GROUP HOSPITAL INDEMNITY CLAIM FORM

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

Toll-free: 1-800-635-5597 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

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 a Voluntary Benefits Group Hospital Indemnity 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 Group Hospital Indemnity 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.

- **Insured/Patient Statement (pages 4-6):** 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 7):** 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.
- **Insured/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.
- **Attending Physician Statement (pages 8-9):** 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.

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.

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.

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.

Instructions (continued) / Claim Fraud Statements

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.

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INSURED/PATIENT STATEMENT (PLEASE PRINT)

A. Information About the Insured

Last Name | Suffix | First Name | MI

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

Home Address

City | State | Zip -

Home Telephone Number | Cellular Telephone Number | Work Telephone Number

Policy Number | Preferred e-mail address (for confirmation purposes only)

Language Preference ☐ English ☐ Spanish

Please check all types of coverage you have with Unum.

☐ Short Term Disability Policy #	☐ Long Term Disability Policy #	☐ Individual Disability Policy #	☐ Life Insurance Policy #
☐ Voluntary Benefits Disability Policy #	☐ Voluntary Benefits Accident Insurance Policy #	☐ Voluntary Benefits Cancer/Critical Illness Insurance Policy #	

While there is no legal requirement for you to provide information regarding other policies you may have with Unum, this information will help us identify any other coverage you have with us for which you may be eligible to file a claim. Failure to provide the requested information may delay claim initiation under the additional policy or policies.

B. Information About the Patient - Check One ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent Child

Last Name | Suffix | First Name | MI

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

Home Address

City | State | Zip -

C. Information About Your Claim

What type of benefits are you claiming?
☐ Diagnostic Testing or Procedure ☐ Outpatient Surgery ☐ Inpatient Surgery ☐ Hospital Confinement ☐ ICU Confinement ☐ Emergency Care

When were you first treated for this medical condition (mm/dd/yy)?

Have you stopped working? ☐ Yes ☐ No If yes, what was the last day you worked (mm/dd/yy)?

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INSURED/PATIENT STATEMENT (Continued)

Insured's Name (Last Name, Suffix, First Name, MI) Date of Birth (mm/dd/yy)

D. Information About Physcians and Hospitals Please provide the following information about your primary care physician and any other physician(s) treating you for this medical condition. If you are being treated by more than four, please share the following information for each physician on a separate sheet of paper and include it with this form.

1. Primary Care Physician Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | ( ) Fax No.
Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

2. Treating Physician Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | ( ) Fax No.
Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

3. Treating Physician Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | ( ) Fax No.
Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

4. Treating Physician Name | Mailing Address | ( ) Telephone No.
Specialty | City | State | Zip | ( ) Fax No.
Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

Please list any recent hospital visits/admissions. If you have had more than three recent hospital visits/admissions, please share the following information for each visit/admission on a separate sheet of paper and include it with this form.

1. Hospital | Address | Date of Visit/Admission (mm/dd/yy)
Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

2. Hospital | Address | Date of Visit/Admission (mm/dd/yy)
Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

3. Hospital | Address | Date of Visit/Admission (mm/dd/yy)
Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

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INSURED/PATIENT STATEMENT (Continued)

Insured's 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 of Insured

I have read and understand the fraud notices listed on pages 2 and 3 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.)**

X _____ _____

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.**

Reminder: Please sign and date the Authorization (last page of this claim form).

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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 claim, 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 my claim(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health and financial information relating to my claim with the family members, friends, and/or other third parties listed below:

My Spouse: _____
(Name) (Telephone Number)

Other Family Member: _____
(Name / Relationship) (Telephone Number)

Other person: _____
(Name / Relationship) (Telephone Number)

I authorize Unum to leave messages about my claim on my voicemail / answering machine.
☐ Yes ☐ No

I understand that information about my claim 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 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 my claim. I may request a copy of the Authorization and a copy shall be as valid as the original.

_____ _____
Insured/Patient Signature Date

_____ _____
Printed Name Social Security Number

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

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ATTENDING PHYSICIAN OR PROVIDER OF SERVICE STATEMENT (PLEASE PRINT)

TO BE COMPLETED BY ATTENDING PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete Section A and Section F for all claims. Please complete Section B for Emergency Care claims, Section C for Diagnostic Testing claims, Section D for Outpatient Surgery claims and Section E for Hospital Confinement claims.

Please provide copies of all test results, operative reports, pathology reports, and/or your detailed medical statement related to the service provided to the patient.

