Group Life Insurance Disability Premium Waiver Application

CO-819 (Rev. 8/2023)

HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

THE COMPLETED APPLICATION MUST BE SUBMITTED **WITHIN TWELVE (12) MONTHS FROM THE EMPLOYEE'S LAST DAY ACTIVELY AT WORK.**

PREMIUM WAIVER POLICY AND QUALIFICATIONS:

- MUST BE CURRENTLY ENROLLED IN THE GROUP LIFE INSURANCE PLAN.
- MUST BE TOTALLY AND PERMANENTLY DISABLED FROM PERFORMING ANY GAINFUL OR REASONABLE WORK FOR A MINIMUM OF NINE MONTHS.
- UNDER SIXTY (60) YEARS OF AGE ON THE LAST DAY PRESENT AND WORKING.
- DETERMINATION FOR WAIVER OF INSURANCE PREMIUM IS MADE NO EARLIER THAN NINE (9) MONTHS AFTER THE LAST DAY PRESENT AND WORKING.
- PREMIUM PAYMENTS MUST BE MADE FOR THIS ENTIRE NINE MONTH PERIOD AND UNTIL A DECISION IS RENDERED BY THE INSURANCE CARRIER, WHICHEVER IS GREATER.

SUBMIT APPLICATION UNDER ANY ONE OF THE FOLLOWING CONDITIONS:

1. WHEN ON LEAVE OF ABSENCE DUE TO PERMANENT AND TOTAL DISABILITY FOR A PERIOD OF 9 MONTHS.
2. WHEN PLANNING TO RETIRE DUE TO PERMANENT AND TOTAL DISABILITY WITH YOUR RETIREMENT APPLICATION PACKAGE

SECTION I. TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME (Last, First. Middle Initial)	EMPLOYEE I. D. NUMBER	SOCIAL SECURITY NUMBER
HOME ADDRESS (Street No., Name, City, Zip Code)	DATE OF BIRTH	HOME TELEPHONE NUMBER

I WISH TO APPLY FOR A WAIVER OF GROUP LIFE INSURANCE PREMIUMS. I UNDERSTAND THAT I MUST CONTINUE TO PAY THE MONTHLY PREMIUM UNTIL A DECISION IS RENDERED BY THE INSURANCE COMPANY REGARDING MY WAIVER APPLICATION OR FOR NINE MONTHS, WHICHEVER IS GREATER. PAYMENTS MUST BE SENT IN MONTHLY TO MY AGENCY HUMAN RESOURCE/PAYROLL OFFICE. I UNDERSTAND THAT COVERAGE MAY BE TERMINATED FOR NON-PAYMENT OF PREMIUM IF I FAIL TO MAKE THE PREMIUM PAYMENTS. I ALSO UNDERSTAND THAT I MUST NOTIFY THE OFFICE OF THE STATE COMPTROLLER IF I RECOVER AND TOTAL AND PERMANENT DISABILITY SHOULD CEASE.

EMPLOYEE SIGNATURE	DATE

SECTION II. TO BE COMPLETED BY AGENCY

AGENCY NAME and ADDRESS	AGENCY TELEPHONE NUMBER	DEPARTMENT I. D.

INDICATE LAST DAY EMPLOYEE WAS PRESENT AND WORKING:

INDICATE LAST DAY PREMIUMS ARE PAID THROUGH:

IS EMPLOYEE ENROLLED IN BENEFITS BILLING?

☐ Y ☐ N

EMPLOYEE ANNUAL SALARY (AS OF LAST DAY WORKED): $

AMOUNT OF BASIC GROUP LIFE INSURANCE: $

HAS EMPLOYEE APPLIED FOR WORKER'S COMPENSATION?	IS EMPLOYEE RECEIVING WORKER'S COMPENSATION?	IF YES, EFFECTIVE DATE:
☐ Y ☐ N	☐ Y ☐ N	

IS EMPLOYEE ON LEAVE OF ABSENCE DUE TO PERMANENT AND TOTAL DISABILITY ?

☐ Y ☐ N

IF YES, EFFECTIVE DATE :

IS EMPLOYEE RETIRED DUE TO DISABILITY?

☐ Y ☐ N

IF YES, EFFECTIVE DATE :

AUTHORIZED AGENCY SIGNATURE	DATE

GROUP LIFE INSURANCE DISABILITY BENEFIT FORM

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

Phone: 1-800-858-6843 Fax: 1-877-851-7624
Monday through Friday 8 a.m. to 8 p.m. Eastern Time

Unum Life Insurance Company of America
First Unum Life Insurance Company*
Unum Insurance Company
Provident Life and Accident Insurance Company
Provident Life and Casualty Insurance Company*
The Paul Revere Life Insurance Company*

For use with policies issued by the above Unum Group ["Unum"] subsidiaries.

