



BASIC GROUP LIFE CLAIM FORM

Please Fax to (207) 575-6096 or Mail to:
UnumProvident, Group Life Customer Care Center
P.O. Box 9061, Portland Maine 04104-5046
Telephone 1-800-445-0402, Fax 207-575-6096

Please send the following documents to UnumProvident Corporation when submitting a claim:**For a Life Claim:**

- A completed basic Group Life claim form
- A copy of the death certificate (a photocopy is acceptable)
- The original enrollment form and any beneficiary change form(s)
- Appropriate salary verification/documentation (see requirements below)
- When named beneficiary has predeceased the insured, a copy of the deceased beneficiary's death certificate and name of contingent beneficiary
- If the beneficiary is the Estate of the insured, a copy of the court appointment naming the Executor, Administrator or Personal Representative.

If this is an Accidental Death Claim, complete Parts 1-5 on Basic Group Life Claim Form (Notice of Death Claim) and A-2

If this is a Dismemberment Claim, complete Attachment A-1 and A-3.

For an Accelerated Benefit Claim, complete Attachments B-1 and B-2

Attention should be given to the following statements:**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 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 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.

In order to accurately determine the Life Benefit payable, please provide the following:**Salary Verification/Documentation*****If Definition of Basic Monthly Earnings is:**

- | | Required Documentation |
|--|---|
| 1 W-2 | Include Previous Year's W-2 form |
| 2 Salary and commissions | One month's payroll records (for month preceding date last worked) plus documentation of commissions earned/paid over the last 12 months |
| 3 Salary, commissions and bonuses | One month's payroll records (for month preceding date last worked) plus documentation of commissions earned/paid and documentation of any bonuses earned/paid over the last 12 months |
| 4 For Salary Only and flat benefit amounts, no verification/documentation is required. | |

1. INSURANCE INFORMATION (Complete for all claims)

Indicate the type of claim being filed:	<input type="checkbox"/> Life	<input type="checkbox"/> Supplemental	Did the deceased have other insurance?	Group Life Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Dependent	<input type="checkbox"/> Accelerated		Individual Life Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	<input type="checkbox"/> AD&D			Disability Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

2. EMPLOYER INFORMATION (Complete for all claims)

Company Name		If an affiliate, subsidiary, branch or employer member, give name	
Address (Number/Street, City, State, Zip Code)			Telephone Number
Signature and Title of Authorized Representative		Date	Policy Number(s) and Division

THIS SECTION MUST BE COMPLETED IN FULL

1. Do you as the Employer pay any portion of the premium for this insurance? No Yes

2. Did you issue a summary plan description? No Yes

3. If you filed this as an ERISA program, please advise us of the plan number. Plan Number: _____

3. EMPLOYEE INFORMATION (Complete for all claims)

Full Name of Insured Employee		Social Security Number	Date of Birth
Address of Employee (Number/Street, City/Town, State, Zip Code)			
Occupation	Salary/Rate of Pay* (See requirements on previous page)	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired <input type="checkbox"/> Other Specify <input type="checkbox"/> Medical Leave _____ If part time: hours per day _____ days per week _____	
Amount of Unum Group Life Insurance: Basic Life \$ _____ Supplemental Life \$ _____		Date Employed	Effective Date of Unum Insurance
Basic AD&D \$ _____ Supplemental AD&D \$ _____			
Date of Last Change in Amount of Insurance	Amount of Last Change	Basic Life \$ _____	Supplemental AD&D \$ _____
		Increased	Decreased
		Increased	Decreased
		Increased	Decreased
Date Last Worked	Reason for Ceasing Work	Date of Death and Age	Have premiums terminated? If yes, please give date.

Was the death considered a homicide/accident? No Yes (If yes, please attach a copy of the police report)

If dismemberment, indicate if Employee is still at work.

4. DEPENDENT CLAIM FORM (Complete for Dependent Life & AD&D Claims only)

Full Name of Deceased Dependent		Relationship to Insured Employee	Date of Birth
Effective Date of Unum Dependent Life Insurance	Amount of Insurance	Date of Last Change in Amount of Insurance	Date of Death and Age

5. BENEFICIARY INFORMATION (Complete for all claims)

Total Number of Beneficiaries: _____ If more than two beneficiaries, attach a separate sheet.

Name of Beneficiary	Relationship to Employee	Beneficiary's Date of Birth
Address (Number/Street, City, State, Zip Code)	Beneficiary's Telephone Number	Beneficiary's Social Security No.
Name of Beneficiary	Relationship to Employee	Beneficiary's Date of Birth
Address (Number/Street, City, State, Zip Code)	Beneficiary's Telephone Number	Beneficiary's Social Security No.

6. SURVIVOR INFORMATION (Complete for employee claims eligible for SurvivorSupport®)

Name of Survivor (This individual may be different than the beneficiary) and Relationship	Telephone Number
Address (Number/Street, City, State, Zip Code)	

Attachment A-1 – Accidental Dismemberment

Please Fax to (207) 575-6096

TO BE COMPLETED BY THE EMPLOYEE

To avoid delay, please answer all questions - please print.

