LONG TERM CARE CLAIM FORM

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

Phone: 1-800-693-4988 Fax: 1-800-268-1377
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.

OUR COMMITMENT TO YOU

We understand that a disabling 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.

WHAT YOU NEED TO KNOW

A Brief Overview of a Long Term Care Policy

- After satisfying your elimination period, benefit entitlement is based on the receipt of assistance (stand-by or hands-on) or supervision from another individual due to:
  1. A loss of independence with at least 2 Activities of Daily Living (ADLs); and/or
  2. A cognitive impairment putting you at risk for health and safety.

Who is responsible for submitting the claim?

- You, as the policy holder, should file the claim within the time frame outlined in your policy.
- If a legal representative is completing or signing these forms on your behalf, you must provide a copy of the legal documents granting authority to do so; such as a Power of Attorney, Guardianship, Conservator, Estate, etc.

WHAT YOU NEED TO DO

Claims Process at a Glance

1. Complete and return all pages of the Claim Form.
   - *Individual Statement* **(required)**
   - *Authorization to Collect and Disclose Information* **(required)**
   - *Attending Physician Statement* **(required – to be completed by Licensed Health Care Practitioner)**
   - *Authorization for Additional Contact* **(optional)**
   - *Enclose any additional information that may assist us in the evaluation of your claim, i.e., medical records, office visit notes, testing, etc.* **(optional)**
2. Submit above documents to Unum – refer to top of page for submission options.
3. Your claim representative will reach out to you by phone once all required documents are received. During this phone call you will initiate the review process by discussing your claim and policy provisions in detail. The full review process may consist of any of the following:
   - A detailed phone call with you, your family, and/or your caregivers to discuss your care needs as related to Activities of Daily Living or Cognitive Impairment;
   - Obtaining and reviewing pertinent medical and care records;
   - Additional input that may include review by our on-staff nurses and/or personal interview/assessment.

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 claim 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.

Alabama: 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: 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: 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: 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: 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: 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: 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: 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: 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: 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: 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: 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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LET'S GET STARTED. TELL US WHO YOU ARE. (TO BE COMPLETED BY YOU)

Full name_____

Full Mailing address_____

_____

Best number to reach you _____

DOB____ / ____ / ____SSN__ __ __ - __ __ - __ __ __ __ Gender _____

Policy number_____ Email _____

If you are completing this form on behalf of the policy holder, please provide your information below:

Your name _____

Relationship to policy holder _____

Best number to reach you _____

Your email address _____

TELL US WHY YOU ARE FILING A CLAIM. (TO BE COMPLETED BY YOU)

What is the medical condition(s) causing your need for help with ADLs and/or supervision due to a cognitive impairment? _____

_____

TELL US ABOUT ADLs. (TO BE COMPLETED BY YOU)

Do you need another person to help you with any of the following ADLs? *(check all that apply)*

Bathing (stepping in or out of the tub or shower; taking a sponge bath; washing hair or body)	☐ Yes ☐ No
Dressing (putting clothes on, taking clothes off; includes upper body, lower body, braces, fasteners, artificial limbs, or compression stockings)	☐ Yes ☐ No
Toileting (getting on/off toilet, managing clothing, performing associated hygiene)	☐ Yes ☐ No
Transferring (moving into/out of bed chair, or wheelchair)	☐ Yes ☐ No
Continence (performing associated hygiene, including caring for catheter or colostomy bag, when unable to control bladder or bowel function)	☐ Yes ☐ No
Eating (getting food into body by utensil, feeding tube, or intravenously)	☐ Yes ☐ No
Ambulating/Mobility (moving from one place to another) *NOT APPLICABLE TO ALL POLICIES/CONTRACTS"	☐ Yes ☐ No

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

TELL US ABOUT YOUR NEED FOR SUPERVISION. (TO BE COMPLETED BY YOU)

Have you suffered a loss in your intellectual capacity which requires supervision for your health and safety? ☐ Yes ☐ No *If yes, please answer the following:*