These forms are to be used when requesting that premiums be waived due to total disability of an employee. Claim forms should be submitted when it appears the employee will be totally disabled beyond the Elimination Period as defined in your policy. Proof of total disability must be received no later than the time frames specified in your policy following the employee's date of loss.

Instructions

This form should be completed by you (the employee), your employer and attending physician.

- **Employer Statement (pages 3-5):** Please give this section of the claim form to your employer and ask him/her to complete, sign and date the form. Your employer should return the completed form via fax or mail.
- **Attending Physician Statement (pages 6-8):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care. Ask him/her to complete and fax the completed form to 1-800-447-2498 or 1-877-851-7624. If s/he prefers, it may be mailed to the address noted above.
- **Employee/Individual Statement (pages 9-10):** Please complete this section of the claim form and fax it to 1-800-447-2498 or 1-877-851-7624. If you prefer, it may be mailed to the address noted above.
- **Work Experience & Education Questionnaire (page 11-15):** Please complete this section of the claim form and fax it to 1-800-447-2498 or 1-877-851-7624. If you prefer it can be mailed to the address noted above.
- **Authorization to Share Information with Third Parties (page 17):** If you wish to give us permission to share the details of your claim with a third party (such as your spouse, child, sibling, friend, etc.), please sign and date this form and fax it to 1-800-447-2498 or 1-877-851-7624. If you prefer, it may be mailed to the address noted above.
- **Employee/Individual Authorization (last page):** Please sign and date this form. Please mail a copy to the address noted above or fax a copy to 1-800-447-2498 or 1-877-851-7624.

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.

* Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.

unum® The Benefits Center

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this 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.

For your protection:

Alabama law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California law requires the following statement to appear on this form: Any person who knowingly presents 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.

Colorado law requires the following statement to appear on this 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.

District of Columbia law requires the following statement to appear on this form: 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.

Florida law requires the following statement to appear on this form: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky law requires the following statement to appear on this 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.

Minnesota law requires the following statement to appear on this form: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire law requires the following statement to appear on this 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.

New Jersey law requires the following statement to appear on this 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, subject to criminal prosecution and civil penalties.

New York law requires the following statement to appear on this 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 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.

Pennsylvania law requires the following statement to appear on this 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.

Puerto Rico law requires the following statement to appear on this 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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EMPLOYER STATEMENT

Please Complete All Items, Omissions May Cause a Delay

Attach:
- ☐ **Photocopy of the insured's enrollment card(s) from initial enrollment to present**
- ☐ **Photocopy of completed beneficiary form(s)**
- ☐ **Photocopy of Social Security award/denial**
- ☐ **Salary Verification - payroll records for last month of full-time employment just prior to date last worked for benefit amounts that are a multiple of the employee's salary. Note: If earnings definition is prior years W-2, please submit.**
- ☐ **Job Description**
- ☐ **Retirement Plan Summary**

Please retain original.

This form represents initial notice of claim. Additional documentation may be requested upon review of this claim.

Employee Information (Complete for all claims)

Full Name of Insured Employee	Social Security No.	Date of Birth (mm/dd/yyyy)	U.S. Citizen ☐ Yes ☐ No

Occupation	Salary/Rate of Pay	Date Effective (mm/dd/yyyy):

What was the employee's regularly scheduled work week? _____ hours per week

Date Employed (mm/dd/yyyy)

Amount of Unum Group Insurance:	Effective Date of Unum Insurance:
Basic Life: $_____ Supplemental: $_____	Basic Life (mm/dd/yyyy): Supplemental Life (mm/dd/yyyy):

Date Last Worked Full Time (mm/dd/yyyy):	Date Last Worked Part Time (mm/dd/yyyy):	Reason for Ceasing Work: ☐ Illness (Disability) ☐ Vacation ☐ Quit ☐ Leave Other Than Disability ☐ Retired ☐ Dismissed

Have premium payments terminated?	Has claimant converted to individual policy?
☐ Yes Date (mm/dd/yyyy): _____ ☐ No	☐ Yes Date (mm/dd/yyyy): _____ ☐ No

Retirement Plan Information — Note: Please send copy of Plan Summary

Do you have a retirement plan? ☐ Yes ☐ No	If yes, what type? ☐ Defined benefit ☐ Defined contribution ☐ 401(k) ☐ Profit Sharing ☐ Other: (specify)

Is the employee eligible for your retirement plan? ☐ Yes ☐ No If no, why?	If eligible, does the employee participate? ☐ Yes ☐ No If no, why?

