First Unum Life Insurance Company
unum

Fax to: Claims 1-888-281-8324
From:____________________________
Fax Number:______________________
Date:____________________________
Number of pages:_________________

Claim Form and Instructions

What can I do to avoid delays?

Missing information is one of the major causes of delay in processing. Please be sure you:

- **Sign** and return the enclosed Certification on page 2 and authorization on page 5 to avoid delay.
- **Complete** the sections that apply to your specific claim.
- **Enclose** copies of all bills connected with your claim, if applicable.

When should I expect a reply?

Mail time is a large contributor to the time it takes for our response to reach you. **Mail** may take up to four or five days each way. **Typical turnaround time is 21 calendar days from mailbox to mailbox.**

To avoid mail delays?

- **Fax** your claim to us at 1-888-281-8324. **If you fax your claim, please keep the original for your files.** Please allow 48 hours for our automated service center to be updated with information confirming receipt of your fax, **or...**

- Have your payment returned by **overnight delivery** by initialing the Service Release below. An $18.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments over $100.00.** ***A street address is required. Your check will be delivered Monday through Friday; however, the time is not guaranteed.***

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below as indicated.

I authorize First Unum Life Insurance Company to facilitate processing this claim by releasing its details if he/she is inquiring on my behalf.

_____ local sales representative (initial) _____ plan administrator (initial) ______ spouse, family member or significant other (initial)

______ (initial) I authorize First Unum Life Insurance Company to communicate information on the status of this claim through **electronic messaging** at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/answering machine. I will program phone number 1.800.325.4368 into my phone to avoid calls being blocked.

______ (initial) Yes, please deduct the $18.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from my claim payment for this claim. This fee does not include weekend delivery. I understand this fee will be deducted for **future payments** for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under $100.00 will be sent by regular mail.

Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying First Unum Life Insurance Company in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by us.

- ***If you are filing a claim for non-accident related benefits for a loss occurring within the first 6 to 24 months of your policy/certificate (based on policy requirements), we need to confirm if the condition is pre-existing. Please notify your doctor we will be contacting him/her and provide him/her with a copy of your authorization to release information to us.***
- Benefits are payable to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called an assignment. If you wish to assign your benefits, please attach a signed written request.

CLAIMANT NAME: *X*______________________________________ **SOCIAL SECURITY NUMBER:**___________________

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

Mail to: **First Unum Life Insurance Company**
Claims Processing Division
PO Box 100172
Columbia SC 29202
1-800-375-8226

Fax to: 1-888-281-8324
If you fax your claim, please keep the original for your files.

It's easy, really… This is a multi-purpose form. Complete the general information section on this page. Then, you only need to have those sections that apply to your individual situation and coverage completed. Information does not have to be written on this form, as long as any documentation you send has the information needed to process your claim. Please check the type claim you are filing below:

❑ **Accidental Injury-** Section A requests specific information from you about the circumstances of your injury.
❑ **Routine Pregnancy-** Have your doctor complete Section B if you are filing for benefits for normal post-delivery disability.
❑ **Total Disability-** Section C and Section D contain parts for both your employer and doctor to complete.

This claim is for: ❑ Self ❑ Spouse ❑ Dependent: if over 18, name of school____________________

Name of Claimant____________________ Name of Policyholder (if not claimant)____________________

Social Security Number: ____________ **Social Security Number:** ____________________

Date of Birth: (mm/dd/yyyy)__________ ❑ male ❑ female Date of Birth: (mm/dd/yyyy) __________ ❑ male ❑ female

Policy Number: ____________________

Address ____
Street (Apt. #) City State Zip

Has your address changed since we last heard from you? ❑ yes ❑ no

Home Phone Number: (_____) ____________ Work Phone Number: (_____) ____________

Fax Number: (_____) ____________Email address for Policyholder:____________________

If you are claiming disability, please list the dates you unable to work from ___/___/ ___ to ___/___/___

Please print **INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL**

Please continue on separate sheet if necessary. Be sure to include any referring physician(s).

1.____________________
Full name of treating doctor
____
Mailing Address
____
City State Zip Code
(____)____________ (____)____________
Phone number Fax number

2.____________________
Full name of referring doctor/hospital
____
Mailing Address
____
City State Zip Code
(____)____________ (____)____________
Phone number Fax number

3.____________________
Full name of primary doctor
____
Mailing Address
____
City State Zip Code
(____)____________ (____)____________
Phone number Fax number

4.____________________
Other
____
Mailing Address
____
City State Zip Code
(____)____________ (____)____________
Phone number Fax number

CERTIFICATION

Policyholder/Employee's Name____________________ **Social Security #**____________

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this 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 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.

X_____/_____/________ **X**____________________ **X**____________________
Date (mm/dd/yyyy) PATIENT SIGNATURE POLICYHOLDER/EMPLOYEE SIGNATURE

CLAIMANT NAME:____ SOCIAL SECURITY NUMBER:__________________

A. ACCIDENTAL INJURY- please complete and attach itemized copies of any related bills including doctor, emergency room, and hospital. Bills should include diagnosis information (from your medical provider).

Date of accident(mm/dd/yyyy): ________________ Time of accident: ______________________ am/ pm (circle one)

Tell us how your accident happened: (If you need more space, you may attach on a separate piece of paper.)

