GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158

Toll-free: 1-800-445-0402 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

During this difficult time, we are committed to providing responsive, compassionate service.

INSTRUCTIONS

Who is responsible for completing this form?

This claim form consists of the following sections to be completed by the person indicated:

- **Employer Statement (pages 4-5):** This section of the form should be completed by the employer who should fax it to 1-800-447-2498 or mail it to the address noted above. The employer should also provide the original enrollment form and any other enrollment forms indicating any change in coverage.
- **Employee Statement for Accidental Dismemberment (pages 6-7):** This section of the form should be completed by the employee who should fax it to 1-800-447-2498 or mail it to the address noted above.
- **Attending Physician Statement (pages 8-9):** The employee should complete Part I of this section of the claim form and give it to the physician primarily responsible for the injured person's care to complete Part II. The completed form should be faxed to 1-800-447-2498 or mailed to the address noted above.
- **Substitute W-9 Form (page 10):** This form should be completed, signed and dated by the beneficiary. If there are multiple beneficiaries, each beneficiary should complete, sign and date a form. The completed form(s) should be faxed to 1-800-447-2498 or mailed to the address noted above.
- **Authorization (last page):** This form should be signed and dated by the employee and faxed to 1-800-447-2498 or mailed to the address noted above.

Questions?

If you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center professionals are available from 8 a.m. to 8 p.m. Eastern Time Monday through Friday.

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

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 Alabama Residents

For your protection, Alabama law requires the following to appear on this claim form:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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.

Instructions (continued) / Claim Fraud Statements

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.

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 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.

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

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

A. Information About the Type of Claim – Please check all that apply and provide the policy and division numbers.

Type of Coverage	Type of Claim Submitted	Policy Number	Division Number
☐ Accidental Dismemberment	☐ Employee Accidental Dismemberment ☐ Dependent Accidental Dismemberment		

B. Information About the Employer

Employer Name

Employer Street Address

City | State | Zip -

Subsidiary/Affiliate/Branch Name

C. Information About the Employee – The term "employee" refers to employees, members and/or retirees.

Employee Name (Last Name, Suffix, First Name, MI)

Employee Street Address

City | State | Zip -

Date of Birth (mm/dd/yy) | Social Security Number | Original Date of Hire (mm/dd/yy) | Gender ☐ Male ☐ Female

Date Employee Entered Eligible Class (mm/dd/yy): | Termination & Rehire Dates (mm/dd/yy): Termination: Rehire: | Acquisition Date (mm/dd/yy):

If this employee is or has been known by another name(s) (such as a nickname, maiden name, etc.), please provide the name(s).

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Exempt ☐ Non-Exempt ☐ Bargaining ☐ Non-Bargaining ☐ Union ☐ Non-Union | Hours Worked Per Week: | If eligibility is not based on hours worked, please describe:

Salary/Rate of Pay: ☐ Hourly ☐ Salary Amount: $ ________________ | Job Title/Class:

Please provide the following salary verification/documentation. This information is necessary to accurately determine the amount of the life insurance benefit.

If the definition of annual earnings is:	Then provide, as stated in your policy:
W-2	A copy of the prior year W-2 and the last payroll statement for the same year.
Salary with commissions and/or bonus	• Payroll records • Documentation of commissions and/or bonuses

Last Date Physically at Work (mm/dd/yy): | Reason for Stopping Work:

Is the employee receiving any company sponsored retirement benefits? ☐ Yes ☐ No | If yes, when did the employee retire (mm/dd/yy)?

If yes, please describe the retirement benefits:

Amount of Insurance	Basic	Effective Date of Coverage (mm/dd/yy)	Supplemental	Effective Date of Coverage (mm/dd/yy)
Accidental Death and Dismemberment	$ ________________	______________________	$ ________________	______________________

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

EMPLOYER STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Changes to the Amount of Insurance	Amount of last change		Date of last change (mm/dd/yy)
Basic Accidental Death and Dismemberment	$ ________	☐ Increase ☐ Decrease	________
Supplemental Accidental Death and Dismemberment	$ ________	☐ Increase ☐ Decrease	________

Date the premium was paid through for this employee (mm/dd/yy):

D. Information About the Dependent – Please complete this section if the claim is for the dismemberment of the employee's dependent.

