**EDUCATOR 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. (all time zones).

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.

**When should you use this claim form?**

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

- Educator Select Income Protection Plan
- Educator Select Short Term Income Protection Plan
- If you have any of the following additional coverages, we may need to contact you or your employer for additional information.

  Short Term Disability • Long Term Disability • Individual Disability • Life Insurance Waiver of Premium • 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. Incomplete or illegible answers may result in a delay of benefit consideration. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- **Attending Physician Statement (page 3):** Please ask the physician or treating provider primarily responsible for your care to complete this statement. Your physician or treating provider should mail or fax the completed form to the address or fax number indicated above. Unum is not responsible for expenses associated with the completion of this form.
- **Employee Statement (pages 4-5):** Please complete this section of the claim form and mail or fax the completed form to the address or fax number indicated above.
- **Direct Deposit Request (page 6):** If your disability is expected to last more than 8 weeks, please complete this form if you wish to have your benefits deposited directly into your bank account.
- **Employer Statement (page 7):** Please ask your employer to complete this section of the claim form and to mail or fax the completed form to the address or fax number indicated above.
- **Employee Authorization:** Please sign and date this form and provide a copy to your attending physician and mail or fax the completed form to the address or fax number indicated above. This form authorizes the release of medical 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. Monday through Friday.

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## CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others 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.

**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 the District of Columbia, Maine, Tennessee and Virginia Residents**

For your protection, the District of Columbia, Maine, Tennessee and Virginia law requires the following to appear on this claim form:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**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 insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents**

For your protection, New Jersey, New Mexico and 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 Statement 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 Statement 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 (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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## A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

| Name of Patient | Home Telephone Number | Date of Birth | Social Security Number |
|---|---|---|---|
| | | | |

**Instructions:** If this claim is related to normal pregnancy, complete the Normal Pregnancy section. For all other claims, including complicated pregnancy, complete the All Other Conditions section. **In all situations, you must complete the signature block at the bottom of this form.**

## NORMAL PREGNANCY

Date of first visit for this pregnancy? When did symptoms first appear?

**1.** Expected Delivery Date: | If Delivered, Actual Delivery Date: | Type of Delivery ☐ Vaginal ☐ C-Section

**2.** Date First Unable to Work | Dates Hospitalized to

**3.** Has patient been released to work in her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No
If not, when should the patient be able to return to work? Full Time Part Time

## ALL OTHER CONDITIONS

**1. Diagnosis** - Please include the primary diagnosis and list any secondary conditions.

Diagnosis (including any complications) include **ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number**

**2.** Date First Unable to Work | Dates Hospitalized to

**3.** Has patient been released to work in his/her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No
If not, when should the patient be able to return to work? Full Time Part Time

**4.** Is this disability related to the patient's employment? ☐ Yes ☐ No ☐ Unknown

**5.** Has patient ever had the same or a similar condition? ☐ Yes ☐ No If yes, when?

**6.** Date of first visit for this illness or injury – When did symptoms first appear or accident happen?

| **7.** Nature of treatment (including surgery and medications prescribed) | Name of Surgical Procedure | Date of Surgery |
|---|---|---|
| | | |

**8.** If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

**RESTRICTIONS** (What the patient should not do)

**LIMITATIONS** (What the patient cannot do)

Date restrictions and limitations began.

**9.** Referring physician or other treating physicians (names, addresses, telephone numbers):

**Please include copies of all applicable office notes and test results.**

**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 and Attending Physician portions of the claim form.**

| Print or Type Name | | Degree | Medical Specialty |
|---|---|---|---|
| Street Address | | | Telephone Number |
| City | State | ZIP Code | Fax |
| Signature of Physician | | | Date |

SSN or Employer's ID Number: | Are you, the physician, related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

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## B. EMPLOYEE'S STATEMENT (PLEASE PRINT)

**1.** Claimant's Name (as printed on your Social Security Card) | Home Telephone Number | Cell Telephone Number | Date of Birth | Social Security Number | ☐ Male ☐ Female | Height | Weight

Home Address (Street, City, State, ZIP)

The state in which you work | Preferred e-mail address where you can be reached

Language Preference: ☐ English ☐ Spanish ☐ Other _____

**2.** Employer Name | Policy Number

**3.** Occupation | **4.** List the duties of your occupation at the time of your disability (grade taught, etc.)

**5.** How does your injury or sickness impede your ability to do your occupational duties?

**6.** Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | If you are married, spouse's name | Spouse's Date of Birth | Is spouse employed? ☐ Yes ☐ No

**7.** Is this disability due to ☐ Motor Vehicle Accident ☐ Other Accident ☐ Sickness ☐ Work-related Injury/Sickness ☐ Pregnancy

For any accident related claim, describe the injury (what, how, where, when). | For Pregnancy, date of pregnancy test?