If the employee is participating, when is he or she eligible for benefits under the plan? (mm/dd/yyyy)

Policyholder Data

Policy No. Div. No.	Name of Policyholder	Name of Subsidiary or Division

Company Name	Claim Correspondent	Title

Address (Street) (City) (State) (Zip Code)	Telephone Number

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 portions of the claim form.

Email Address:	Telephone Number

By (Signature & Title of employer's authorized representative)	Date (mm/dd/yyyy)

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To Be Completed By The Employee's Supervisor

This claim is for (Employee's Name)

Employee's Social Security Number	Last Date Worked (mm/dd/yyyy)

A. General information about the employee's job

Job Title	Minimum education or training required

Does the employee perform supervisory functions?
☐ Yes ☐ No If yes, how many people?_____ Describe duties

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Occasionally	Frequently	Continuously
Relate to others	☐	☐	☐
Written and verbal communication	☐	☐	☐
Reasoning, math and language	☐	☐	☐
Make independent judgments	☐	☐	☐

Which of the following describe the employee's working environment? Check all that apply.
☐ Unprotected heights ☐ Changes in temperature or humidity ☐ Exposure to dust, fumes and gases
☐ Being near moving machinery ☐ Driving automotive equipment ☐ Other hazards

Is the employee required to travel?
☐ Yes ☐ No If yes, complete the following information:

How does the employee travel? (Automobile, plane, train, etc.)	Where does the employee travel?	What percent of the time does the employee travel?

B. Information about the physical aspects of the employee's job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence				
	Occasionally	Frequently	Continuously		
☐ Standing	☐	☐	☐		
☐ Walking	☐	☐	☐		
☐ Sitting	☐	☐	☐		
☐ Balancing	☐	☐	☐		
☐ Stooping	☐	☐	☐		
☐ Kneeling	☐	☐	☐		
☐ Crouching	☐	☐	☐		
☐ Crawling	☐	☐	☐		
☐ Reaching/working overhead	☐	☐	☐		
☐ Climbing:	☐	☐	☐		
☐ Stairs Number of stairs:_____	☐	☐	☐		
☐ Ladders Height of Ladder:_____	☐	☐	☐	**Describe Activity**	**Weight**
☐ Pushing	☐	☐	☐	_____	_____ lbs.
☐ Pulling	☐	☐	☐	_____	_____ lbs.
☐ Lifting/carrying	☐	☐	☐	_____	_____ lbs.

(Continued on Next Page)

Can the job be performed by alternating sitting and standing?
☐ Yes ☐ No

Does the job require using the feet to operate foot controls?
☐ Yes ☐ No If yes, on what type of equipment?

How important is good vision in the job?

What are the major tasks requiring use of one or both hands?	One Hand	Both Hands
	☐	☐
	☐	☐
	☐	☐
	☐	☐

C. Information about the job as it relates to the disability

Can the job be modified to accommodate the disability either temporarily or permanently?
☐ Yes ☐ No If yes, explain

Is it possible to offer the employee assistance in doing the job (through use of technology or personal assistance for example)?
☐ Yes ☐ No If yes, explain

D. Attachments and Signature (Attach a copy of the employee's job description)

Name of person completing this form:

x _____ _____ _____
Signature Title Date (mm/dd/yyyy)

Telephone: Fax:

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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER
Instructions: Please complete, sign and date this form. The purpose of this form is to assist us in making a disability determination. Please complete all questions on this form and provide copies of supporting reports, such as office notes, medical records, medication logs, consultations and/or testing. Be sure to sign and date this form in Section D.

Name of Patient (Last Name, Suffix, First Name, MI)	Social Security Number

Date of Birth (mm/dd/yyyy)	Patient Telephone Number

Employer Name

A. Patient Information

Date of first visit for this current condition(s) (mm/dd/yyyy):	Date of last office visit (mm/dd/yyyy):	Date of next office visit (mm/dd/yyyy):	Did you advise your patient to stop working? ☐ Yes ☐ No If yes, effective when? (mm/dd/yyyy):

Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yyyy): From Through

Is the patient's condition work related? ☐ Yes ☐ No ☐ Unknown	Patient's Height:	Patient's Weight:

What is the primary diagnosis that may impact your patient's functional capacity?