Dependent Name (Last Name, Suffix, First Name, MI)

Relationship to Employee
☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

Dependent Date of Birth (mm/dd/yy)

Dependent Social Security Number

Dependent Gender
☐ Male ☐ Female

Dependent Effective Date of Coverage (mm/dd/yy)

Amount of Insurance	Basic	Effective Date of Coverage (mm/dd/yy)	Supplemental	Effective Date of Coverage (mm/dd/yy)
Accidental Death and Dismemberment	$ ________	________	$ ________	________

Changes to the Amount of Dependent Insurance	Amount of last change		Date of last change (mm/dd/yy)
Basic Accidental Death and Dismemberment	$ ________	☐ Increase ☐ Decrease	________
Supplemental Accidental Death and Dismemberment	$ ________	☐ Increase ☐ Decrease	________

Date the premium was paid through for this dependent (mm/dd/yy):

Was the employee in active employment at the time of the dependent's dismemberment? ☐ Yes ☐ No

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.

E. Information About and 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

Title of Person Completing Form

Telephone Number

Fax Number

Signature
X

Date Signed

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402   Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

EMPLOYEE STATEMENT FOR ACCIDENTAL DISMEMBERMENT (PLEASE PRINT)
To be completed by the employee. Please attach copies of any police and/or emergency medical services reports.

A. Information About the Employee

Employee Name (Last Name, Suffix, First Name, MI)

Date of Birth (mm/dd/yy)

Employer Name

Employer Telephone Number

B. Information About the Injured Person

Individual Name (Last Name, Suffix, First Name, MI)

Telephone Number

Individual Social Security Number

Individual Date of Birth (mm/dd/yy)

Date of Injury (mm/dd/yy)

Date of Loss (mm/dd/yy)

Relationship to the Employee ☐ Self ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

C. Information About the Injury/Loss

Type of Loss (please check all that apply): ☐ Finger ☐ Hand ☐ Arm ☐ Foot ☐ Leg ☐ Vision ☐ Hearing ☐ Speech ☐ Paralysis

Please describe how the loss occurred. If you need more space, please continue on a separate sheet of paper and include it with this form.

D. Information About Physicians/Hospitals

Please provide the following information about all the physicians/hospitals who treated the injured person for this injury/loss. If there were more than three, please share the following information for each additional physician/hospital on a separate sheet of paper and include it with this form.

Physician/Hospital Name	Mailing Address	Telephone Number

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

EMPLOYEE STATEMENT (Continued)

Employee 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.

E. Signature

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

Language Preference: ☐ English ☐ Spanish

Print Name	Telephone Number
Signature **X**	**Date Signed**

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

ATTENDING PHYSICIAN STATEMENT FOR ACCIDENTAL DISMEMBERMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT OR EMPLOYEE

A. Information About the Patient

Name of Patient (Last Name, Suffix, First Name, MI)

Patient Social Security Number | Patient Date of Birth (mm/dd/yy) | Patient Home Telephone Number

B. Information About the Employee

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

Name of Employer | Employer Telephone Number

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: The purpose of this statement is to assist us in making a benefit determination. Please complete all applicable sections and provide copies of all supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, please complete the signature section at the end of this statement.

A. Information About the Loss

Diagnosis or Nature of Injury: | Date First Consulted for this Loss (mm/dd/yy):

Date of Accident Causing the Loss (mm/dd/yy): | In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

If no, did illness or disease, in any way, cause or contribute to the loss? ☐ Yes ☐ No
If yes, please explain.

Please describe the accident that caused this loss.

Please list any other medical conditions for which you have treated this patient and advise the first date of treatment.

If the loss is paralysis, please indicate the neurologic level and specifically describe the associated sensory and/or motor loss.

