



INCOME PROTECTION CLAIM

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

ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number	Date of Birth	Social Security Number
Employer Name Costco Wholesale Corp.			Employer Telephone Number

Instructions: If this claim is related to normal pregnancy, complete the Normal Pregnancy section. For all other claims, including complicated pregnancy, complete the All Other Conditions section. **In all situations, you must complete the signature block at the bottom of this form.**

Normal Pregnancy

1. Expected Delivery Date:	If Delivered, Actual Delivery Date:	Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
2. Date First Unable to Work	Date Hospitalized	
3. Has patient been released to work in her own occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No In any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If not, when should the patient be able to return to work? Full Time		Part Time

All Other Conditions

1. **Diagnosis** - Please include the primary diagnosis and list any secondary conditions.

Diagnosis (including any complications) include **ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number**

2. Date First Unable to Work	Date Hospitalized		
3. Has patient been released to work in his/her own occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No In any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If not, when should the patient be able to return to work? Full Time			
4. Is this disability related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
5. If complicated pregnancy	Expected Delivery Date:	If Delivered, Actual Delivery Date:	Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
6. Date of first visit for this illness or injury			

7. Nature of treatment (including surgery and medications prescribed)	Name of Surgical Procedure	Date of Surgery
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8. If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

RESTRICTIONS (What the patient should not do)

LIMITATIONS (What the patient cannot do)

Date restrictions and limitations began.

9. Referring physician or other treating physicians (names, addresses, telephone numbers):

Please include copies of all applicable office notes and test results.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what is the relationship?		

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