Group LTD
Spouse Disability Claim

Employer: _____

Group Policy Number: _____

SPOUSE DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Telephone: 1-800-858-6843 Fax: 1-800-447-2498

To the Plan Administrator:

To file a Spouse disability claim, send this completed form to Unum Life Insurance Company of America (Unum) at the above address 4 to 6 weeks before the end of the spouse disability elimination period or earlier if possible. If you have questions concerning a claim or if you need help completing this form, call the benefits office 800 number shown above.

There are 4 sections to be completed in this form:

Section 1 - Spouse's Statement
Section 2 - Employer's Statement
Section 3 - Attending Physician's Statement
Authorization

The spouse disability claim form requests information that is critical to the speedy and accurate administration of the claim. The information we request will be used to determine benefits according to the group insurance contract. Some identifying information may be repeated from section to section in case the form becomes separated and a particular section is sent to Unum alone. The duplicated information will help us properly identify the claim to which the form belongs.

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 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.

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Claim Fraud Statements

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.

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 Oregon Residents

For your protection, Oregon law requires the following to appear on this claim form:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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

SPOUSE DISABILITY CLAIM FORM
SPOUSE STATEMENT

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To be completed by Spouse. (A designated representative may complete this form if the Spouse is unable to do so.)

Name of Spouse (Last, First, Middle Init.)	Date of Birth	Social Security #	Spouse's Occupation

Address (Street, City, State, Zip)	☐ Male ☐ Female	Telephone ( )

Name of Employee	Employee's Social Security #	Date of Marriage	Employee's Occupation

Date of your injury or the date you first noticed symptoms of your illness:

Describe your current condition and its cause:

Does your current condition prevent you from caring for yourself? ☐ Yes ☐ No If yes, how?

Which of the following Activities of Daily Living (ADLs) do you currently require human assistance in performing?

ADL	Date on which you first required and received assistance
☐ Bathing	_____
☐ Dressing	_____
☐ Toileting	_____
☐ Transferring	_____
☐ Continence	_____
☐ Eating	_____

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 _____

SPOUSE DISABILITY CLAIM FORM
SPOUSE STATEMENT

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In which of the following locations are you currently receiving care? (check appropriate box below)

☐ Residence
☐ Assisted Living/Personal Care Facility (Custodial)
☐ Nursing Care Facility (Nursing Home)
*☐ Hospital (Please complete below if discharged within last 3 months.)

Date on which you entered this facility: _____

Name of Hospital / Care Facility	Date Admitted
Address (Street, City, State, Zip)	Date Discharged

You may be contacted so that an assessment of your functional ability can be scheduled for you. Please indicate a phone number and address (if different from page 2) where you or your designated representative can be reached in order to make these arrangements.

Name	Telephone ( )

Address (Street, City, State, Zip)

Name and address of individual completing this form if other than the Spouse:

Name	Telephone ( )
Address (Street, City, State, Zip)	Relationship to Insured

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.

The above statements are true and complete to the best of my knowledge and belief. I have read and understand the fraud notices listed on the instruction page of this form.

X_____ _____
Claimant's Signature Date

X_____ _____
Employee's Signature Date

SPOUSE DISABILITY CLAIM FORM
EMPLOYER STATEMENT

The Benefits Center
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To Be Completed By Employer:

Name of Spouse (Last, First, Middle Init.)	Date of Birth	Social Security #

Address (Street, City, State, Zip)	Telephone
	( )

Name of Employee	Employee's Social Security #	Employee's Occupation

Address (Street, City, State, Zip)	Telephone
	( )

Employer Name	Group Policy Number

Address (Street, City, State, Zip)	Telephone: ( ) Fax: ( )

Name and address of division where employee works (if different from above)

Information about the employee

Date employee was hired	Date employee became become insured under this plan?	Date spouse become insured under this plan?

How was the Spouse Disability premium paid for the plan year in which the disability occurred?

Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No

Percentage paid by Employee_____ ☐ Pre-tax ☐ Post-tax

If the premium is paid in whole or in part by the employee, please attach a copy of the employee's payroll records for the past two pay periods.

Name / Address / Policy Number of your medical insurance carrier

Name of person completing this form (if claim is approved for spouse disability benefits, the benefit check will be sent to the claimant with a carbon copy to you.)

FRAUD NOTICE

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer portions of the claim form.

X

_____ _____ _____

Signature Title Date

SPOUSE DISABILITY CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
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This form should be completed by the physician who is treating the claimant for the disability.

To be Completed By The Attending Physician

This claim is for (Patient's Name)

Patient's Social Security Number	Height	Weight	Blood Pressure	Date of Birth

Primary Diagnosis	ICD 9 or DSM code

Describe reported symptoms

Describe physical findings (MRI, X-rays, EMG/NCV Studies, lab tests, clinical findings, GAF, etc.)

Are there secondary conditions contributing to the disability?
☐ Yes ☐ No If yes, What are they?

Is this a cardiac condition, what is the functional capacity? (American Heart Association)	☐ Class 1 - No limitation ☐ Class 2 - Slight limitation	☐ Class 3 - Marked limitation ☐ Class 4 - Complete limitation

When did symptoms first appear?	Date of patient's first visit	Date of the patient's last visit

Has the patient undergone surgery?
☐ Yes ☐ No If yes, advise date, procedure and result. Date:

If no, do you expect surgery to be performed in the future? Date:
☐ Yes ☐ No If yes, advise date and type of surgery.

What medication and dosage is the patient currently taking?

Please indicate other types and frequencies of treatment.

Has the patient been referred to a medical rehabilitation or therapy program?
☐ Yes ☐ No If yes, give details

Have you referred the patient for other types of consultations?
☐ Yes ☐ No If yes, give details.

Has the patient been hospital confined?
☐ Yes ☐ No If yes, complete the following:

Name of Hospital

Address	Dates of Confinement _____ through _____

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ATTENDING PHYSICIAN'S STATEMENT

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Has your patient had loss of cognitive functioning? Cognitively impaired means deterioration or loss in intellectual capacity resulting from injury, sickness, advanced age, Alzheimer's disease or similar forms of irreversible dementia and the patient needs another person's assistance or verbal cueing for his/her own protection or the protection of others.

☐ Yes ☐ No If yes, please explain and provide supporting documentation.

Based upon your observation of this patient, medical history, and condition, indicate which of the following Activities of Daily Living (ADLs) the patient needs hands-on or stand-by assistance in performing.

☐ **Bathing:**	The ability to wash either in the tub or shower by sponge bath, with or without equipment or adaptive devices.
☐ **Dressing:**	The ability to put on and take off garments, and medically necessary braces or artificial limbs usually worn.
☐ **Toileting:**	The ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
☐ **Transferring:**	The ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
☐ **Continence:**	The ability to voluntarily control bowel and bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.
☐ **Eating:**	The ability to get nourishment into the body.

Date the patient first required assistance	Is the need for assistance ☐ persistent ☐ periodic

How soon do you expect fundamental changes in the patient's medical condition?

Additional remarks:

Required Attachments

After you have fully completed this form, please attach:

- **OFFICE NOTES for at least the past two years, but longer if available**
- **TEST RESULTS**
- **HOSPITAL ADMISSION/DISCHARGE SUMMARIES**
- **CONSULTING PHYSICIAN REPORTS**

Including the above information with the claim submission will allow us to make a more timely claim determination for your patient.

Your Name	Degree
Specialty	Telephone ( ) Fax ( )

Address

FRAUD NOTICE

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes the Attending Physician portions of the claim form.

X_____ _____

Signature of Attending Physician (no stamp) 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

I authorize health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group, Inc., GENEX Services, Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

To disclose information, whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits;

To the following persons: Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies ("Unum"), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims, including assistance with return to work. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

_____ _____
Spouse'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.

1155-94-AUTH (09/10)