**8.** Date you first noted symptoms of your disability. _____

**9.** You have been unable to work because of this disability since what date? _____

**10.** Have you returned to work? If yes, when?
Part Time: _____
Full Time: _____

**11.** If you have not returned to work, when do you expect to return?
Part Time: _____ Full Time: _____

**12.** Number of Hours Worked on Date Last Worked

**13.** Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.

**If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.**

Have you filed for Sabbatical Leave? ☐ Yes ☐ No
Do you intend to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
Date Payment Began: _____
Payment Amount $ _____ wk/month

If you work in the state of Louisiana, have you filed for LA 90-day Extended Sick Leave? ☐ Yes ☐ No
If no, do you intend to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
If approved: Date Payment Began: _____
Payment Amount $ _____ month

Other Leave: ☐ Yes ☐ No What Type? Payment Amount $ _____ wk/month

| | If yes | | | | Date Benefits | |
|---|---|---|---|---|---|---|
| | Yes | No | | WEEKLY / MONTHLY | Begin Date | Through Date |
| Social Security Retirement | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| Social Security Disability | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| State Disability | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| Teacher's Retirement - Disability | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| Teacher's Retirement | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| Public Employee Retirement | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| Public Employee Disability | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| Pension/Disability | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |
| Unemployment | ☐ | ☐ | $_____ | ☐ ☐ | _____ | _____ |

Other (Include Individual Disability or Group Disability Benefits) ☐ Yes ☐ No Payment Amount $ _____ wk/month.

**14.** Number of Regular Sick Days Accumulated _____

**15.** Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No
Do you intend filing a Workers' Compenation Claim? ☐ Yes ☐ No
If filed has it been approved? ☐ Yes ☐ No
Amount _____ Date Payment Began _____

**16a.** Have you ever been employed by any other school(s) or District(s)? ☐ Yes ☐ No

**16b.** Please list name(s) of school(s)/District(s) and years employed.

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**17.** Information about physicians and hospitals **NOTE: TO AVOID DELAY IN PROCESSING YOUR CLAIM, ADVISE YOUR DOCTOR(S) TO ATTACH COPIES OF MEDICAL RECORDS AND TEST RESULTS**

First medical attention for the current disability was given by (complete below):

| Doctor's Name | Telephone: ( ) Fax: ( ) | Specialty |
|---|---|---|
| Address (Street, City, State, Zip) | | Dates Seen to |

List all other physicians and hospitals you have seen for this condition:

| Doctor's Name | Telephone: ( ) Fax: ( ) | Specialty |
|---|---|---|
| Address (Street, City, State, Zip) | | Dates Seen to |
| Doctor's Name | Telephone: ( ) Fax: ( ) | Specialty |
| Address (Street, City, State, Zip) | | Dates Seen to |
| Doctor's Name | Telephone: ( ) Fax: ( ) | Specialty |
| Address (Street, City, State, Zip) | | Dates Seen to |

Hospital

| Address (Street, City, State, Zip) | Dates of Confinement to |
|---|---|

Have you ever had the same or a similar condition in the past?

☐ Yes ☐ No If yes, complete the following concerning your past treatment:

| Doctor's Name | Telephone: ( ) Fax: ( ) | Specialty |
|---|---|---|
| Address (Street, City, State, Zip) | | Dates Seen to |

Hospital

| Address (Street, City, State, Zip) | Dates of Confinement to |
|---|---|

List your dependent children who are under age 25 (attach additional sheets if necessary).

| Name | Date of Birth | Attending College? |
|---|---|---|
| | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No |

Information about your income tax withholding:

If your request for benefits is approved, do you want the minimum $88.00 per month withheld from your check for Federal Income Tax purposes. ☐ Yes ☐ No

If you would like more than $88.00 withheld please state the dollar amount (to the nearest dollar only) you want withheld monthly. $ _____

I have read and understand the fraud notices listed on the instruction page of this form.

The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

_____ _____

Signature Date

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## C. DIRECT DEPOSIT REQUEST

If your claim is approved, we are pleased to offer you the security and convenience of having your monthly benefit check deposited electronically to your bank account. Direct Deposit means no more mail delays or trips to the bank to cash your check.

- **How does direct deposit work?**
  Each month, our bank will transfer your benefit payment directly into your bank account. We recommend this payment option because it is predictable, safe and convenient. This is the same system enjoyed by over 15 million Social Security recipients.

- **How do I sign up?**
  Complete the below section of this form and forward to us. Be sure to print the information clearly. You may want to verify your account and transit/routing numbers with your bank to avoid delays.

- **How soon can my direct deposits begin?**
  To ensure accuracy, your Direct Deposit will begin within 30 days of our notification to your bank. This means you may still receive checks by mail after you send in your request. Once Direct Deposit processing begins, your funds will be deposited into your bank account on the second business day after the day your benefit payment is processed.

- **What if I have questions?**
  Call our Customer Service Line at 1-800-413-7671. This toll-free number is available Monday through Friday from 8:00 A.M. to 4:00 P.M. EST.

- **What happens if I am out of town when the benefit payment is due?**
  Your deposit is in your account. You may access it anytime after it is deposited.

