



DISABILITY CLAIM FORM

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
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

For use with policies issued by the following Unum Group ["Unum"] subsidiaries:

Unum Life Insurance Company of America Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

OUR COMMITMENT TO YOU

We understand that a disabling illness or injury creates emotional, physical and financial challenges and we want to do whatever we can to help you. You have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during the claim process.

INSTRUCTIONS

When should you use this claim form?

Use this claim form to apply for disability benefits with Unum. This form should be used for the following types of claims only:

- Short Term Disability
- Voluntary Benefits Disability
- Any combination of the following: Short Term Disability, Long Term Disability, Individual Disability, Life Insurance Waiver of Premium, and Voluntary Benefits Disability

If you are covered for more than one of these products, you only have to complete this one form.

Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for disability benefits. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- **Employee/Individual Statement (pages 4-7):** Please complete this section of the claim form and fax it to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If you prefer, it may be mailed to the address noted above.
- Please complete the name and date of birth fields at the top of every page for easy identification purposes in case the pages become separated.
- **Authorization to Share Information with Third Parties (page 8):** If you wish to give us permission to share the details of your claim with a third party (such as your spouse, son, daughter, friend, etc.), please sign and date this form and fax it to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If you prefer, it may be mailed to the address noted above.
- **Employee/Individual Authorization (last page):** Please sign and date this form and provide a copy to your attending physician. Fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones) or mail it to the address noted above.
- **Employer Statement (pages 9-11):** If you are applying for Short Term Disability, Long Term Disability, Individual Disability or Life Insurance Waiver of Premium, please give this section of the claim form to your employer and ask him/her to complete, sign and date the form. Your employer should fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones) or mail it to the address noted above. If you are applying for Voluntary Disability Benefits only, we do not require the Employer Statement.
- **Attending Physician Statement (pages 12-14):** Please complete Part I of this statement, then give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to complete Part II and fax the completed form to 1-877-851-7624 (Pacific time zone) or 1-800-447-2498 (all other time zones). If s/he prefers, it may be mailed to the address noted above.

Questions?

If, at any time, you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center is staffed with experienced professionals who can be contacted from 8 a.m. to 8 p.m. Monday through Friday.



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Instructions (continued) / Claim Fraud Statements

Fraud Warning

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, New Mexico, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, Washington, and West Virginia require the following statement to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning for California Residents

For your protection, California law requires the following to appear on this claim form:

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

For your protection, Colorado law requires the following to appear on this claim form:

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 Residents

For your protection, the District of Columbia requires the following to appear on this claim form:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Fraud Warning for Florida Residents

For your protection, Florida law requires the following to appear on this claim form:

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

Fraud Warning for Kentucky Residents

For your protection, Kentucky law requires the following to appear on this claim form:

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Fraud Warning for Minnesota Residents

For your protection, Minnesota law requires the following to appear on this claim form:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Fraud Warning for New Hampshire Residents

For your protection, New Hampshire law requires the following to appear on this claim form:

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Fraud Warning for New Jersey Residents

For your protection, New Jersey law requires the following to appear on this claim form:

Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and civil penalties.



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Instructions (continued) / Claim Fraud Statements

Fraud Warning for New York Residents

For your protection, New York law requires the following to appear on this claim form:
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.

Fraud Warning for Oregon Residents

For your protection, Oregon law requires the following to appear on this claim form:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Fraud Warning for Pennsylvania Residents

For your protection, Pennsylvania law requires the following to appear on this claim form:
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 Warning for Puerto Rico Residents

For your protection, Puerto Rico law requires the following to appear on this claim form:
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.



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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI) _____ Date of Birth (mm/dd/yy) _____

4. For all medical conditions, answer the following questions:
What specific duties of your occupation are you unable to perform due to your medical condition?

Is your condition related to your occupation? Yes No If yes, please explain how: _____

Have you filed a Workers' Compensation claim? Yes No
If no, do you intend to file a Workers' Compensation claim? Yes No If no, please explain why you are not filing a Workers' Compensation claim. _____

C. Information About Your Disability

Date Last Worked (mm/dd/yy)	Number of Hours Worked on Date Last Worked	Date you were first unable to work due to this medical condition (mm/dd/yy)
-----------------------------	--	---

D. Information About Physicians and Hospitals

Please provide the following information about all your current medical treatment providers (physicians, hospitals, physical therapists, etc.). If you are being treated by more than three, please share the following information for each provider on a separate sheet of paper and include it with this form.