Please include primary ICD or DSM codes	ICD Code: DSM:

What are the other diagnoses that may impact your patient's functional capacity? ☐ NA

Secondary Diagnosis:	ICD Code:
Secondary Diagnosis:	ICD Code:

Has the patient been hospitalized? ☐ Yes ☐ No If yes, date hospitalized (mm/dd/yyyy): through (mm/dd/yyyy):

Was surgery performed? ☐ Yes ☐ No If yes, what procedure was performed? CPT Code: Date Surgery Performed (mm/dd/yyyy):

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name	Date of Birth (mm/dd/yyyy)

B. Functional Capacity

If your patient ***does not*** have physical and/or behavioral health RESTRICTIONS (activities patient should not do) and/or LIMITATIONS (activities patient cannot do), please initial here _____ and go to ***SECTION D.***

Please note: When considering a standard 8 hour workday with breaks (approximately every two hours) please quantify terms that may not be uniformly understood such as "prolonged", "repetitive", "light-duty", "heavy lifting", or "stressful situations". In addition, never means not at all, occasional means more than never but less than 33% of the time; frequent means 34-66% of the time, and constant means 67-100% of the time.

Physical Restrictions and/or Limitations

If your patient has CURRENT PHYSICAL RESTRICTIONS (activities patient should not do) and/or PHYSICAL LIMITATIONS (activities patient cannot do) list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

Behavioral Health Restrictions and/or Limitations

If your patient has CURRENT BEHAVIORAL HEALTH RESTRICTIONS (activities patient should not do) and/or BEHAVIORAL HEALTH LIMITATIONS (activities patient cannot do) please list below. Please be specific and understand that a reply of "no work" or "totally disabled" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

What diagnostic or clinical findings support your patient's restrictions and/or limitations as noted above?

What is your treatment plan? Please include all medications.

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name	Date of Birth (mm/dd/yyyy)

C. Other Treating Providers, Facilities or Hospitals

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

Name	Specialty	City, State

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 Attending Physician portion of the claim form.

D. Signature of Attending Physician

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?

Signature of Physician	**Date**
X	

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EMPLOYEE/INDIVIDUAL STATEMENT

To Avoid Delay, Answer All questions

Full Name Last	First	Middle	Social Security Number

Address	City	State	Zip Code

Email	Phone Number

Date of Birth (mm/dd/yyyy)	Height	Weight	Sex ☐ Male ☐ Female	Marital Status	Name of Employer	Occupation

What was your last day at work:	What was the first day you were unable to work because of your disability:	What was the date of your accident or the date you first noticed the symptoms of your illness:
(mm/dd/yyyy)	(mm/dd/yyyy)	(mm/dd/yyyy)

Date you were first treated for your illness or injury: _____ (mm/dd/yyyy)

What is the name of your medical condition?

Describe how and where accident occurred or describe the first symptoms of your illness:

Describe your current symptoms:

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If "Yes," When?

Describe your current day to day activities (for ex. household chores, reading, caring for family, etc):

Information About Physicians, Hospitals and Medications: This information will assist us in the evaluation of your claim.

Please provide the following information about all your current medical treatment providers (physicians, hospitals, physical therapists, etc). If you are being treated by more than two, please use a separate sheet of paper and include it with this form.

1. Provider Name | Mailing Address | Telephone No.
   Specialty | City | State | Zip | Fax No.
   Date of First Visit (mm/dd/yyyy) | Date of Next Visit (mm/dd/yyyy)
2. Provider Name | Mailing Address | Telephone No.
   Specialty | City | State | Zip | Fax No.
   Date of First Visit (mm/dd/yyyy) | Date of Next Visit (mm/dd/yyyy)

Please list any recent (within the last 12 months) hospital visits/admissions. If you have had more than two, use a separate sheet of paper and include it with this form.

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

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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Information about other employment or additional income

Have you returned to work for your same or different employer? ☐ Yes ☐ No

If yes, what date? _____ (mm/dd/yyyy) Part time ☐ Full time ☐ Hours per week _____

Please describe type of work:

Please indicate what other types of benefits you are eligible to receive or are receiving as a result of your disability.

Have you been awarded Social Security Disability? ☐ Yes ☐ No If yes, date of award _____ (mm/dd/yyyy)

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.

I have read and understand the fraud notices listed on this form. I also acknowledge 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.

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.