Have the Attending Physician's Statement Completed

Full Name (Last, First, Middle)	Social Security Number	Telephone Number
Date of Accident ____/____/____	Date of Loss ____/____/____	Occupation

Name, Address and Telephone Number of the Physician who treated you for this accident

Name and Address of the Hospital where you received treatment for this accident

Full account of the accident (Please attach an additional sheet, if necessary)

DISCLOSURE INFORMATION

I authorize any doctor, hospital, practitioner, pharmacist, clinic, other medical facility, or provider of health care, banking or financial institution, insurer or reinsurer, consumer reporting agency, governmental agency, including the Social Security Administration, Medical Information Bureau, Employers and other persons or institutions; to provide Unum Life Insurance Company of America and its representatives who are employed to assist in the evaluation of my claim any information, data or records you may have regarding me, my employment, medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and, but not limited to, information regarding my HIV status and test results, and any disability I may now have or have had) and income.

I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to any agency, insurance support organization or person employed by Unum to assist with this purpose. This authorization is valid during the pendency of my claim. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photostatic copy of this form will be valid as the original.

____/____/____

Signature of Insured Date Signed

**TO BE COMPLETED BY BENEFICIARY OR AUTHORIZED REPRESENTATIVE
PLEASE ANSWER ALL QUESTIONS**

Full Name of Deceased	Social Security Number
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When did accident happen (month, day, year) ____/____/____	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Where did accident happen? (if city or town, show street no.)
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How did accident happen? (Describe fully)

What was deceased doing at the time of the accident?

List all Physicians and Surgeons who attended deceased for these injuries

Name	Name	Name
Address	Address	Address

Advise if Autopsy or Inquest was held (Note: attach summary of autopsy or copy of inquest verdict)

List all witnesses to the accident

Name	Name	Name
Address	Address	Address

List all investigating authorities: (Please include Addresses)

Investigating Officer _____ Telephone Number () _____

List all physicians who have attended deceased during the last five years. (State ailments involved)

Name and Address	Ailment
Name and Address	Ailment

In what capacity are you acting to complete this form?

Named Beneficiary Representative of Named Beneficiary Administrator of Estate Other _____

Telephone Number () _____ Named Beneficiary's Social Security Number or Taxpayer I.D. Number _____

DISCLOSURE INFORMATION

I authorize any doctor, hospital, practitioner, pharmacist, clinic, other medical facility, or provider of health care, banking or financial institution, insurer or reinsurer, consumer reporting agency, governmental agency, including the Social Security Administration, Medical Information Bureau, Employers and other persons or institutions; to provide Unum Life Insurance Company of America and its representatives data or records you may have regarding the employment, medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and, but not limited to, information regarding HIV status and test results) and income of the deceased.

I understand that any information obtained pursuant to this authorization will be used to evaluate the claim and may be transferred to any agency, insurance support organization or person employed by Unum, to assist with this purpose. This authorization is valid during the pendency of the claim. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photostatic copy of this form will be valid as the original.

_____/_____/_____
Beneficiary or Authorized Person's Signature Date Signed

Attachment A-3 — Physician's Statement for AD&D

Please Fax to (207) 575-6096

TO BE COMPLETED BY THE ATTENDING PHYSICIAN FOR ACCIDENTAL DEATH OR DISMEMBERMENT

Patient's Name	Social Security Number	Date of Birth
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Date of Accident causing present loss	Date first consulted you for this condition	Has patient ever had same or similar Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: _____
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Diagnosis or nature of injury _____

When did symptoms first appear or accident happen? _____

Patient ceased work due to disability? _____

Is condition arising out of employment? Yes No

When do you think patient will be able to resume work?
Approximate Date _____
Indefinite
Never

If loss is extremity, where is amputation? Use diagram below.

If loss is speech, is loss total and irreversible? Yes No

If no, speech at this time _____

If loss of hearing, is loss in both ears? Yes No

Is loss total and irrecoverable? Yes No

If no, hearing at this time? _____

If loss of vision please provide the following: (Snellen Notation)

	Mo. / Day / Yr.		Uncorrected	Corrected
a Give date of first eye examination	_____		O.D. _____	O.D. _____
b Give date of last examination	_____		O.S. _____	O.S. _____
c If the injury necessitated removal of either or both eyes, give date of removal: _____				
d Vision can be restored in whole or in part by <input type="checkbox"/> Lenses <input type="checkbox"/> Treatment <input type="checkbox"/> Operation <input type="checkbox"/> Not restorable				
e If by operation, do you recommend it? <input type="checkbox"/> Yes <input type="checkbox"/> No				
f Date corrected vision was irrecoverably reduced to 20/200 or less (Snellen Notation) _____				

In your opinion, was the loss caused by an accident independent of all other causes? Yes No

