ACCIDENT CLAIM FORM



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

Phone: 1-800-635-5597 Fax: 1-800-447-2498 Monday through Friday, 8 a.m. to 8 p.m. Eastern Time Unum Life Insurance Company of America First Unum Life Insurance Company* Unum Insurance Company Provident Life and Accident Insurance Company Provident Life and Casualty Insurance Company* The Paul Revere Life Insurance Company*

For use with policies issued by the above Unum Group ["Unum"] subsidiaries.

OUR COMMITMENT TO YOU

We understand an 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 submit an Supplemental Health Accident claim to Unum.

Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for Supplemental Health Accident 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 Statement (pages 3-5): Please complete this section of the claim form and fax the completed form to 1-800-447-2498. 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 in case the pages become separated.
- Authorization to Share Information with Third Parties (page 6): 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 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- Attending Physician Statement (page 7): Please give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete. Your physician or treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above. Unum is not responsible for expenses associated with the completion of this form.
- Patient Authorization (last page): Please sign and date this form, provide a copy to your attending physician, and fax the completed form to 1-800-447-2498. If you prefer, it may be mailed to the address noted above. This form authorizes the release of medical and other types of information needed to evaluate your claim.

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. Eastern Time, Monday through Friday.

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* Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.



Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this claim form.

Fraud Warning: Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California: Any person who knowingly presents 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.

Colorado: 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.

District of Columbia: 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.

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

Kentucky: 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.

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

New Hampshire: 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.

New Jersey: 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, subject to criminal prosecution and civil penalties.

New York: 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 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.

Pennsylvania: 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.

Puerto Rico: 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 (5,000) dollars and not more than ten thousand (10,000) dollars, 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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ACCIDENT CLAIM FORM The Benefits Center

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EMPLOYEE/PATIENT STATEMENT (PLEASE PRINT)

A. Information About the Employee			
Last Name		Suffix First Name MI	1
Date of Birth (mm/dd/yy) Social Sec	curity Number	Gender Accident Policy Number	
Home Address		□ Female	
			٦
City		State Zip	_
Preferred Telephone Number	Preferred E-mail Address		
Employer Name			
			٦
Language Preference	h		
Please check all types of coverage you have w	vith Unum. 🛛 Disability 🗆 Life Insurance	ce ☐ Critical Illness Insurance ☐ Hospital	
		icies you may have with Unum, this information will help us identify any oth ovide the requested information may delay claim initiation under the addition	
B. Information About the Patient (if different	t from Employee)		
Last Name		Suffix First Name MI	í
Date of Birth (mm/dd/yy) Social Sec	curity Number	Gender Relationship to Insured/Policyholder (check one)	_
		Male Spouse/Domestic Partner	
		Female Dependent Child	
If claim is for a child, please state your relations	ship to the child		
C. Information About Your Condition			
Date of Accident Time	e of Accident	□ a.m. □ p.m.	
Please explain how your accident happened	<u>d.</u> (If you need more space, please attac	ach a separate sheet of paper).	

Were you at work at the time of your accident? Yes No
If yes, have you received Workers' Compensation benefits for your occupational injury? Yes No
Is your claim pending a Workers' Compensation decision? Yes No
Did accident occur while playing an organized sport with required registration and referee/official was present? Yes No
While confined did you incur expenses for child care or pet boarding? Have you stopped working? Yes No
If yes, what was the last day that you worked? (mm/dd/yy)_____ Was this a motor vehicle accident? Yes No
(If yes, please attach traffic/police report)

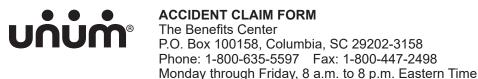
ACCIDENT CLAIM FORM UNUM® The Benefits Center P.O. Box 100158, Columbia, SC 29202-3158 Phone: 1-800-635-5597 Fax: 1-800-447-2498 Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

