



BASIC GROUP LIFE CLAIM FORM

Please Fax to (412)963-0415 or Mail to:
Provident Agency, Inc.
P.O. Box 11588, Pittsburgh, PA 15238
Telephone 1-800-447-0360, Fax (412)963-0415

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. | |

Notice of Claim

Please Fax to (412)963-0415

1. INSURANCE INFORMATION (Complete for all claims)

Indicate the type of claim being filed:	<input type="checkbox"/> Life <input type="checkbox"/> Dependent <input type="checkbox"/> AD&D	<input type="checkbox"/> Supplemental <input type="checkbox"/> Accelerated	Did the deceased have other insurance?	Group Life Insurance Individual Life Insurance Disability Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Did you issue a summary plan description?	<input type="checkbox"/> No <input type="checkbox"/> 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 \$ _____ Basic AD&D \$ _____ Supplemental AD&D \$ _____		Date Employed
Date of Last Change in Amount of Insurance		Effective Date of Unum Insurance
	Amount of Last Change	Basic Life \$ _____ Increased Decreased Supplemental \$ _____ Increased Decreased AD&D \$ _____ 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? <input type="checkbox"/> No <input type="checkbox"/> 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 (412)963-0415

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

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

Please Fax to (412) 963-0415

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

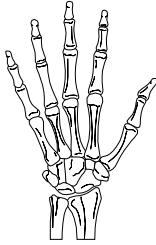
If yes, list dates you provided treatment for this illness: _____

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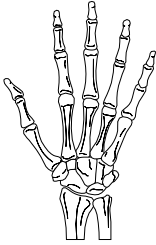
List names of any other physician who treated insured for a contributory condition:

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

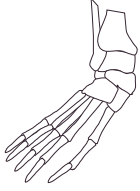
Please indicate where the injury occurred using the illustration below: _____ Remarks: _____



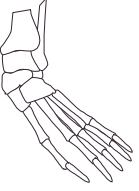
RIGHT



LEFT



RIGHT



LEFT

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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