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

Insured Social Security Number

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

Patient Social Security Number

Patient Gender: ☐ Male ☐ Female

Patient Date of Birth (mm/dd/yy)

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent Child

A. Complete this section for all medical conditions

Date of injury or first symptom (mm/dd/yy)	Date patient first consulted you for this condition (mm/dd/yy)?	Diagnosis	ICD Code

Has the patient been treated for the same or a similar condition by another physician in the past? ☐ Yes ☐ No
If yes, what was the first date of treatment (mm/dd/yy)?

Other Providers: Please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To

B. Complete this section for EMERGENCY CARE claims

Was transportation provided by air ambulance? ☐ Yes ☐ No

If yes, provider name: Destination:

Was transportation provided by ground ambulance? ☐ Yes ☐ No

If yes, provider name: Destination:

Was treatment provided by a physician in an emergency room? ☐ Yes ☐ No

If yes, facility name: Location:

C. Complete this section for DIAGNOSTIC TESTING claims

Please check the tests conducted for this patient:

Test	Date Test Performed	Facility Where Performed
☐ Amniocentesis		
☐ Angiogram		
☐ Afteriogram		
☐ Athroscopy		
☐ Biopsy-Breast		
☐ Biopsy-Bone Marrow Aspiration		
☐ Biopsy-Renal		
☐ Biopsy-Respiratory		
☐ Biopsy-Cervical		
☐ Biopsy-Cone		
☐ Biopsy-Endometrial		
☐ Biopsy-Live		
☐ Biopsy-Lymphatic		
☐ Biopsy-Skin		

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ATTENDING PHYSICIAN STATEMENT (Continued)

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

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

C. Complete this section for DIAGNOSTIC TESTING claims (continued)

Please check the tests conducted for this patient:

Test	Date Test Performed	Facility Where Performed
☐ Biopsy-Thyroid		
☐ Barium enema/Lower GI series		
☐ Barium Swallow/Upper GI series		
☐ Bronchoscopy		
☐ Colonoscopy		
☐ Computed Tomography Scan (CT)		
☐ Cystoscopy		
☐ Electroencephalogram (EEG)		
☐ Esophogagastroduodenoscopy (EGD)		
☐ Excision of lesion (skin)		
☐ Hysteroscopy		
☐ Laryngoscopy		
☐ Loop Electrosurgical Excisional Procedure (LEEP)		
☐ Magnetic Resonance Imaging (MRI)		
☐ Myelogram		
☐ Nuclear Medicine Test		
☐ Positron Emission Tomography Scan (PET)		
☐ Pulmonary Function Test		
☐ Thallium Stress Test		
☐ Transesophageal Echocardiogram (TEE)		

D. Complete this section for INPATIENT/OUTPATIENT SURGERY claims

Surgery Date (mm/dd/yy)	Place of Service *(refer to Place of Service Codes below)*	Procedure Code (CPT Code)	Name/Description of Surgery	Diagnosis Code Related to the Surgery (ICD Code)	Address/Phone Number

E. Complete this section for HOSPITAL/ICU CONFINEMENT claims

Date of Admission (mm/dd/yy)	Date of Discharge (mm/dd/yy)	Place of Service *(refer to Place of Service Codes below)*	Diagnosis Code Related to the Hospital Confinement (ICD Code)	Adress/Phone Number

Place of Service Codes

11–Office
12–Home
21–Inpatient Hospital
22–Outpatient Hospital
23–Emergency Room/Hospital
24–Ambulatory Surgical Center
25–Birthing Center
26–Military Facility
31–Skilled Nursing Facility
32–Nursing Facility
33–Custodial Care Facility
34–Hospice
41–Ambulance (Land)
42–Ambulance (Air or Water)
51–Inpatient Psychiatric Facility
52–Psychiatric Facility Partial Hospitalization
53–Community mental Health Center
54–Intermediate Care Facility/Mentally Retarded
55–Residential Substance Abuse Treatment Facility
56–Psychiatric Residential Treatment Center
61–Comprehensive Inpatient Rehabilitation Facility
62–Comprehensive Outpatient Rehabilitation Facility
65–End Stage Renal Disease Treatment Facility
71–State or Local Public Health Clinic
72–Rural Health Clinic
81–Independent Laboratory
99–Other Unlisted Facility

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ATTENDING PHYSICIAN STATEMENT (Continued)

Insured's Name (Last Name, Suffix, First Name, MI) | Date of Birth (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 the Attending Physician portion of the claim form.

F. Signature of Attending Physician or Provider of Service

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?

X _____ _____

Physician Signature **Date**

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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 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 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, 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, 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, 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, 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.

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 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.

_____ _____
Insured's Signature Date Signed

_____ _____
Printed Name Social Security Number

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