1. Provider Name _____ Mailing Address _____ Telephone No. _____
Specialty _____ City _____ State _____ Zip _____ Fax No. _____
Date of first visit for this condition (mm/dd/yy) _____ Date of next visit for this condition (mm/dd/yy) _____
2. Provider Name _____ Mailing Address _____ Telephone No. _____
Specialty _____ City _____ State _____ Zip _____ Fax No. _____
Date of first visit for this condition (mm/dd/yy) _____ Date of next visit for this condition (mm/dd/yy) _____
3. Provider Name _____ Mailing Address _____ Telephone No. _____
Specialty _____ City _____ State _____ Zip _____ Fax No. _____
Date of first visit for this condition (mm/dd/yy) _____ Date of next visit for this condition (mm/dd/yy) _____

Please list any hospital visits/admissions you have had in the last 12 months. If you have had more than two, provide the following information for each visit/admission on a separate sheet of paper and include it with this form.

1. Hospital/Facility Name _____ Address _____ Date of Visit/Admission (mm/dd/yy) _____
Procedure _____ City _____ State _____ Zip _____ Date of Discharge (mm/dd/yy) _____
2. Hospital/Facility Name _____ Address _____ Date of Visit/Admission (mm/dd/yy) _____
Procedure _____ City _____ State _____ Zip _____ Date of Discharge (mm/dd/yy) _____



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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI) _____ Date of Birth (mm/dd/yy) _____

E. Information About Other Disability Income. This information is important to ensure the accuracy of your disability benefit calculation.

You may be receiving income from other sources that could reduce your benefit from Unum. Please indicate what other income benefits you may be eligible to receive or are receiving as a result of your disability and complete the information requested.

Other Source of Income	May Be Eligible to Receive	Receiving
State Disability Plan (CA, HI, NJ, NY, PR, RI)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Workers' Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Motor Vehicle 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
Third Party Settlement/Income	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Social Security/Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Social Security/Family	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Social Security/Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pension/Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pension/Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Canada Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Public Employee Retirement System	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
State Teachers Retirement System	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Other Short Term Disability Coverage Yes No If yes, please list the insurance company name.

F. Information About Your Return-to-Work

Have you returned to work? Yes No If yes, indicate date below.

Part Time (mm/dd/yy): _____ Full Time (mm/dd/yy): _____ Hours per week: _____

If you have not returned to work, when do you expect to return?

Part Time (mm/dd/yy): _____ Full Time (mm/dd/yy): _____ Unknown

G. Information About Income Tax Withholding. The following information will ensure your benefit is taxed appropriately according to Federal and State regulations.

TAX INFORMATION

If you do not know if you are covered under a fully-insured or self-funded plan, please contact your employer for assistance.

- **For Fully-Insured Plans** – If your request for benefits is approved, should Unum withhold Federal and/or State Income Taxes from your benefit checks?
Federal Income Tax: Yes No If yes, how much should be withheld from each check? (whole dollar amount) \$ _____
 Minimum Withholding: \$20/week for Short Term Disability and \$88/month for Long Term Disability.
State Income Tax: Yes No If yes, how much should be withheld from each check? (whole dollar amount) \$ _____
- **For Self-Funded Plans** – Attach a copy of your completed W-4 for accurate calculation of Federal and State income taxes. **Note:** If not provided, we are required by law to withhold 25% of your benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.



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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI)														Date of Birth (mm/dd/yy)				

Fraud Warning: For your protection, Arizona law requires the following to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:

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.

H. Signature of Employee/Individual

I have read and understand the fraud notices listed on page 2 of this form. I also acknowledge that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

X

Signature

Date

Reminder: Please sign and date the Authorization (last page of this claim form).



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You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your claim, we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of my claim(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health and financial information relating to my claim with the family members, friends, and/or other third parties listed below:

My Spouse: _____
(Name)

Other Family Member: _____
(Name / Relationship)

Other person: _____
(Name / Relationship)

I authorize Unum to leave messages about my claim on my voicemail / answering machine.
 Yes No

I understand that information about my claim may include information about my health and that such information about my health may be related 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 do not wish the following information about my claim to be shared (leave blank if not applicable):

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.

I may revoke this authorization in writing at any time except to the extent Unum or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of my claim. I may request a copy of the Authorization and a copy shall be as valid as the original.

Employee/Individual Signature Date

Printed Name Social Security Number

I signed on behalf of the employee/individual as _____ (indicate relationship). If Power of Attorney Designee, Personal Representative, Guardian, or Conservator, please attach a copy of the document granting authority.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.