Has the patient reached maximum medical improvement (MMI)? ☐ Yes ☐ No If no, when do you expect the patient to reach MMI?

Other Providers: Are you aware of or have you referred your patient to other treating providers? If yes, please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Telelphone #

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

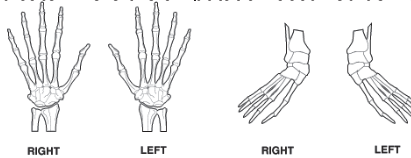
ATTENDING PHYSICIAN STATEMENT FOR ACCIDENTAL DISMEMBERMENT (Continued)

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

B. Information About the Amputation

If the loss is an extremity, where is the amputation? If applicable, please indicate if the amputation is above the wrist or ankle joint.

If the amputation is at or below the wrist or ankle, please indicate where the amputation occurred using the illustration below



Additional Comments:

C. Information About Loss of Hearing or Speech

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

If the loss is hearing, is the loss in both ears? ☐ Yes ☐ No
Is the hearing loss total and irrecoverable? ☐ Yes ☐ No (Please attach audiograms.)

D. Information About Loss of Vision

If the loss is vision, please provide the following information:

Date of first eye exam (mm/dd/yy): | Date of last eye exam (mm/dd/yy):

Visual Acuity (using Snellen Notation)

	Uncorrected	Corrected
______	O.D. ______	O.D. ______
______	O.S. ______	O.S. ______

If injury necessitated the removal of one or both eyes, please indicate the date of the surgery (mm/dd/yy):

O.D. ______ O.S. ______ Both. ______

Vision can be restored in whole or in part by: ☐ Lenses ☐ Treatment ☐ Surgery ☐ Not Restorable
If by surgery, do you recommend it? ☐ Yes ☐ No

Date corrected vision was irrecoverably reduced to 20/200 or less (mm/dd/yy):

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.

E. 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 Tax ID Number:

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

Signature of Physician
X

Date

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

Form **W-9**
Substitute
(Rev. August 2013)

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▸ ________

☐ Other (see instructions) ▸

Exemptions (see instructions):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN).

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

For further instructions, see http://www.irs.gov/pub/irs-pdf/fw9.pdf

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. **For further instructions, see http://www.irs.gov/pub/irs-pdf/fw9.pdf**

Sign Here **Signature of U.S. person** ▸ **Date** ▸

Please return this substitute W-9 form as soon as possible to the address below; otherwise the IRS may require us to withhold taxes from the interest we pay you to ensure that the tax will be collected. For more information on withholdings, please refer to the IRS website at http://www.irs.gov.

Return address:
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

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

Authorization – Accelerated Benefit or Dismemberment Claim

I authorize the following persons: health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies, and all other medical or medically related providers, facilities or services, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, professional licensing bodies, law enforcement agencies, consumer reporting agencies, 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 or my dependent insured's 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, laboratory test results and findings, toxicology results, police reports, accident reports, or incident reports of any kind, photographs, blood, urine, or other specimens, insurance claims and benefits, and all other claims and benefits of ___________________________ (print name of insured or dependent insured) ("Information"):

To 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");

So that Unum may evaluate and administer my claims. For evaluation and administration of claims, this authorization is valid for two years or the duration of my or my dependent insured's claim, whichever is shorter. I understand that once Information is disclosed to Unum, privacy protections established by HIPAA may not apply to information, but other privacy laws continue to apply. Unum may then disclose the Information only as permitted by law, including state fraud reporting laws, or as authorized by me.

I also authorize Unum to disclose Information to the following persons (for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative, or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purpose of these disclosures by Unum, this authorization is valid for one year, or for the length of time otherwise permitted by law.

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, except as specified above, Unum may not be able to evaluate my or my dependent insured's claim(s), which may lead to my or my dependent insured's 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.

______________________________	______________________________
Insured or Dependent Insured's Signature	Date Signed
______________________________	______________________________
Printed Name	Social Security Number

I signed on behalf of the Insured or Dependent Insured as ____________________(print relationship).
If Power of Attorney Designee, 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.