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

How to File A Claim

1. Answer all questions on Parts I and II of this form for all claims. We cannot process your claim without this proof of loss information.
2. In lieu of Part II, we will accept copies of bills for service, provided the diagnosis code and procedures are noted on the bills.
3. Please read notices dealing with employer-sponsored plans of disability insurance, if applicable.
4. When all sections of this form have been completed, submit the form to the following address:
   Worcester Disability Benefits Center
   P.O. Box 15112
   Worcester, MA 01615-0112
5. If you have any questions concerning this form or your claim, call us at:
   1-888-226-7959 (Toll Free)
   1-774-437-7041 (Fax)

1622-96-WORC (8/07)

**Treatment of Injury Benefits/
Non-Disability Injury Claim Form**

		Agency
		Association
Insured	Home Telephone Number ( )	Policy Number(s)
Address	Social Security Number	Date of Birth
Date of Accident	Nature of Accident	Date Notice Received
Service Office	Broker or Agent's Name	
Broker or Agent's Telephone Number	By	Date

Forward fully completed Notice of Claim to the Company before giving claim form to insured.

1622-96-WORC (8/07)

Treatment of Injury Benefits/ Non-Disabling Injury Claim Form

Mail this form to:
Worcester Disability Benefits Center
P.O. Box 15112, Worcester, MA 01615-0112
1-888-226-7959 (Toll Free) 1-774-437-7041 (Fax)

PLEASE READ THESE STATEMENTS

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:

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:

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

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, Maine, Tennessee and Virginia Residents

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

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

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

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 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

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.

Treatment of Injury Benefits/ Non-Disabling Injury Claim Form

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Part I

Please Print All Entries

		Agency
		Association
Name of Insured	Date of Birth	Residence Telephone ( )
Home Address (Street, City, State, Zip Code)		Occupation
Name of Employer	Business Telephone ( )	Social Security #
Business Address	Annual Earned Income (Before Taxes) Last Calendar Year $	

Policy Numbers	Does your employer pay any portion of the premium?	What other disability insurance do you have? (List group and individual) Name of Company	Policy Number	Benefit
____________	Yes ☐ What Percentage? ______ % No ☐	____________	____________	$__________
____________	Yes ☐ What Percentage? ______ % No ☐	____________	____________	$__________
____________	Yes ☐ What Percentage? ______ % No ☐	____________	____________	$__________
____________	Yes ☐ What Percentage? ______ % No ☐	____________	____________	$__________

How, when and where did the accident happen?
Date of Injury ____________

Health Insurance Carrier (Name, Address and Policy Number)	If self-employed, are you personally insured for Worker's Compensation? ☐ Yes ☐ No	Is claim being made for Worker's Compensation ☐ Yes ☐ No

List all physicians or practitioners consulted in the past (5) years, including this accident.

Name	Address	Dates Consulted	Reason for Consultation

List all hospitals or institutions where confined in the past (5) years.

Name	Address	From	To	Reason Confined

FRAUD NOTICE: Any person who knowingly files a statement of claim containing any false information is subject to criminal and civil penalties.

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

_________________________ Signature of Insured

_____________ Date Signed

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Part II Please have your physician (without cost to the company) complete this portion, or attach copies of itemized bills for which you are seeking reimbursement.

Physician or Supplier Information

If itemized bills are provided in lieu of Part II, please be sure they include:
1. Provider's name, address, and phone number
2. Diagnosis
3. Date and nature of service

1. Injury - Date of Accident	2. Date first consulted you for this condition
3. Name of referring physician	4. For services related to hospitalization give hospitalization dates — Date Admitted — Date Discharged

5. Name & Address of facility where services rendered

6. Diagnosis or nature of accidental injury requiring services or supplies (relate diagnosis to procedure by reference to numbers 1, 2, etc. in Column D)

ICD - 9 Code ______________________

7. Does your patient have any chronic or recurring condition(s) not noted above? If so, please provide dates and details:

A Date of Each Service	B Place of Service *See Codes Below	C Describe surgical or medical procedures and other services or supplies furnished for each date given (explain unusual services) Procedure Code	D DX No. ICD-9	E Charged (Explain unusual circumstances in Column C)

8. Physician or Supplier's Name, Address, Zip Code & Telephone No.	9. Total Charges
10. Is patient current being treated by any other practitioner or therapist? ☐ Yes If "Yes": Name ______________________ ☐ No Address ______________________	11. Amount Paid

12. Social Security Number	13. Employer I.D. No.	14. Other Identifying No.	15. Balance Due

16. Signature of physician or supplier Sign Here	17. Date Signed	18. Your Patient's Account #

Place of Service Codes

1 - (H)	- Inpatient Hospital	4 - (H)	- Patient's Home	7 - (NH)	- Nursing Home
2 - (OH)	- Outpatient Hospital	5 -	Day Care Facility	8 - (SNF)	- Skilled Nursing Facility
3 - (O)	- Doctor's Office	6 -	Night Care Facility	9 -	Ambulance
O - (OL)	- Other Locations	A - (IL)	- Independent Laboratory	B -	Other Medical/Surgical Facility

Approved by AMA Council on Medical Services 10-73

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

Worcester Disability Benefits Center
P.O. Box 15112, Worcester, MA 01615-0112
Toll-free 1-888-226-7959 Fax 1-774-437-7041

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; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and 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”). 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).

________________________________ __________________________
(Claimant 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.