____

____

____

Were you at work, working for wage or profit, at the time of your accident? ❑ yes ❑ no

Have you ever had a similar injury? __________If so, please tell us when (mm/dd/yyyy): _________________________

If you are claiming disability, please have your employer complete section C and have your doctor complete section D.

B. ROUTINE PREGNANCY (6 weeks for vaginal delivery, or 8 weeks for c-section — less the elimination period)

First Date of Treatment(mm/dd/yyyy):______________________Date of Delivery: (mm/dd/yyyy) ___________________

Type delivery: Vaginal/ C-Section (circle one) Dates of Hospital Confinement (mm/dd/yyyy): ____________________

Name of Hospital: _________________________________ Hospital Phone Number: (_____)______________________

Name of doctor: _______________________________ Phone: (_____)________________ Fax:(_____)_____________

Address: ____

Email address:____Tax ID or SSN: ______________________

Treating Doctor's Signature: __________________________________ Date (mm/dd/yyyy): _______________________

Referring Physician: ______________________________________ Phone number: (_____) _____________________

____

Mailing address

If disabled due to complications of pregnancy, before or after delivery, please have your employer complete *Section C and have your doctor complete section D*.

C. To be completed and signed by your *EMPLOYER*:

Name of Employer: _________________________________

Employee's Job Title:_______________________________

Dates this employee has been unable to work:

From: ____/____/____ am/pm To: ____/____/____ am/pm

From: ____/____/____ am/pm To: ____/____/____ am/pm

Date employee returned to main or principal duties: ____/____/____

Date employee returned to light duty: ____/____/____

Monthly Salary $_____________________

Did the accident occur while working for wage/profit? ❑ yes ❑ no

Has Worker's Compensation been approved? ❑ yes ❑ no

Name and address of Workers Compensation carrier, if applicable:

____

Phone Number: (_____) ________________________

Fax Number: (_____) ___________________________

Employee's Job Title Duties Include:

Lifting ❑ less than 15 lbs. ❑ 15 to 44 lbs. ❑ over 45 lbs.

Stooping/bending	❑ none	❑ seldom	❑ frequent
Crawing/climbing/ kneeling	❑ none	❑ seldom	❑ frequent
Reaching/pulling/ pushing	❑ none	❑ seldom	❑ frequent
Repetitive	❑ none	❑ seldom	❑ frequent
Management duties	❑ none	❑ seldom	❑ frequent

Sitting (Number of hours each day):______________

Standing/Walking (hours each day):______________

Signed: ____________________________________ Title: ____________________ Date (mm/dd/yyyy): _____________

CLAIMANT NAME:______________________________________**SOCIAL SECURITY NUMBER:**__________________

D: DISABILITY BENEFITS: To be completed and signed by the DOCTOR treating you for this disability:

Diagnosis/ primary disabling condition ICD9 code(s): ____

Is this condition the result of an accidental injury? ❑ yes ❑ no If yes, please provide us with the date and description.

____

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment:

____

Dates of Inpatient Hospital Confinement: From: ____/____/____To: ____/____/_____

Hospital: ____
Name

____
Address

List any surgeries performed and submit a copy of the operative report. _______________________________

How soon do you expect significant improvement in the patient's medical condition?
❑ less than 1 month ❑ 1-2 months ❑ 3-4 months ❑ 5-6 months ❑ more than 6 months

If due to complications of pregnancy prior to delivery, what is EDC? _____________________________________

Dates **unable** to work: From: _______/________/____________ To: _______/________/____________

From: _______/________/____________ To: _______/________/____________

Anticipated return to work/release date: _________________________________ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

Dates of treatment (mm/dd/yyyy): ____

Restrictions/Limitations preventing work:____

Secondary conditions contributing to this disability: ____

Would the patient be disabled without regards to these secondary conditions? ❑ yes ❑ no

Is this patient permanently disabled? ❑ yes ❑ no If yes, what is recommended frequency of treatment? ________

Does this patient have permanent restrictions/limitations? If so, list: __________________________________

Signature of doctor: ________________________ **Date** (mm/dd/yyyy): _____________ **Patient #:** __________

Name of doctor: ____________________________ Phone: (_____)______________ Fax: (______)__________

Specialty:____

Address: ____

Email address:____Tax ID or SSN: ___________________

Referring physician:

____
Full name of referring doctor

____
Mailing Address City State Zip Code

(_________)____ (_________)____________________________
Phone number Fax number

NOTE: Please make a copy of the patient's signed authorization to release information for your records. If your facility requires a special authorization, please have your patient sign the form and include it with this claim.

Phone 1-800-375-8226 *Fax 1-888-281-8324*

Authorization for First Unum Life Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to First Unum Life Insurance Company (First Unum) and its duly authorized representatives.

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information First Unum obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. First Unum will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent First Unum has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, First Unum may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: First Unum, Processing Center, Attn. Disability Benefits, P. O Box 100172, Columbia, SC 29202.

You may refuse to sign this form; however, First Unum may not be able to evaluate and administer your claim without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

______________________________________ ______________________
(Printed name of individual subject to this disclosure) (Social Security Number)

____ _____________________________
(Signature) (Date Signed)

If applicable, I signed on behalf of the insured as _____________________________(indicate relationship). If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

____
(Printed name of legal representative)

____ _____________________________
(Signature of legal representative) (Date Signed)