In your opinion was the loss caused in any way by illness? Yes No

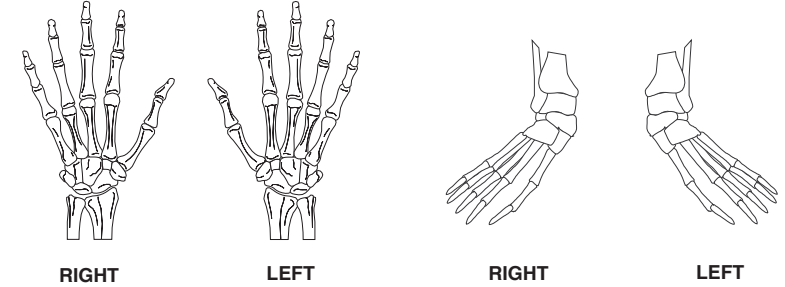
If yes, list dates you provided treatment for this illness: _____

MM DD YYYY MM DD YYYY

List names of any other physician who treated insured for a contributory condition:

Name of Physicians	Address
(1) _____	_____
(2) _____	_____

Please indicate where the injury occurred using the illustration below: Remarks: _____



PLEASE ATTACH COPIES OF OFFICE NOTES RELATED TO THIS INJURY

Name (Attending Physician) — Please print	Degree/Professional Designation	Telephone Number ()
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Physician's Address (Number and Street, City/Town, State, Zip Code)

Signature	Date
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TO BE COMPLETED BY THE CLAIMANT:

Date of accident or date you first noticed symptoms of your illness.	Describe how and where accident occurred or describe the first symptoms of your illness and nature of illness.
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Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain.
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Have you filed a Worker's Compensation Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, do you intend to? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date you were first treated for your illness or injury.	Treated By:	Name	Street Address	City	State	Zip Code
Hospital: _____						
Doctor: _____						
		Street Address	City	State	Zip Code	

If More Than One Hospital/Doctor Attach a Separate Listing

Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	Treated By:	Name	Street Address	City	State	Zip Code
Hospital: _____						
Doctor: _____						
		Street Address	City	State	Zip Code	

If More Than One Hospital/Doctor Attach a Separate Listing

Disclosure Information

I authorize any doctor, hospital, practitioner, pharmacist, clinic, other medical facility, or provider of health care, banking or financial institution, insurer or reinsurer, consumer reporting agency, governmental agency, including the Social Security Administration, Medical Information Bureau, Employers and other persons or institutions; to provide Unum Life Insurance Company of America and its representatives who are employed to assist in the evaluation of my claim any information, data or records you may have regarding me, my employment, medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and, but not limited to, information regarding my HIV status and test results, and any disability I may now have or have had) and income.

I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to any agency, insurance support organization or person employed by UNUM, to assist with this purpose. This authorization is valid during the pendency of my claim. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photostatic copy of this form will be valid as the original.

Special Notice To Minnesota Claimants:

This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, fire-fighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care and or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who qualify under the good Samaritan law.

Signature of Insured

Date Signed

Attachment B-2 — Accelerated Benefit Claim — Attending Physician's Statement

Please Fax to (207) 575-6096

Name of Patient	Date of Birth	Social Security No.
		Group/Policy No.

History

When did symptoms first appear or accident happen?	Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" state when and describe.
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Names and addresses of other treating physicians

DIAGNOSIS

Date of Diagnosis	Diagnosis (including any complications)
Subjective symptoms	Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)
Secondary diagnosis(es)	Date of Diagnosis(es)
Subjective symptoms	Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)

TREATMENT

Date of first visit	Frequency <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)	Date of last examination
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PROGNOSIS

During last 6 months, has patient <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed	Is Patient <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed Confined <input type="checkbox"/> House Confined <input type="checkbox"/> Hospital Confined
Has Patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" give name and address of hospital.
What is the estimated life expectancy? <input type="checkbox"/> less than 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> 12-24 months <input type="checkbox"/> greater than 24 months	

Cardiac (If Applicable)

Functional Capacity (American Heart Assn.) <input type="checkbox"/> Class 1 (no limitation) <input type="checkbox"/> Class 2 (slight limitation) <input type="checkbox"/> Class 3 (marked limitation) <input type="checkbox"/> Class 4 (complete limitation)	Therapeutic Class (Activity) <input type="checkbox"/> A. (no restric.) <input type="checkbox"/> B. (slight restric.) <input type="checkbox"/> C. (moderate restric.) <input type="checkbox"/> D. (marked restric.) <input type="checkbox"/> E. (complete restric.)	Blood pressure last visit Systolic/Diastolic
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Cancer (If Applicable)

If Diagnosis is Cancer, Indicate Stage _____

Physical Impairment

(*As defined in federal dictionary of occupational titles)

Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)

Class 2 - Medium manual activity* (15-30%)

Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)

Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)

Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)

Remarks:

Mental Impairment (If Applicable)

In your opinion, is this individual competent to make decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Remarks:
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Restrictions

Does this patient currently have limitations/restrictions?	Patient's Occupation Any Other Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe specific limitations and restrictions
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PLEASE INCLUDE COPIES OF MEDICAL RECORDS FOR THIS CONDITION, INCLUDING BUT NOT NECESSARILY LIMITED TO:

- Treatment Notes
- Consultation to/by Other Physicians
- Diagnostic Tests and Results
- Hospital Records

Name of Attending Physician – Please Print	Degree	Telephone
Medical Specialty		
Street Address	City or Town	State or Province
Signature		Zip Code
Date		

Claimant Please Complete Reverse Side