Signature of Employee

I have read and understand the fraud notices listed above and on page 2 of this form. I also acknowledge 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.)**

Social Security No._____ _____ _____ - _____ _____ - _____ _____ _____ _____

_____ _____
Employee's Signature **Date** (mm/dd/yyyy)

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

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WORK EXPERIENCE & EDUCATION QUESTIONNAIRE

NAME	DATE OF BIRTH

Instructions for completing this Questionnaire:

The purpose of this questionnaire is to provide us with information about your work experience, education and skills. This information will be used in the continued evaluation of your claim. Please complete each section as described. *If you have a resume, please include a copy with this questionnaire.* After you complete this questionnaire, please sign and date it in Section F.

A. Information About Your Education and Training

High School Diploma	☐ YES	Date Completed _____	☐ NO	Highest Grade Completed:
GED Obtained	☐ YES	Date Completed _____	☐ NO	

Additional Education and/or Training. Please provide information requested. *Please include any additional education/training on a separate sheet of paper and include with this form.*

Degree or Certificate Completed (e.g. Certificate, Associates, Bachelors, Masters, etc)	Area of Study/Training (e.g. HVAC, Nursing, Education, Liberal Arts, etc)	School or Training Facility's Name	Dates Attended
			Start:_____ End: _____
			Start:_____ End: _____
			Start:_____ End: _____
			Start:_____ End: _____

Professional Certificates and On-the-Job Trainings. Please provide information requested in each category that applies. P*lease include any additional certificates/on-the-job training on a separate sheet of paper and include with this form.*

Certifications	Dates
	_____
	_____
	_____

Licenses	Dates
	_____
	_____
	_____

On-the-Job Training	Dates
	_____
	_____
	_____

Military Service ☐ YES ☐ NO Branch: Start Date: _____ End Date: _____

Job Title/Rank at Discharge MOS/MOC Code(s):

B. Information About Employment History

Describe each job you have had starting with the most recent. If you have been with the same employer, please write each position you have held separately since you started. *Please include any additional employment experience on a separate sheet of paper and include with this form.*

1. Name of Employer	Job Title	Employment Dates	Salary	Reason for Leaving
		Start: _____ End: _____		
Job Duties/Responsibilities				
Tools, equipment, training and/or machines used:				
Did you use a computer? ☐ YES ☐ NO If yes how often? ☐ Daily ☐ Weekly ☐ Occasionally				
Did you supervise others? If yes, describe supervisory duties and number of employees supervised.				

GROUP LIFE INSURANCE DISABILITY BENEFIT FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone: 1-800-858-6843 Fax: 1-877-851-7624
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

WORK EXPERIENCE & EDUCATION QUESTIONNAIRE (Continued)

NAME	DATE OF BIRTH

2. Name of Employer	Job Title	Employment Dates	Salary	Reason for Leaving
		Start: _____ End: _____		
Job Duties/Responsibilities				
Tools, equipment, training and/or machines used:				
Did you use a computer? ☐ YES ☐ NO If yes how often? ☐ Daily ☐ Weekly ☐ Occasionally				
Did you supervise others? If yes, describe supervisory duties and number of employees supervised.				

3. Name of Employer	Job Title	Employment Dates	Salary	Reason for Leaving
		Start: _____ End: _____		
Job Duties/Responsibilities				
Tools, equipment, training and/or machines used:				
Did you use a computer? ☐ YES ☐ NO If yes how often? ☐ Daily ☐ Weekly ☐ Occasionally				
Did you supervise others? If yes, describe supervisory duties and number of employees supervised.				

4. Name of Employer	Job Title	Employment Dates	Salary	Reason for Leaving
		Start: _____ End: _____		
Job Duties/Responsibilities				
Tools, equipment, training and/or machines used:				
Did you use a computer? ☐ YES ☐ NO If yes how often? ☐ Daily ☐ Weekly ☐ Occasionally				
Did you supervise others? If yes, describe supervisory duties and number of employees supervised.				

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WORK EXPERIENCE & EDUCATION QUESTIONNAIRE (Continued)

NAME	DATE OF BIRTH

C. Volunteer Activities and Interests

1. Volunteer Organization:	Volunteer Title	Employment Dates Start: _____ End: _____	Tools, equipment, training:
Volunteer Duties:			
2. Volunteer Organization:	Volunteer Title	Employment Dates Start: _____ End: _____	Tools, equipment, training:
Volunteer Duties:			

Please include any additional volunteer experience on a separate sheet of paper and include it with this form.

