

This form should be used for the following types of claims only:
- Educator Select Income Protection Plan (Employees of any Educational Institution)
- Educator Select Short Term Income Protection Plan (Employees of any Educational Institution)
- Select Income Protection Plan
- Select Short Term Income Protection Plan

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

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

INSTRUCTIONS:

A. Attending Physician's Statement: This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form. Advise your physician(s) to attach copies of medical records and test results.

B. Employee's Statement: This section must be completed by you, the employee. It includes a Physician/Medication page that must also be completed by you. If necessary, you may include additional information on the back of this page. To avoid delay in evaluating your claim, advise your physician(s) to attach copies of medical records and test results.

C. Employer's Statement: The employer must complete this form.

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

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

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this claim form.

Fraud Warning: Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California: Any person who knowingly presents 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.

Colorado: 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.

District of Columbia: 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: 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.

New Jersey: 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, subject to criminal prosecution and civil penalties.

New York: 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 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.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present; it may be reduced to a minimum of two (2) years.

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ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

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

Employer Name/Address	Employer Telephone Number

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

NORMAL PREGNANCY

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

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

Date First Unable to Work Date Hospitalized through:

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

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

ALL OTHER CONDITIONS

Patient Information

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

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

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

If yes, please describe

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

Diagnosis and Treatment
Primary Diagnosis

a) What is the primary diagnosis preventing your patient from working?

Please include Primary ICD Code and/or DSM IV Multi-Axial Diagnoses and Codes

b) Date of last examination

c) Describe Reported Symptoms

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

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

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

a) Secondary ICD Codes Diagnosis

Secondary ICD Codes Diagnosis

b) Describe Reported Symptoms

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

Treatment

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

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

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

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

Name/Address of facility

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

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Claimant Name: Social Security Number:

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	To

Physical Capabilities

a) Patient's ability to: *(Please Check Number of Hours Per Workday and How Often)*

	Number of Hours									How Often	
Sit	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently
Stand	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently
Walk	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently

b) Patient's ability to: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☐	☐	☐	☐
Twist/bend/stoop	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate heavy machinery	☐	☐	☐	☐

c) Patient's ability to lift/carry: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐

d) Patient's ability to perform: *(Please Check)*

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
	R	L	R	L	R	L	R	L
Fine Finger movements	☐	☐	☐	☐	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☐ Right ☐ Left

Psychological Features
Are there any cognitive deficits or psychiatric conditions that interfere with the patient's ability to perform his/her occupation? If so, please describe specifically how any identified condition prevents the patient from performing his/her occupation.

Return to Work

a) When do you expect improvement in the patient's capabilities?

b) Have you advised patient to return to work? ☐ Yes ☐ No Expected Return to Work Date ☐ Full Time ☐ Part Time
If yes, please indicate any ongoing restrictions and limitations in the space provided below.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below.

c) RESTRICTIONS (activities patient should not do)

d) LIMITATIONS (activities patient cannot do)

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

Cell Telephone 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:

2. Employer Name | Policy Number

Occupation:	If you have returned to work, list the duties of the occupation you are performing.	# of weekly hours spent at duty
Have you returned to work? If yes, when? Part Time: Full Time:		
Hours per week:		
If you have not returned to work, when do you expect to return? Part Time: Full Time:		

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

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

3. Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced

If you are married, spouse's name: | Spouse's Date of Birth | Policy Number

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

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

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

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

5. Date Last Worked: | Number of Hours Worked on Date Last Worked:

6. Number of Regular Sick Days Accumulated:

7. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.
If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

Social Security/Retirement	☐ Yes ☐ No	Social Security/Disability	☐ Yes ☐ No	Dependent Social Security	☐ Yes ☐ No
Canada Pension Plan	☐ Yes ☐ No	Pension/Retirement	☐ Yes ☐ No	Pension/Disability	☐ Yes ☐ No
Unemployment	☐ Yes ☐ No	No-Fault Insurance	☐ Yes ☐ No	Public Employee Retirement/Disability	☐ Yes ☐ No
State Disability	☐ Yes ☐ No	Third Party Settlement/Income	☐ Yes ☐ No		

Short Term Disability ☐ Yes ☐ No – Ins. Co. Name and Policy #

Any other insurance coverage ☐ Yes ☐ No – Ins. Co. Name and Policy #

8. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No
Do you intend filing a Workers' Compensation claim? ☐ Yes ☐ No
If filed has it been approved? ☐ Yes ☐ No
Payment Amount _____ week/month Date Payment Began _____

9. If your request for benefits is approved, do you want Federal Income Tax withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ _____week/month (Note: Minimum withholding is $20.00 per week for weekly benefits and $88.00 per month for monthly benefits)

Do you want State Income Tax withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ _____week/month (Note: The amount indicated must be a whole dollar increment)

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Employee Name: Social Security Number:

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

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

11. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.
If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

