



## CLAIM FOR SELECT INCOME PROTECTION BENEFITS

The Benefits Center, P.O. Box 100158

Columbia, SC 29202-3158

Pacific Time Zone

Toll-free: 1.877.851.7637

Fax: 1.877.851.7624

All Other Time Zones

Toll-free: 1.800.858.6843

Fax: 1.800.447.2498

For use with policies issued by the following UnumProvident Corporation ["UnumProvident"] 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

Pacific Time Zone Toll-free: 1.877.851.7637    Fax: 1.877.851.7624

All Other Time Zones    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.

Our centralized mail processing center, located in Columbia, SC, services our Benefits Centers located in:  
• Chattanooga, TN    • Glendale, CA    • Portland, ME

**The employee is responsible for completion of all portions of this form without expense to the UnumProvident Corporation 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.**



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## A. 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 — 9 and/or DSM IV Multi-Axial Diagnoses and Codes

b) Date of last examination: \_\_\_\_\_

c) Describe Subjective Symptoms: \_\_\_\_\_

d) Describe Objective 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-9s	Diagnosis
Secondary ICD-9s	Diagnosis

b) Describe Subjective Symptoms: \_\_\_\_\_

c) Describe Objective 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: \_\_\_\_\_

Employee 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently							
Stand	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently							
Walk	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently							

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

	Never	Occasionally	Frequently	Continuously
	0%	1-33%	34-66%	67-100%
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist/bend/stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate heavy machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Never	Occasionally	Frequently	Continuously
	0%	1-33%	34-66%	67-100%
Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Never		Occasionally		Frequently		Continuously	
	0%		1-33%		34-66%		67-100%	
	R	L	R	L	R	L	R	L
Fine Finger movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand/eye coordinated movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dominant Hand	<input type="checkbox"/> Right		<input type="checkbox"/> 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.

Prognosis

a) Has patient achieved maximum medical improvement?

Yes  No If no, complete the following:  
How soon do you expect fundamental changes in the patient's medical condition?  
 1 - 2 months  5 - 6 months  
 3 - 4 months  more than 6 months

Has the patient:

Recovered  Improved  Unchanged  Regressed

Is the patient:

Ambulatory  Bed Confined  House Confined  Hospital Confined

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
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 ( )		
		<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:      Weight:

Home Address (Street, City, State, ZIP)

The state in which you work:	Preferred e-mail address where you can be reached:
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2. Employer Name	Policy Number
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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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	If you are married, spouse's name:	Spouse's Date of Birth	Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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List your dependent children who are under age 25 (attach additional sheets if necessary).

Name	Date of Birth	Attending School? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> 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:
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No
Canada Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No	No-Fault Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Employee Retirement/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Third Party Settlement/Income <input type="checkbox"/> Yes <input type="checkbox"/> 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 Worker's 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)

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:

Teachers' Retirement - Disability  Yes  No

PAYMENT AMOUNT

WEEKLY MONTHLY

Begin Date

Through Date

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

**Employee Signature Required**

I have read and understand the fraud notices listed below.

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.)**

Signature \_\_\_\_\_

Date \_\_\_\_\_

**CLAIM FRAUD WARNING STATEMENTS**

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

**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.

**Fraud Warning for California Residents**

For your protection, California law requires the following to appear:

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**

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, Maine, Tennessee and Virginia Residents**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Fraud Warning for Florida Residents**

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

**Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents**

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 Statement for New York Residents**

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.



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## B. EMPLOYEE'S STATEMENT — Physician/Medication List (PLEASE PRINT)

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

Employee's Full Name	Policy No.
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### 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 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).		
<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> 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.).**

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:

Table with 7 columns: 16. Is employee eligible for: Yes No, If yes, weekly or monthly amount, Weekly, Monthly, When do benefits begin?, When do benefits end?. Rows include Salary Continuation, State Disability, Other Disability Benefits, Social Security, Public Employee Retirement, Health Insurance, Life Insurance, Workers' Compensation.

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

If so has Workers' Compensation claim been filed? Yes No If yes, Name and Address of Carrier

If 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

Table with 2 columns: 19. Has the employee filed for: Sabbatical Leave, Is the employee eligible to file?, If filed, has it been approved?, Amount of payment; Has the employee filed for: Teachers' Retirement, Teachers' Retirement Disability, Is the employee eligible to file?, If filed, has it been approved?, Amount of payment.

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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**FOR EMPLOYEE TO COMPLETE**

**NOTE:** This authorization has been crafted to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

**Authorization**

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries\* and duly authorized representatives ("UnumProvident"). Information about my health may relate 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 understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. 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.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

\_\_\_\_\_  
(Claimant Signature)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Social Security Number)

I signed on behalf of the claimant as \_\_\_\_\_ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

\* This authorization is valid for the following UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.