PORTABILITY LIFE AND/OR ACCIDENTAL DEATH 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 for Completing this Form

This claim form includes the following sections:

- **Insured Statement** – This section of the claim form should be completed by the insured person, beneficiary or next of kin who should fax it to 1-800-447-2498 or mail it to the address noted above. If death is not related to an accident, do not complete sections F through I. Please sign and date the form in section J.

  If available, the following information should also be provided:

  - A copy of the death certificate (a photocopy or fax is acceptable);
  - Copies of any police and/or emergency medical service reports, if the claim is related to an accident.

- **Authorization** – This form should be signed and dated by the insured person, beneficiary or next of kin.

Important Information About Portability Coverage

- While the Portability coverage has the same policy features as the group coverage, it is considered to be new coverage. If the insured individual/dependent individual dies within two years of the effective date of the portability coverage, it may be necessary to conduct a medical review at the time a claim is filed.
- The benefit amount may have decreased due to the age of the insured individual/dependent individual.

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.

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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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INSURED STATEMENT - To be completed by the insured person, beneficiary or next of kin. Sections F through I need to be completed only if death was the result of an accident. (PLEASE PRINT)

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

☐ Insured Life Insurance ☐ Dependent Life Insurance
☐ Insured Accidental Death ☐ Dependent Accidental Death

Policy Number______________________________________

B. Information About the Insured

Insured Name ______________________________________ ☐ Male ☐ Female

Street Address ______________________________________

City ______________________________ State ______ Zip ________

Date of Birth (mm/dd/yy) ____________________ Social Security Number ____________________

C. Information About the Dependent – Please complete this section if the claim is for the death of the insured's dependent.

Dependent Name ______________________________________ ☐ Male ☐ Female

Relationship to Insured ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child Dependent SSN ____________________

Dependent Date of Birth (mm/dd/yy) ____________________ Dependent Date of Death (mm/dd/yy) ____________________

D. Information About the Insured's Beneficiary(ies) – If the claim is for the death of the insured, please complete this section. If there are more than five, please provide the following information for each additional beneficiary on a separate sheet of paper and include it with this form.

1. Name: ______________________________________

   Street: ______________________________________

   City: ______________________________ State: ______ Zip: __________

   Telephone: ____________________ Email address: __________________________

   Relationship: ____________________ Social Security Number: __________________ Date of Birth: ________

2. Name: ______________________________________

   Street: ______________________________________

   City: ______________________________ State: ______ Zip: __________

   Telephone: ____________________ Email address: __________________________

   Relationship: ____________________ Social Security Number: __________________ Date of Birth: ________

3. Name: ______________________________________

   Street: ______________________________________

   City: ______________________________ State: ______ Zip: __________

   Telephone: ____________________ Email address: __________________________

   Relationship: ____________________ Social Security Number: __________________ Date of Birth: ________

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INSURED STATEMENT (Continued)

Insured Name	Date of Birth (mm/dd/yy)

E. Information About Minor Beneficiary – If any of the above beneficiaries are minor children, please complete this section. If there is more than one, please provide the following information for each additional minor beneficiary on a separate sheet of paper and include it with this form.

Name of Minor Child: ______________________________

Adult Representative of Minor Child: ______________ Relationship to Child: ______________

Mailing Address: ______________________________

City: ______________ State: ________ Zip: ________

Telephone: ______________ Email Address: ______________

F. Information About the Accident

Date of the accident (mm/dd/yy):	Time of the accident:

Address where the accident occurred?

Describe how the accident happened:

G. Information About the Investigating Authorities – Please complete this section only if the claim is related to an accidental death.

Names of Public Agencies (Fire Dept., Police Dept. EMS, etc.)	Telephone Number
Other: Name/Title	Telephone Number
Other: Name/Title	Telephone Number

H. Information About Physicians/Hospitals – Please complete this section only if the claim is related to an accidental death.

Please provide the following information about all the physicians/hospitals who attended the deceased for injuries sustained in this accident. If there were more than two, please provide 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

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INSURED STATEMENT (Continued)

Insured Name ______________________ Date of Birth (mm/dd/yy) ______________

I. The Accidental Death policy may provide an education benefit.

Does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled full time in an institution of higher learning beyond the 12th grade? ☐ Yes ☐ No If yes, please provide the following information for each child:

1. Name:______________________ Date of Birth (mm/dd/yy) ______________

   Mailing Address:______________________

   Social Security Number:______________ Telephone Number:______________

2. Name:______________________ Date of Birth (mm/dd/yy) ______________

   Mailing Address:______________________

   Social Security Number:______________ Telephone Number:______________

3. Name:______________________ Date of Birth (mm/dd/yy) ______________

   Mailing Address:______________________

   Social Security Number:______________ Telephone Number:______________

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.

J. Signature

I have read and understand the fraud notices listed above and on pages 2 and 3 of this form. The above statements are true and complete to the best of my knowledge and belief.

Print Name ______________________ Telephone Number ______________

Signature X ______________________ **Date Signed** ______________

Email:______________________

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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 – Life or Accidental Death 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, medical examiner's offices, coroner's offices, 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 the deceased'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, death, earnings, financial or credit history, professional licenses, employment history, autopsy reports and findings, 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 deceased) ("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 the claim(s). For such evaluation and administration of claims, this authorization is valid for two years, or the duration of the claim, whichever is shorter. I understand that once Information is disclosed to Unum, privacy protections established by HIPAA may not apply to the 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, 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.

Signature of Beneficiary or Personal Representative	Date Signed
Printed Name	Deceased's Social Security Number

I signed on behalf of the Beneficiary or Personal Representative as ______________________(print relationship). If Guardian, Conservator, or court-appointed guardian of the minor's property/estate for a Minor Beneficiary, please attach a copy of the document granting authority.

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