- **What if I change banks?**
  Simply call and we will send a request form for your completion or you can provide us with the new bank information in writing. You may receive a paper check in the mail for one payment while we process your change request.

- **Can I change my mind?**
  Yes. You can start or stop Direct Deposit at any time. Just write and tell us.

- **Now what?**
  We will transfer your benefits directly to your bank every month. No more waiting for the mailman, standing in line at the bank, or remembering to send us a change of address each time you establish a temporary residence.

Social Security Number: _____

Name: _____

Address: _____

_____

Tel #: ( ) _____

I authorize Unum to deposit my Benefit payments to the bank shown here.

Signed _____ Date: _____

Name of Bank _____

City _____ State _____ Zip _____

Phone ( ) _____

Type of Account ☐ Checking ☐ Savings

Account Number _____

Transit/Routing Number* ☐☐☐☐☐☐☐☐☐

*Checking (Attach a Voided Check)

*Savings (Contact Bank/Credit Union for Transit/Routing Number)

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## D. EMPLOYER STATEMENT (PLEASE PRINT)

**To be completed by Employer**

**1.** Employer Name | Employer's Phone Number ( )

Employer Address (Street, City, State, ZIP)

Policy Numbers | Division Number

**2.** Employee's Name

Social Security Number | Date of Hire | Effective Date of LTD Insurance | Employee's Work Schedule at Time Last Worked _____Days per week _____Hours per day

Average monthly earnings in effect at last annual enrollment date $_____
Please refer to your contract for your earnings definition.
Has the employee's employment been terminated? ☐ Yes ☐ No If yes, please provide termination date

Please advise the following benefit selections applicable to this employee. Elimination Period _____ EE Benefit Election _____ Benefit Duration _____

Does the employee have the following types of coverage? Life Insurance ☐ Yes ☐ No Voluntary Benefits Disability ☐ Yes ☐ No

**3.** Has employee returned to work? ☐ Yes ☐ No If yes, date ☐ Full Time ☐ Part Time Hours Per Week

**4.** Job Title/Major Job Duties
Is the Employee also a Coach? ☐ Yes ☐ No

**5.** Date last worked prior to claim | **6.** Number of hours worked that day

**7.** Date paid through For ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick Pay

**8.** Does this employee contribute to FICA? ☐ Yes ☐ No Medicare SSDI? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No

**9.** Are you as the employer able to accommodate the employee's restrictions and limitations, if appropriate, for an early return to work? (i.e. job modification, part time, etc.) Please elaborate.

**10.** Employee's immediate supervisor: Name_____Title_____Telephone Number_____

**11.** How was the LTD premium paid for the plan year in which the disability occurred?
☐ Pre-tax _____ % paid by Employer
☐ Post-tax _____ % paid by Employee **Please call 1-800-845-2290 for tax related questions**

**12.** Is employee eligible for:

| | Yes | No | If yes | WEEKLY | MONTHLY | Date Benefits Begin Date | Through Date |
|---|---|---|---|---|---|---|---|
| Unemployment | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| State Disability | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Teacher's Retirement System-Disability | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Teacher's Retirement | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Social Security Retirement | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Social Security Disability | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Public Employee Retirement-Disability | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Other Benefits | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Workers' Compensation | ☐ | ☐ | $_____ | ☐ | ☐ | _____ | _____ |
| Has Workers' Compensation claim been filed? | ☐ | ☐ | If Workers' Compensation Claim has been denied, please submit a copy of the denial with this claim. | | | | |

Has the employee filed for Sabbatical Leave? ☐ Yes ☐ No
Is employee eligible to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
Date Payment Began: _____

If the employee works in the state of Lousiana:
Is he/she eligible for LA Extended Sick Leave? ☐ Yes ☐ No
If yes, has he/she filed? ☐ Yes ☐ No
If no, does he/she intend to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
If approved: Date Payment Began: _____ Payment Amount $ _____ per month

Other Leave: ☐ Yes ☐ No What Type? Payment Amount $ _____ wk/month

**13.** Will (or has) the employee filed for disability benefits provided by any employer, employee, labor management, state disability or union welfare plant? ☐ Yes ☐ No If yes, Weekly Amount $_____ Date _____

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

Name of Person Completing Form

Employer's Taxpayer ID Number (EIN) or Public Employer Social Security Number. If you have neither, please explain | Telephone Number ( )

Title of Person Completing Form | E-mail Address | Fax Number ( )

Signature | Date Signed

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**EMPLOYEE AUTHORIZATION – FOR EMPLOYEE TO COMPLETE**

**NOTE:** This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

## Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; professional licensing body; and employer that has information about my health, financial or credit history, professional license, earnings, employment history, or other insurance claims and benefits, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum Group, its insurance subsidiaries* and duly authorized representatives ("Unum"), and, where applicable, to persons or entities that may assist me with or provide services related to my claim(s) for Social Security or other government-sponsored benefits. Information about my health may relate 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 understand that any information Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. 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.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____
(Employee Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

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

* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.