



SECTION 1: INSURANCE INFORMATION

Indicate the type of claim being filed:

- Life – Policy Number _____ Division _____
 - Dependent? Voluntary
 - Accelerated? % Requested _____ Individual
- AD&D – Policy Number _____ Division _____
 - Dependent?
- Special Risk – policy number _____ GTA _____
 - Dependent?

SECTION 2: EMPLOYER INFORMATION

Company Name _____ Subsidiary/Affiliate/Branch _____
 Street Address _____ City _____ State _____ Zip _____
 Name and Title of Authorized Representative _____
 Telephone number _____ Fax Number _____
 Signature of Authorized Representative _____

SECTION 3: EMPLOYEE INFORMATION

Full Name _____ Social Security # _____

Please provide any other names (i.e., maiden name, alias, hyphenated name, etc.) that this person is or has been known by.

Address of Employee _____

Date of Birth _____ Employment Status: Full Time Part Time Hours/week _____
 Hourly or Salary Employee? _____

Job Title/Class _____ Salary/Rate of Pay _____

Date of Hire _____ Effective Date of Coverage _____

Date Last Physically at Work _____ Reason for Ceasing Work _____

Is the employee receiving any company sponsored retirement benefits? Yes No

If yes, please explain type _____

Date of Death _____ Accidental Claim being submitted? Yes No

Amount of Unum Group Life Insurance:

Basic Life	\$ _____	Supplemental Life	\$ _____	Special Risk Basic	\$ _____
Basic AD&D	\$ _____	Supplemental AD&D	\$ _____	Special Risk Supp	\$ _____
		Travel Accident	\$ _____		

Date of Last Change in Amount of Insurance _____	Amount of Last Change	Basic Life	\$ _____	Increased	Decreased
		Supplemental Life	\$ _____	Increased	Decreased
		Basic AD&D	\$ _____	Increased	Decreased
		Supplemental	\$ _____	Increased	Decreased
		Travel Accident	\$ _____	Increased	Decreased
		Special Risk Basic	\$ _____	Increased	Decreased
		Special Risk Supp	\$ _____	Increased	Decreased

Date of Last Premium Payment _____

If accidental claim being submitted, does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled in an institution of higher learning beyond the 12th grade? Yes No

Name of dependent child _____ Age _____

Name of dependent child _____ Age _____



TO BE COMPLETED BY THE CLAIMANT

Date of injury or date you first noticed symptoms of your illness _____

Describe how and where injury occurred or describe the first symptoms of your illness and nature of illness. _____

Is your injury or illness related to your occupation? Yes No If yes, explain _____

Date you were first treated for your illness or injury _____
List all those that treated you for your illness or injury

Physician Name _____

Physician Address _____

Physician Telephone Number _____

Hospital Name _____

Hospital Address _____

Hospital Telephone Number _____

Have you ever had the same or similar condition in the past? Yes No
(If yes, please attach Physician/Hospital information)

Special Notice to Minnesota Claimants:

Your 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.



Name of Patient _____

Date of Birth _____ Social Security # _____

When did symptoms first appear or injury happen? _____

Has patient ever had same or similar condition? Yes No

If “Yes” state when and describe _____

Names and addresses of other treating physicians:

Name _____ Address _____

Name _____ Address _____

Date of Diagnosis _____

Diagnosis _____
(Including any complications)

If Cancer, indicate Stage _____

Date of Distant Metastases _____ Location of Metastasis _____

Hospice Referral? Yes No If yes, Date _____

Date of First Visit _____ Frequency: Daily Weekly Monthly Other
If “Other” please specify _____

Date of Last Examination _____

During last 6 months, has patient: Recovered Improved Retrogressed Unchanged

Is patient: Ambulatory Bed Confined House Confined Hospital Confined

Has Patient been Hospital Confined? Yes No Dates: _____

If “Yes” give name and address of hospital _____

Functional Capacity (American Heart Association)

- Class 1 (no limitation) Class 3 (marked limitation)
- Class 2 (slight limitation) Class 4 (complete limitation)

Therapeutic Class (Activity)

- A. (No restrictions) C. (moderate restrictions)
- B. (slight restrictions) D. (marked restrictions)
- E. (complete restrictions)

What is the estimated life expectancy?

- Less than 6 months
- 6 – 12 months
- 12 – 24 months
- Greater than 24 months

Name of Attending Physician – Please Print _____

Degree _____ Medical Specialty _____

Telephone Number _____

Street Address _____

City/Town _____ State _____ Zip Code _____

Signature of Physician _____ Date _____



Unum, Group Life Benefits Services
 P.O. Box 100158, Columbia, SC 29202-3158
 Telephone: 1-800-445-0402

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to the address above.

**AUTHORIZATION
 For Accidental Dismemberment or Accelerated Benefit Claim**

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy, emergency medical service agency, or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurer; reinsurer; insurance service provider; third party administrator; producer; government organization; law enforcement agency; consumer reporting agency; and employer that has (1) information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits, or (2) my blood, urine or other specimens to disclose any and all of this information and specimens to persons who administer claims for Unum, its insurance subsidiaries* and duly authorized representatives ("Unum"). Information may include, but is not limited to, laboratory test results and findings, toxicology results, police reports, accident reports, or incident reports of any kind. Health information 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 Unum obtains pursuant to this authorization will be used for evaluating and administering the claim(s). 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 the 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 Unum 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, alter, or do not sign this authorization, Unum 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.

 Signature of Claimant

 (Date Signed)

 (Print Name)

 (Social Security Number)

I, _____, signed on behalf of the claimant as the claimant's personal representative. If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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