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EMPLOYER STATEMENT - To be completed by the Employer (PLEASE PRINT)

A. Information About the Employer

Employer Name: D I O C E S E O F D A L L A S
Employer's Telephone Number: 2 1 4 3 7 9 2 8 0 2
Employer Address: 3 7 2 5 B L A C K B U R N
City: D A L L A S State: T X Zip: 7 5 2 1 9 - 4 4 0 4

B. Information About the Employee

Employee/Individual's Name (Last Name, Suffix, First Name, MI)
Employee/Individual's Address
City State Zip
Employee/Individual Telephone Number Social Security Number Date of Hire (mm/dd/yy)
Date Last Worked (mm/dd/yy) Number of hours worked on date last worked

If this is a Section 125/Cafeteria plan, indicate which option of coverage this employee/individual has chosen.

Previous Plan Year Current Plan Year
Date of Open Enrollment (mm/dd/yy): Option: Date of Open Enrollment (mm/dd/yy): Option:

Please check all types of coverage this employee has with Unum.
 Short Term Disability Long Term Disability Individual Disability Life Insurance Waiver of Premium Voluntary Benefits Disability
 Voluntary Benefits Cancer/Critical Illness Voluntary Benefits Accident Voluntary Benefits MedSupport

Short Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description
0134275-001	n/a	n/a	Employer Paid STD
Long Term Disability Policy Number	Division Number	Class Number	Division Description / Class Description
Life Insurance Policy Number	Division Number	Class Number	Division Description / Class Description
Voluntary Benefits Disability Policy Number	Division Number	Class Number	Division Description / Class Description
Effective Date of Short Term Disability Coverage (mm/dd/yy)	Effective Date of Long Term Disability Coverage (mm/dd/yy)	Effective Date of Individual Disability Coverage (mm/dd/yy)	

C. Information About the Employee/Individual's Occupation

Occupation Title (please attach a copy of the employee's job description)
Primary duties of the employee's occupation on date last worked:

Employee/Individual's Pre-Disability Work Status: Full-time Part-time Exempt Non-exempt Bargaining Non-bargaining

Did the employee/individual's occupational duties and/or hours change prior to his/her last day worked due to disability? Yes No If yes, please explain.

Has the employee/individual's employment been terminated? Yes No If yes, termination date (mm/dd/yy):

Has employee/individual returned to work? Yes No If yes, date (mm/dd/yy): Full Time Part Time Hours Per Week:



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EMPLOYER STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI) _____ Date of Birth (mm/dd/yy) _____

D. Information About the Employee's Salary

How was the employee/individual paid? (please check all that apply)
 Hourly Salary Overtime Bonus Commissions Other

Salary/Wage prior to date last worked: Hourly Weekly Bi-Weekly Semi-Monthly
Bonuses (per week) \$ _____ Commissions (per week) \$ _____

Employee/Individual Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability so that earnings will be calculated as defined by the policy.

401(k)/403(b) _____% Pre-tax medical and other insurance \$ _____/week Flexible spending account \$ _____/week

Date of last salary/wage increase (mm/dd/yy) _____ Work schedule at time last worked: Days/Week _____ Hours/Day _____ Hours/Week _____

Check off regular work days: Sun Mon Tues Wed Thurs Fri Sat

Date paid through (mm/dd/yy): _____ For: Salary Continuation Vacation Pay Accrued Sick pay Other Paid Time Off/Sick Leave balance as of last day worked: _____

New York Disability Benefits Law or New Jersey Temporary Disability Benefits Salary Information

If this policy provides New York Disability Benefits Law or New Jersey Temporary Disability Benefits coverage, please provide the earnings for the 8 weeks prior to disability. (For Disability Benefits Law - include the week in which disability began. For Temporary Disability Benefits - include the 8 full weeks of income just prior to date disability began.)

Week Ending					Week Ending				
Mo.	Day	Yr.	No. Days Worked	Amount	Mo.	Day	Yr.	No. Days Worked	Amount
1					5				
2					6				
3					7				
4					8				

E. Information Needed for Calculation of FICA

What percent of the Short Term Disability benefit is taxable? _____%

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

What percent of the Long Term Disability benefit is taxable? _____%

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

What percent of the Individual Disability benefit is taxable? _____%

[See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percent.]

Note: We will assume the benefit is 100% taxable if this information is not provided.

Year to Date Earnings (from January 1 to the present for FICA Deductions) \$ _____



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EMPLOYER STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI) _____ Date of Birth (mm/dd/yy) _____

F. Information About Other Disability Income

Is employee/individual eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	When do benefits begin? (mm/dd/yy)	When do benefits end? (mm/dd/yy)
Salary Continuation	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
State Disability Plan (CA, HI, NJ, NY, PR, RI)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Other Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Social Security Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
Public Employee Retirement System	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		
State Teachers Retirement System	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>		

Is the claim the result of a work related injury or sickness? Yes No If yes, has a Workers' Compensation claim been filed? Yes No

If yes, name of Workers' Compensation carrier _____ Telephone Number _____

Address of Carrier _____ Fax Number _____

City _____ State _____ Zip _____

If a Workers' Compensation claim has been denied, please submit a copy of denial with this claim.

