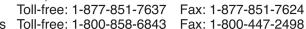


DISABILITY CLAIM FORM

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



Pacific Time Zone 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).

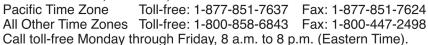


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PART I: TO BE COMPLETED BY PATIENT Name of Patient (Last Name, Suffix, First Name, MI) Social Security Number																																	
Name of Patient (Las	st Name	, Suffix,	First	Name	e, MII) T	Т	$\overline{}$	\top	$\overline{}$	\top			_		Т	Т	\neg]	S	OCI	ai Se T	ecu T	rity	Nu	mbe T	er	1 F	\neg			
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Date of Birth (mm/do	l/yy) □ □ □		Ho	me T	eleph	one	Nun	nber T		ı —					l	E	Ξmp	oloye T	r Tel	eph □ Γ	one	· Νι	ımbe	er		_			_	\neg			
Employer Name										_						_				_				_				_					
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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 Da												/erv	Туре	· D	ate c	of fi	irst	visit	for th	nis r	orea	nar	ncv		Da	te l	Hosi	nita	lize	d (n	nm/d	d/yy).
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Did you advise your	patient t	o stop v	workin	g? [☐ Yes	s [No	If y	es, c	on v	vhat	date	e (mr	n/dd	/yy)?)																	
Diagnosis:			ICD9	Diagr	nosis	Cod	le:			ŀ	Heig	ıht:		V	/eigh	ıt:							Blo	od	l Pre	essi	ure:						
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B. Complete this se		or all co	onditio	ons e	хсер	t no	rmal	pre	gnaı	псу																							
Patient Information	1			1																													
Height:	beight: Weight: Date of first visit for this current condition(s) (mm/dd/yy): Did you advise your patient to stop working? If yes, on what date (mm/dd/yy)?																																
Has the patient beer	as the patient been treated for the same/similar condition in the past?																																
If yes, please provide	e treatm	ent date	es (mn	n/dd/y	/y):	Fror	n								Thr	ou	gh																
Is the patient's condi	tion due	to injur	y or si	ickne	ss inv	/olvii	ng th	e pa	tient	's e	mpl	oym	ent?		Yes		No		Unk	now	/n												
Diagnosis																																	
What is the primary	diagnosi	s preve	nting t	the pa	atient	fron	n woi	rking	?																								
Please include prima	ary ICD-9	or DS	MIV	∕lulti-	Axial	diag	nose	s co	des	IC	D9:																						
DSMIV: I			П							III								IV								٧							
What other condition	s prever	nt the p	atient	from	worki	ng?		NA																									
Secondary ICD-9	s:					ı	Diagi	nosis	s:																								
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Are there any cognit If yes, please provide						ons 1	that i	mpa	ct fu	ncti	ion?		Yes		No																		
Date of last examina	tion (mn	n/dd/yy)	:							Da	ate (of ne	ext ex	amii	natio	n (ı	mm	/dd/	/y):														
What symptoms is y	our patie	ent repo	rting a	about	his/h	er co	ondit	ion?																									
What diagnostic or c	linical fir	ndings s	suppor	t you	r diag	gnos	is?																										
What diagnostic or c	linical fir	ndings s	suppor	t you	r pati	ent's	wor	k res	strict	ions	s an	d lim	nitatio	ns?																			



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Pacific Time Zone Toll-free: 1-877-851-76





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Return to Work Assessment	ATTENDING PHYSICIAN STATEMENT (Continu	ıed)														
Have you advised the patient to return to work?	Patient's Name (Last Name, First Name, MI, Suffix)									Di	ate of	Birt	th (mi	n/dd/y	y)	
Have you advised the patient to return to work?																
If yes, please indicate any ongoing restrictions and limitations in the space provided below. In o, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below. CURRENT FIESTRICTIONS (activities patient should not do) CURRENT FIESTRICTIONS (activities patient cannot do) COURTENT FIESTRICTIONS (activities patient cannot do) COURTENT LIMITATIONS (activities patient cannot do) If yes, as of (mm/dd/yy): If yes, what is the relationship patient cannot do) COURTENT LIMITATIONS (activities patient cannot do) If yes, as of (mm/dd/yy): If yes, as of (mm/dd/yy):	Return to Work Assessment										•	_				
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?	Have you advised the patient to return to work? $\ \square$ Yes $\ \square$ N	o If yes, expecte	ed return to	work da	ate (n	nm/dd/	/yy):	□ Ful	II Ti	me	□ Pa	art T	ïme	Hour	s per	day
Do you support your patient's return to work within the restrictions and limitations you provided?	If yes, please indicate any ongoing restrictions and limitations in If no, please indicate the restrictions and limitations that preven	the space provic t the patient from	ded below. returning t	o work ir	the	space	provio	ded be	elow	·.						
Do you support your patient's return to work within the restrictions and limitations you provided?	CURRENT RESTRICTIONS (activities patient should not do)															
Do you support your patient's return to work within the restrictions and limitations you provided?																
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?	CURRENT LIMITATIONS (activities patient cannot do)															
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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	If no, when do you expect improvement in the patient's function	al capacity?														
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?	FRAUD NOTICE: Any person who knowing information is subject to criminal and civil program.	gly files a st penalties. Ti	atemer his incl	nt of c udes <i>F</i>	lain Atte	n coi ndin	ntair ıg Pl	ning nysid	fa cia	lse In p	or r orti	nis ons	lea s of	ding the	cla	im
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	C. Signature of Attending Physician															
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? Date	The above statements are true and complete to the best of my	knowledge and be	elief.													
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	Physician Name (Last Name, First Name, MI, Suffix) Please Pri	nt														
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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 MİB 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.

	<u> </u>
Insured's Signature	Date Signed
Printed Name	Social Security Number
I signed on behalf of the Insured as Attorney Designee, Guardian, or Conservator, please attach a copy	(Relationship). If Power or of the document granting authority.
Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidia	ariae

CL-1088 (02/10)