



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 complete Part I of this statement, then give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete Part II. 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.



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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.



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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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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.

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



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ATTENDING PHYSICIAN OR PROVIDER OF SERVICE STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY INSURED/PATIENT

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

Grid for Insured Name

Insured Social Security Number

Grid for Insured Social Security Number

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

Grid for Patient Name

Patient Social Security Number

Grid for Patient Social Security Number

Patient Gender: Male Female

Patient Date of Birth (mm/dd/yy)

Grid for Patient Date of Birth

Patient Relationship to Insured: Self Spouse Domestic Partner Dependent Child

PART II: 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.

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	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
<input type="checkbox"/> Amniocentesis		
<input type="checkbox"/> Angiogram		
<input type="checkbox"/> Afterigram		
<input type="checkbox"/> Athroscopy		
<input type="checkbox"/> Biopsy-Breast		
<input type="checkbox"/> Biopsy-Bone Marrow Aspiration		
<input type="checkbox"/> Biopsy-Renal		
<input type="checkbox"/> Biopsy-Respiratory		
<input type="checkbox"/> Biopsy-Cervical		
<input type="checkbox"/> Biopsy-Cone		
<input type="checkbox"/> Biopsy-Endometrial		
<input type="checkbox"/> Biopsy-Live		
<input type="checkbox"/> Biopsy-Lymphatic		
<input type="checkbox"/> Biopsy-Skin		



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ATTENDING PHYSICIAN STATEMENT (Continued)

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

Grid for Insured's Name

Date of Birth (mm/dd/yy)

Grid for Insured's Date of Birth

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

Grid for Patient's Name

Date of Birth (mm/dd/yy)

Grid for Patient's Date of Birth

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

Please check the tests conducted for this patient:

Table with columns: Test, Date Test Performed, Facility Where Performed. Lists various diagnostic tests like Biopsy-Thyroid, Barium enema, etc.

D. Complete this section for INPATIENT/OUTPATIENT SURGERY claims

Table with columns: Surgery Date, Place of Service, Procedure Code, Name/Description of Surgery, Diagnosis Code, Address/Phone Number.

E. Complete this section for HOSPITAL/ICU CONFINEMENT claims

Table with columns: Date of Admission, Date of Discharge, Place of Service, Diagnosis Code, Address/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)

Grid for name input

Grid for date of birth input

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

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 Advocator Group and other Social Security advocacy vendors, 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.

 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.