Interests/Activities/Hobbies

D. Information About Your Past and Present Computer Use

Please check off tasks you have performed: *provide details when appropriate.*

TASKS	Most Recent Job	Previous Jobs	Personal Computer Use	Tablet/ Smartphone
Data Entry	☐	☐	☐	☐
Database (e.g. Oracle, SQL Server, FileMaker, SAP, etc)	☐	☐	☐	☐
Writing Reports (e.g. Quarterly reports, product presentations, etc)	☐	☐	☐	☐
Analyzing Data (e.g. Comparing Sales Information, Quality Insurance, etc)	☐	☐	☐	☐
Writing Letters	☐	☐	☐	☐
E-mail	☐	☐	☐	☐
Spreadsheet Programs (e.g. MS Excel, Google Sheets, Lotus, etc)	☐	☐	☐	☐
Research (e.g. Google search, Bing search, etc)	☐	☐	☐	☐
Microsoft Office (e.g. Word, PowerPoint, Access, Publisher, Outlook, etc)	☐	☐	☐	☐
Programming Software (e.g. Java, VB, C++, etc)	☐	☐	☐	☐
Drafting (e.g CAD, CNC, etc)	☐	☐	☐	☐
Graphic/Web Design	☐	☐	☐	☐
Accounting (e.g. Quickbooks, Peachtree Accounting, etc)	☐	☐	☐	☐
Deskside or Remote Computer Support	☐	☐	☐	☐
Typing (Words Per Minute___)	☐	☐	☐	☐
Personal Website	☐	☐	☐	☐
Shopping (eBay, Amazon, etc)	☐	☐	☐	☐
Social Networking (e.g. Facebook, Twitter, LinkedIn, Google+, etc)	☐	☐	☐	☐
On-Line Banking	☐	☐	☐	☐
Personal Accounting/ Tax Prep (e.g. Quicken, TurboTax, H&R Block, etc)	☐	☐	☐	☐
Online Gaming	☐	☐	☐	☐
Other:	☐	☐	☐	☐

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WORK EXPERIENCE & EDUCATION QUESTIONNAIRE (Continued)

NAME	DATE OF BIRTH

E. Additional Skills

Do you have personal or work experience with any of the following areas:

- ☐ Public Speaking _____
- ☐ Performing/Entertaining _____
- ☐ Writing Skills _____
- ☐ Creative _____
- ☐ Management/Supervision _____
- ☐ Persuading/Motivating Others _____
- ☐ Childcare _____
- ☐ Mechanical Repair _____
- ☐ Electronic Repair _____
- ☐ Sales _____
- ☐ Foreign Language _____
- ☐ Other _____

Do you have an active Driver's License? ☐ YES ☐ NO
Active CDL: ☐ YES ☐ NO If yes endorsements: _____

F. Return to Work Assistance

Are you currently receiving any assistance to return to work? (e.g. State Vocational Rehabilitation or Veteran Services)
☐ YES ☐ NO If yes, please provide details:

Are you interested in speaking with a Unum Vocational Rehabilitation Professional about return to work services? ☐ YES ☐ NO

G. Nursing Information – *Please complete this section ONLY if you are a nurse (RN, LPN, LVN).*

Please check all areas in which you have experience:

- ☐ Auditing
- ☐ Case Management
- ☐ Clinic
- ☐ Computer Experience
- ☐ Dialysis
- ☐ Discharge Planning
- ☐ Home Care
- ☐ Hospice
- ☐ Hospital Administration
- ☐ ICU/CCU
- ☐ IV Therapy
- ☐ Mental Health Nursing
- ☐ Pediatrics
- ☐ Physician's Office
- ☐ Pre-certification Review
- ☐ Re-certification Review
- ☐ Recruiting
- ☐ Rehabilitation
- ☐ School Nursing
- ☐ Supervisory Experience
- ☐ Teaching/Training
- ☐ Telephone Triage
- ☐ Utilization review/Bill Audit
- ☐ Other_____

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WORK EXPERIENCE & EDUCATION QUESTIONNAIRE (Continued)

NAME	DATE OF BIRTH

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.

H. Signature of Employee/Individual

I have read and understand the fraud notices listed above on this form. I also acknowledge 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**

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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 leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), 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 any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) 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 understand that information about my claim(s) and/or leave(s) 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(s) and/or leave(s) 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 any of my claim(s) and/or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

_____ _____

Claimant 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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www.unum.com

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, Brown & Brown Absence Services 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, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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, First Unum Life Insurance Company*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty 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 (to include any subsequent financial management and/or benefit recovery review), 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.

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.

*Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.