Have you filed for Sabbatical Leave?	☐ Yes ☐ No	Date Payment Began: _____
Do you intend to file?	☐ Yes ☐ No	Payment Amount $ _____ week/month
If filed, has it been approved?	☐ Yes ☐ No	
Other Leave:	☐ Yes ☐ No	What Type? _____
If yes, date benefits began: _____		Payment Amount $ _____ week/month

Have you filed for:		PAYMENT AMOUNT	WEEKLY	MONTHLY	Begin Date	Through Date
Teachers' Retirement - Disability	☐ Yes ☐ No	$_____	☐	☐	_____	_____
Teachers' Retirement	☐ Yes ☐ No	$_____	☐	☐	_____	_____
If no, do you intend to file?	☐ Yes ☐ No					

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

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

13. If you work in the state of Louisiana:

Have you filed for LA 90-day Extended Sick Leave?	☐ Yes ☐ No	Date Payment Began:_____
Do you intend to file?	☐ Yes ☐ No	Payment Amount $_____ week/month
If filed, has it been approved?	☐ Yes ☐ No	

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 on page 2 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 and the information provided on the physician/medication list (if applicable) are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

X
Signature **Date**

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

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EMPLOYEE STATEMENT — Physician/Medication List (PLEASE PRINT)

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

Claimant's Full Name | Policy No.

Please list ALL treatment providers with whom you are currently treating.

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

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

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

Please list any recent hospital confinements.

1) Hospital | Address | Dates of Confinement
Procedure | City | State | Zip

2) Hospital | Address | Dates of Confinement
Procedure | City | State | Zip

Please list all current medications.

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

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C. EMPLOYER'S STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

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

1. Employer Name	Employer's Phone Number

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

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

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

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

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

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

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

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

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

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

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

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

5. How was the STD or Select Short Term Income Protection premium paid for the plan year in which the disability occurred?
Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No
Percentage paid by Employee _____ ☐ Pre-tax ☐ Post-tax

6. How was the LTD or Select Income Protection premium paid for the plan year in which the disability occurred?
Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No
Percentage paid by Employee _____ ☐ Pre-tax ☐ Post-tax

7. How was the ID premium paid for the plan year in which the disability occurred?
Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No
Percentage paid by Employee _____ ☐ Pre-tax ☐ Post-tax

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

9. Does this employee contribute to FICA: ☐ Yes ☐ No Medicare SSDI: ☐ Yes ☐ No Medicare: ☐ Yes ☐ No

10. How was the employee paid? (please check all that apply)
☐ Hourly ☐ Salary ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other

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

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

11. Required for LTD, ID and Select Income Protection: Financial Documentation (please refer to your contract for your Earnings definition and attach the appropriate documentation).
Salary Only/Current Earnings definition: **Attach copy of payroll records or paystubs for 3 months just prior to disability.**
Bonus/Commissions Included: **Attach copy of payroll records for the 12 or 24 months (see definition) just prior to disability.**
Other Earnings definitions: **Attach referenced document per Earnings definition (W-2, K-1s, Schedule Cs, teacher's contract, etc.).**

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Employee Name: Social Security Number:

12. Employee Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability
401(k)/403(b) %; Pre-tax medical and other insurance $ /week; Flexible spending account $ /week

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

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

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

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

14. Does the employee have an ownership interest in this business? ☐ Yes ☐ No If yes, what is the % of ownership? %
Type of business entity? ☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship

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

16. Is employee eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	When do benefits begin?	When do benefits end?
Salary Continuation	☐	☐	$	☐	☐		
State Disability	☐	☐	$	☐	☐		
Other Disability Benefits	☐	☐	$	☐	☐		
Social Security	☐	☐	$	☐	☐		
Public Employee Retirement	☐	☐	$	☐	☐		
Health Insurance	☐	☐	If yes, Name and Address of Carrier				
Life Insurance	☐	☐	If yes, please provide the amount of coverage: $				
Workers' Compensation	☐	☐	$	☐	☐		

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

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

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

17. Information about your pension plan

Do you have a pension plan? ☐ Yes ☐ No | If yes, what type? ☐ Defined benefit ☐ Defined contribution ☐ 401(k)/403(b) ☐ Profit Sharing ☐ Other: (specify)

Is employee eligible for your pension plan? ☐ Yes ☐ No | If eligible, does the employee participate? ☐ Yes ☐ No | What % does employee contribute?

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

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

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

19. Has the employee filed for:
Sabbatical Leave? ☐ Yes ☐ No
Is the employee eligible to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
If yes, date payment began: _____
Amount of payment: $_____ per week/month

Has the employee filed for:
• Teachers' Retirement ☐ Yes ☐ No
• Teachers' Retirement Disability ☐ Yes ☐ No
Is the employee eligible to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
If yes, date payment began: _____
Amount of payment: $_____ per week/month

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

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

Name of Person Completing Form (please print) | Telephone Number

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

Signature | Date Signed

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Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time)

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, Brown & Brown Absence Services 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, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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.