Employee's Last Name								Employee's First Name and MI										Date of Birth (mm/dd/yy)										
Patient's Last Name						Pat	Patient's First Name and MI								Date of Birth (mm/dd/yy)													
D. Information abo	ut you	ur Pe	ersor	nal S	Safet	ty Be	enefit	t. Co	mple	te this s	ection	for F	Persor	nal Sa	afety	Benefit	Cla	ims,	the	n go	to se	ctior	H.					
Please check the co certificate of covera	vered ge or p	certi	ficatio	on pi letai	rogra ls.	am fo	or whi	ch yo	ou are	e filing tl	nis cla	im. P	lease	Note	: Not	all cert	ficat	tions	s are	COV	ered o	n all p	olicie	es, c	onsı	ilt you	r	
Defensive driving	cours	se or	a driv	ver e	educa	ation	cour	se fo	rap	ersonal	autom	obile																
CPR certification																												
□ First Aid certifica	tion																											
□ Swim lessons wi	th a de	fined	d curr	iculu	um a	nd o	verse	en b	y an	individu	al cert	ified t	o act	in tha	it cap	acity												
□ Self-defense cou	rse wit	th a c	define	ed cu	urricu	ulum	overs	seen	by a	n individ	ual ce	ertified	d to ad	ct in th	hat ca	apacity												
Self-defense couState or federally									,	n individ	ual ce	ertified	d to ad	ct in th	hat ca	apacity												
□ State or federally	appro	oved	Recr						,	n individ	ual ce	ertified	d to ac	ct in th	hat ca	apacity												
 Self-defense cou State or federally Date of certification E. Information Abo 	appro (mm/d	oved d/yy	Recro yy):	eatio	onal	Safe			,	n individ	ual ce	ertified	d to ad	t in th	hat ca	apacity												
 State or federally Date of certification 	appro (mm/d	oved d/yy	Recro yy):	eatio	onal	Safe			,	n individ	ual ce	ertified	d to ad	ct in th	hat ca	apacity												
 State or federally Date of certification 	appro (mm/d	oved d/yy	Recro yy):	eatio	onal	Safe			,	n individ	ual ce	ertified	d to ad	ct in th	hat ca	apacity												
 State or federally Date of certification 	appro (mm/d	oved d/yy	Recro yy):	eatio	onal	Safe		urses	\$	n individ		ertified	d to ad	et in th	hat ca	apacity				elept	ione N	Numb	er					
 State or federally Date of certification E. Information Abo 	appro (mm/d	oved d/yy	Recro yy):	eatio	onal	Safe		urses	\$			ertified	d to ad	et in th	hat ca	apacity			Te	eleph	ione N	Jumb	er					
 State or federally Date of certification E. Information Abo 	appro (mm/d	oved d/yy	Recro yy):	eatio	onal	Safe		urses	Mailin		ess	ertified	d to ad	t in th	hat ca	apacity			_		umbe		er					
 State or federally Date of certification E. Information Abo 	appro (mm/de out Ph	oved d/yy	Recro yy):	eatio	onal	Safe		urses	Mailin City,	ng Addr	ess	ertified	d to ad	st in th	hat ca	apacity			F	ax N		r						

Please attach itemized copies of any bills related to this accident including doctor, emergency room, hospital, and motor vehicle incident/accident report. Bills should include diagnosis information (from your medical provider). Additional medical information may be requested to evaluate your claim.

G. Tax Considerations

Benefit payments under this policy could be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.



EMPLOYEE/PATIENT STATEMENT (Continued)		
Employee's Last Name	Employee's First Name and MI	Date of Birth (mm/dd/yy)
Patient's Last Name	Patient's First Name and MI	Data of Pith (mm/dd/uu)
Patient's Last Name	Patient's First Name and 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 Insured/Policyholder

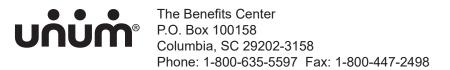
I have read and understand the fraud notices listed above and on page 2 of this form. I also understand that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. **(Your signature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

Χ

Signature

Date

I signed on behalf of the insured, as ______ (Indicate relationship). If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.



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 leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), 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 any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) with the family members, friends, and/or other third parties listed below:

My Spouse:

(Name)

Other Family Member:

(Name / Relationship)

Other person: _

(Name / Relationship)

(Telephone Number)

(Telephone Number)

(Telephone Number)

I understand that information about my claim(s) and/or leave(s) 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.

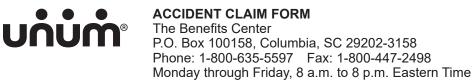
I do not wish the following information about my claim(s) and/or leave(s) to be shared (leave blank if not applicable):

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.

