ACCIDENT CLAIM FORM

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

Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

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

For use with policies issued by the above Unum Group ["Unum"] subsidiaries.

OUR COMMITMENT TO YOU

We understand an 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.

INSTRUCTIONS

When should you use this claim form?

Use this claim form to submit an Supplemental Health Accident 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 Supplemental Health Accident 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.

- **Employee Statement (pages 3-5):** Please complete this section of the claim form and fax the completed form to 1-800-447-2498. 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 in case the pages become separated.
- **Authorization to Share Information with Third Parties (page 6):** 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 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- **Attending Physician Statement (page 7):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete. Your physician or treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above. Unum is not responsible for expenses associated with the completion of this form.
- **Patient Authorization (last page):** Please sign and date this form, provide a copy to your attending physician, and fax the completed form to 1-800-447-2498. If you prefer, it may be mailed to the address noted above. This form authorizes the release of medical and other types of 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. Eastern Time, Monday through Friday.

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EMPLOYEE/PATIENT STATEMENT (PLEASE PRINT)

A. Information About the Employee

Last Name | Suffix | First Name | MI

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

Home Address

City | State | Zip -

Preferred Telephone Number | Preferred E-mail Address

Employer Name

Language Preference ☐ English ☐ Spanish

Please check all types of coverage you have with Unum. ☐ Disability ☐ Life Insurance ☐ Critical Illness Insurance ☐ Hospital

While there is no legal requirement for you to provide information regarding other policies you may have with Unum, this information will help us identify any other coverage you have with us for which you may be eligible to file a claim. Failure to provide the requested information may delay claim initiation under the additional policy or policies.

B. Information About the Patient (if different from Employee)

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female | Relationship to Insured/Policyholder (check one) ☐ Spouse/Domestic Partner ☐ Dependent Child

If claim is for a child, please state your relationship to the child _____

C. Information About Your Condition

Date of Accident | Time of Accident ☐ a.m. ☐ p.m.

Please explain how your accident happened. (If you need more space, please attach a separate sheet of paper).

Were you at work at the time of your accident? ☐ Yes ☐ No

If yes, have you received Workers' Compensation benefits for your occupational injury? ☐ Yes ☐ No

Is your claim pending a Workers' Compensation decision? ☐ Yes ☐ No

Did accident occur while playing an organized sport with required registration and referee/official was present? ☐ Yes ☐ No

While confined did you incur expenses for child care or pet boarding? ☐ Yes ☐ No

Have you stopped working? ☐ Yes ☐ No If yes, what was the last day that you worked? (mm/dd/yy)_____

Was this a motor vehicle accident? ☐ Yes ☐ No (If yes, please attach traffic/police report)

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EMPLOYEE/PATIENT STATEMENT (Continued)

Employee's Last Name	Employee's First Name and MI	Date of Birth (mm/dd/yy)

Patient's Last Name	Patient's First Name and MI	Date of Birth (mm/dd/yy)

D. Information about your Personal Safety Benefit. Complete this section for Personal Safety Benefit Claims, **then go to section H.**

Please check the covered certification program for which you are filing this claim. Please Note: Not all certifications are covered on all policies, consult your certificate of coverage or policy for details.

- ☐ Defensive driving course or a driver education course for a personal automobile
- ☐ CPR certification
- ☐ First Aid certification
- ☐ Swim lessons with a defined curriculum and overseen by an individual certified to act in that capacity
- ☐ Self-defense course with a defined curriculum overseen by an individual certified to act in that capacity
- ☐ State or federally approved Recreational Safety Courses

Date of certification (mm/dd/yyyy):_____

E. Information About Physician and Hospital

Hospital Name	Mailing Address	Telephone Number
	City, State, Zip	Fax Number
Treating Physician Name	Mailing Address	Telephone Number
	City, State, Zip	Fax Number

F. Additional Medical Information Required

Please attach itemized copies of any bills related to this accident including doctor, emergency room, hospital, and motor vehicle incident/accident report. Bills should include diagnosis information (from your medical provider). Additional medical information may be requested to evaluate your claim.

G. Tax Considerations

Benefit payments under this policy could be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.

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EMPLOYEE/PATIENT STATEMENT (Continued)

Employee's Last Name	Employee's First Name and MI	Date of Birth (mm/dd/yy)
Patient's Last Name	**Patient's First Name and 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 of Insured/Policyholder

I have read and understand the fraud notices listed above and on page 2 of this form. I also understand 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**

I signed on behalf of the insured, as _____ (Indicate relationship). **If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.**

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

Authorization to Collect and Disclose Information

(Not for FMLA Requests)

I authorize the following persons: health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The 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, First Unum Life Insurance Company*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty 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.

_____ _____

Patient'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.

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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 leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), 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 any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) 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(s) and/or leave(s) 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(s) and/or leave(s) 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 any of my claim(s) and/or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

_____ _____

Patient 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

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

Patient's Last Name | Patient's First Name and MI | Date of Birth (mm/dd/yy)

ACCIDENT DETAILS

Is this condition the result of an accidental injury? ☐ Yes ☐ No If yes, date of accident (mm/dd/yy)
Is this condition the result of his/her employment ☐ Yes ☐ No ☐ Unknown
Please verify treatment for the accident listed above. Please print in fields provided below.

Primary Diagnosis (ICD): _____ Primary Diagnosis Description: _____

Secondary Diagnosis Code (ICD): _____ Secondary Diagnosis Description: _____

First Office Visit Date (mm/dd/yy): _____ Last Office Visit Date (mm/dd/yy): _____

Next Office Visit Date (mm/dd/yy): Was patient hospitalized as a result of this accident? ☐ Yes ☐ No _____
(If yes, please provide dates below.)

Hospital Admission Date (mm/dd/yy): _____ Hospital Discharge Date: (mm/dd/yy): _____

Hospital Facility Name: _____

Hospital Facility City: _____ Hospital Facility State: _____

Was surgery performed? ☐ Yes ☐ No Surgery Date (mm/dd/yy): _____

Surgery/Procedure Description: _____

Was the patient referred to Physical/Speech/Occupational/Acupuncture/Alternative Therapy? ☐ Yes ☐ No

If yes, please provide the therapy facility patient was referred to or prescribed therapy frequency on the line provided below.

_____

Was the patient referred to Behavioral Health therapy? ☐ Yes ☐ No

Was the patient treated in the Emergency Room related to the accidental injury? ☐ Yes ☐ No

Date of Emergency Room Treatment (mm/dd/yy): _____

Did you advise the patient to stop working? ☐ Yes ☐ No If yes, as of what date? (mm/dd/yy)

Have you advised the patient to return to work? ☐ Yes ☐ No If yes, as of what date? (mm/dd/yy)

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 the Attending Physician portion of the claim form.

Attending Physician's Information

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

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

Medical Specialty | Degree

Address

City | State | Zip

Telephone Number | Fax Number | Physician's Tax ID Number

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

X _____ _____
Physician Signature **Date**