Please indicate why supervision is needed (check all that apply):

☐ short term memory loss
☐ long term memory loss
☐ poor judgment
☐ wandering
☐ disorientation to person/place/time
☐ cueing for daily activities
☐ behavioral changes
☐ changes in or lack of attention
☐ confusion
☐ medication management
☐ impaired decision making
☐ other (please explain):_____

How often do you receive supervision? (for example: hours per day, days per week) _____

Who provides this supervision? (home care, facility, family, friends) _____

Please indicate your highest level of education completed: _____

TELL US WHERE YOU ARE CURRENTLY LIVING. (TO BE COMPLETED BY YOU)

☐ **Your Residence** ☐ **Care Facility** ☐ **Other** _____

If you are in a care facility, please provide the contact information below:

Name of facility: _____
Address: _____
Telephone #: _____ Date entered: _____
Fax # or email address: _____
Who prescribed this treatment/care?_____

If you are living at another location (residence/other), please provide the contact information for your primary caregiver (if there is more than one caregiver, list additional caregivers on the next page):

Name of caregiver/home care agency: _____
Address: _____
Telephone #: _____ Date care started: _____
Fax # or email address: _____

☐ home health aide ☐ companionship/supervision ☐ adult day care
☐ therapy (physical, occupational, speech) ☐ other: _____

Who prescribed this treatment/care?_____

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Date of Birth (mm/dd/yy) _____ / _____ / _____

TELL US WHO HAS BEEN INVOLVED IN YOUR TREATMENT/CARE. (TO BE COMPLETED BY YOU)

In the spaces below, please identify **additional care (facilities, home care, therapy)** you have received since the date you began to require assistance or supervision from another person.

1. Name of care provider: _____
   Telephone: _____ Fax: _____
   Address: _____
   Start of care: _____ End of care: _____
   ☐ assisted living facility ☐ nursing facility ☐ rehab facility ☐ skilled nursing
   ☐ home health aide ☐ companionship/supervision ☐ adult day care
   ☐ therapy (physical, occupational, speech) ☐ other: _____
   Who prescribed this treatment/care? _____

2. Name of care provider: _____
   Telephone: _____ Fax: _____
   Address: _____
   Start of care: _____ End of care: _____
   ☐ assisted living facility ☐ nursing facility ☐ rehab facility ☐ skilled nursing
   ☐ home health aide ☐ companionship/supervision ☐ adult day care
   ☐ therapy (physical, occupational, speech) ☐ other: _____
   Who prescribed this treatment/care? _____

3. Name of care provider: _____
   Telephone: _____ Fax: _____
   Address: _____
   Start of care: _____ End of care: _____
   ☐ assisted living facility ☐ nursing facility ☐ rehab facility ☐ skilled nursing
   ☐ home health aide ☐ companionship/supervision ☐ adult day care
   ☐ therapy (physical, occupational, speech) ☐ other: _____
   Who prescribed this treatment/care? _____

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Date of Birth (mm/dd/yy) _____ / _____ / _____

TELL US WHO HAS BEEN INVOLVED IN YOUR TREATMENT/CARE. (TO BE COMPLETED BY YOU)

In the spaces below, identify the **medical providers (physicians, hospitals)** that have been involved in the treatment of the condition causing your need for assistance or supervision.

1. Name of medical provider: _____

   Telephone: _____ Fax: _____

   Address: _____

   Start of care: _____ End of care: _____

   ☐ primary care physician ☐ speciality: _____ ☐ hospital

2. Name of medical provider: _____

   Telephone: _____ Fax: _____

   Address: _____

   Start of care: _____ End of care: _____

   ☐ primary care physician ☐ speciality: _____ ☐ hospital

3. Name of medical provider: _____

   Telephone: _____ Fax: _____

   Address: _____

   Start of care: _____ End of care: _____

   ☐ primary care physician ☐ speciality: _____ ☐ hospital

4. Name of medical provider: _____

   Telephone: _____ Fax: _____

   Address: _____

   Start of care: _____ End of care: _____

   ☐ primary care physician ☐ speciality: _____ ☐ hospital

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Individual's/Employee's Name (Last Name, Suffix, First Name, MI) _____

Date of Birth (mm/dd/yy) _____ / _____ / _____

Fraud Warning: For your protection, Arizona law requires the following to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

H. Signature of Employee/Individual

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.)**

X _____ _____

Insured Signature **Date**

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

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**.