G. Information About Your Pension Plan. This information is necessary to ensure your benefit is calculated accurately. (Do not complete for a maternity claim).

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/individual eligible for your pension plan? Yes No
 If eligible, does the employee/individual participate? Yes No What % does employee/individual contribute? _____ %

H. Information About Your Rehire or Return-to-Work Program

If the employee/individual is released to return-to-work in restricted duty, are you willing to discuss accommodations? Yes No

If yes, who should we should contact to discuss a return-to-work plan?

Name _____

Title _____

Telephone Number _____

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 portions of the claim form.

I. Signature of Benefit Administrator (Please Print)

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form
Jay Salem

Title of Person Completing Form
Director of Human Resources

Telephone Number 214.379.2802 Fax Number 214.379.3224 Employer Tax ID Number 75-0800637

E-mail Address
jrsalem@cathdal.org

Signature **X** _____ Date Signed _____



DISABILITY CLAIM FORM

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
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT

Name of Patient (Last Name, Suffix, First Name, MI) Social Security Number

Date of Birth (mm/dd/yy) Home Telephone Number Employer Telephone Number

Employer Name

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete, sign and date this statement. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete Section A. 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, please complete the signature block at the bottom of this form.

A. Complete this section for normal pregnancy, then go to section C

Expected Delivery Date (mm/dd/yy):	Actual Delivery Date (mm/dd/yy):	Delivery Type: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	Date of first visit for this pregnancy (mm/dd/yy):	Date Hospitalized (mm/dd/yy):
Did you advise your patient to stop working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, on what date (mm/dd/yy)?				
Diagnosis:	ICD9 Diagnosis Code:	Height:	Weight:	Blood Pressure: As of date (mm/dd/yy):

B. Complete this section for all conditions except normal pregnancy

Patient Information

Height:	Weight:	Date of first visit for this current condition(s) (mm/dd/yy):	Did you advise your patient to stop working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, on what date (mm/dd/yy)?
Has the patient been treated for the same/similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, please provide treatment dates (mm/dd/yy): From _____ Through _____			
Is the patient's condition due to injury or sickness involving the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

Diagnosis

What is the primary diagnosis preventing the patient from working?

Please include primary ICD-9 or DSM IV Multi-Axial diagnoses codes	ICD9:
DSMIV: I	II
III	IV
V	

What other conditions prevent the patient from working? NA

Secondary ICD-9s:	Diagnosis:
Secondary ICD-9s:	Diagnosis:

Are there any cognitive deficits or psychiatric conditions that impact function? Yes No
If yes, please provide restrictions and limitations:

Date of last examination (mm/dd/yy): Date of next examination (mm/dd/yy):

What symptoms is your patient reporting about his/her condition?

What diagnostic or clinical findings support your diagnosis?

What diagnostic or clinical findings support your patient's work restrictions and limitations?



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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name (Last Name, First Name, MI, Suffix) Date of Birth (mm/dd/yy)
[Grid for name and date of birth]

Return to Work Assessment
Have you advised the patient to return to work? Yes No If yes, expected return to work date (mm/dd/yy): Full Time Part Time Hours per day

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.

CURRENT RESTRICTIONS (activities patient should not do)

CURRENT LIMITATIONS (activities patient cannot do)

Do you support your patient's return to work within the restrictions and limitations you provided? Yes No If yes, as of (mm/dd/yy):
If no, when do you expect improvement in the patient's functional capacity?

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 Attending Physician portions of the claim form.

C. Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, First Name, MI, Suffix) Please Print

Medical Specialty Degree

Address

City State Zip

Telephone Number Fax Number Physician's Tax ID Number:

Are you related to this patient? Yes No
If yes, what is the relationship?

Signature of Physician **Date**
X



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EMPLOYEE/INDIVIDUAL AUTHORIZATION – FOR EMPLOYEE TO COMPLETE

Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Authorization

I authorize health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group, Inc., GENEX Services, Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

To disclose information, whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits;

To the following persons: Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies ("Unum"), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims, including assistance with return to work. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

Insured's Signature

Date Signed

Printed Name

Social Security Number

I signed on behalf of the Insured as _____ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

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CL-1008-AUTH (04/10)