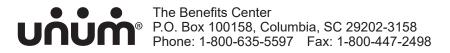
This authorization is valid for the shorter of two (2) years or the duration of any of my claim(s) and/ or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

Patient Signature	Date
Printed Name	Social Security Number
I signed on behalf of the claimant as Power of Attorney Designee, Personal Representative, copy of the document granting authority.	(indicate relationship). If Guardian, or Conservator, please attach a
Unum is a registered trademark and marketing brand of Unum Group	and its insuring subsidiaries.



ATTENDING PHYSICIAN STATEMENT	Г															
Employee's Last Name	Employe	ee's F	irst Nar	ne ar	nd MI			Date	Date of Birth (mm/dd/yy)							
Patient's Last Name		Patient's	s First	Name	and N	AI .	1 1		Date	of Bi	th (m	m/dd	/уу)			
ACCIDENT DETAILS																
Is this condition the result of an accidental injury? Is this condition the result of his/her employment Please verify treatment for the accident listed above		Jnknown		,	nm/do	d/yy)										
Primary Diagnosis (ICD):			Prima	ary Diag	gnosis	s Desci	ription:									
Secondary Diagnosis Code (ICD):			Seco	ndary D	Diagn	osis De	escriptior	1:								
First Office Visit Date (mm/dd/yy):			Last	Office ∖	/isit D	ate (m	m/dd/yy)	:								
Next Office Visit Date (mm/dd/yy):							as a res ates belo	ult of this	acciden	t? E] Yes		No _			
Hospital Admission Date (mm/dd/yy):			Hosp	ital Dis	charg	e Date	: (mm/do	l/yy):								
Hospital Facility Name:																
Hospital Facility City:			Hosp	ital Fac	ility S	state: _										
Was surgery performed? ☐ Yes ☐ No			Surge	ery Date	e (mn	n/dd/yy):									
Surgery/Procedure Description:																
Was the patient referred to Physical/Speech/Occup	pational/Acupuncture/A	Alternativ	ve The	erapy?	ΠY	′es □	No									
If yes, please provide the therapy facility patient wa	as referred to or presc	ribed the	erapy f	frequen	cy on	the lin	e provide	ed below.								
Was the patient referred to Behavioral Health thera	apy? □ Yes □ No															
Was the patient treated in the Emergency Room re	elated to the accidenta	al injury?	ΠY	∕es □	No											
Date of Emergency Room Treatment (mm/dd/yy):																
Did you advise the patient to stop working?	es □ No If y	/es, as of	f what	date? ((mm/o	dd/yy)]					
						,]					
Have you advised the patient to return to work?	⊐Yes □No Ify	ves, as of	f what	date? (mm/c	ld/yy)										
FRAUD NOTICE: Any person who kn subject to criminal and civil penalties.											nfori	nat	ion	is		
Attending Physician's Information																
The above statements are true and complete to	-	vledge a	nd be	elief.												
Physician Name (Last Name, Suffix, First Name, M	1I) Please Print															
Medical Specialty			Degree													
Address																
City						Sta	te	Zip								
Telephone Number	Fax Number						Physic	ian's Tax I	ID Numb	er						
Are you related to this patient? Yes No	If yes, what is the relat	itionship?	?				1									
X		-														
Physician Signature							Dat	e								

7



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 to Collect and Disclose Information (Not for FMLA Requests)

I authorize the following persons: 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, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocator Group, Brown & Brown Absence Services Group and other Social Security advocacy vendors, 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, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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 ("My Information");

To Unum Group and its subsidiaries, Unum Life Insurance Company of America, First Unum Life Insurance Company*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty 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, including providing assistance with return to work. For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits (to include any subsequent financial management and/or benefit recovery review), whichever is shorter. I understand that once My Information is disclosed to Unum, any privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum may then disclose My Information only as permitted by law, including, state fraud reporting laws or as authorized by me.

I also authorize Unum to disclose My 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; or, the Social Security Administration. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purposes of these disclosures by Unum, this authorization is valid for one year or for the length of time otherwise permitted by law.

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 or administer 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 Unum requests or discloses prior to Unum receiving my revocation request.

Patient's Signature

Date Signed

Printed Name

I signed on behalf of the Insured as Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Social Security Number

(Relationship). If Power of Attorney

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CL-1023-AUTH (10/22)