If you are filing on behalf of the insured because they are deceased, please provide:

Date of Death ____/_____/_____

Name of Executor of the Estate: _____

NOTE: Most Power of Attorney documents expire upon the death of an individual and may not be sufficient representation of the insured. Please include any medical and care information that supports this claim.

LONG TERM CARE
ATTENDING PHYSICIAN STATEMENT
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ATTENDING PHYSICIAN STATEMENT (TO BE COMPLETED BY PHYSICIAN)

A. Patient Information

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

_____ _____

Date of Birth (mm/dd/yy) Home Telephone Number Height Weight

_____ _____ _____ _____

Instructions: This form is to assist Unum in making a disability determination and should be completed by a physician, physician assistant, nurse practitioner, registered nurse, or licensed social worker. **Please complete all questions, provide copies of supporting reports, such as office notes, medical records, medication logs, consultations and/or testing, then sign and date in section F.**

What is the primary diagnosis impacting functional and/or cognitive capacity?	ICD Code(s):

Date of first visit for this current condition(s) (mm/dd/yy):	Date of last office visit (mm/dd/yy):	Date of next office visit (mm/dd/yy):

B. Functional and/or Cognitive Capacity

Please provide your opinion below as to what ADL loss, if any, your patient has experienced and indicate when this loss began, as well as how long it will last.

ADL	Assistance Required? Yes	Assistance Required? No	Begin Date	From the begin date, how long do you expect the loss to last? <90 days	From the begin date, how long do you expect the loss to last? 90 days or more
Bathing					
Dressing					
Toileting					
Transferring (into/out of bed/chair)					
Continence care					
Eating (ability to bring food to mouth)					
Ambulation/mobility*					

*not covered in all states/policies

Is your patient still working? ☐ Yes ☐ No ☐ Unknown Is your patient still driving? ☐ Yes ☐ No ☐ Unknown

1. Does your patient have a cognitive impairment that puts them at risk for health and safety and requires the consistent and regular supervision of another person? ☐ Yes ☐ No
2. If yes, based on what diagnosis? _____
3. When did your patient begin requiring consistent and regular supervision? _____
4. Do you anticipate cognitive recovery? ☐ Yes ☐ No If yes, in what time frame? _____
5. Has any cognitive testing been completed? ☐ Yes ☐ No

☐ CT/MRI date _____ ☐ Neurology consultation date _____
☐ MMSE date/score _____ ☐ Neuropsychological eval date _____
☐ MoCA date/score _____

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ATTENDING PHYSICIAN STATEMENT (TO BE COMPLETED BY PHYSICIAN)

C. Patient Information

Individual's/Employee's Name (Last Name, Suffix, First Name, MI) _____

Date of Birth (mm/dd/yy) _____ / _____ / _____

D. Plan of Care

Date care to begin _____ Date care to be reassessed _____

Please check type of medical care to be provided by a skilled agency or licensed professional and indicate frequency to be provided.

- ☐ skilled nursing visits _____
- ☐ physical therapy _____
- ☐ occupational therapy _____
- ☐ speech therapy _____
- ☐ respiratory therapy _____
- ☐ hospice _____
- ☐ other _____

Please check type of non-medical care that can be provided by an unskilled agency or individual and indicate frequency to be provided.

- ☐ personal care/HHA _____
- ☐ companion care _____
- ☐ respite care _____
- ☐ homemaker services _____

E. Other Treating Providers, Facilities or Hospitals

Please provide complete name, contact information and specialty for any other treating providers your patient is seeing for his/her disabling condition(s) or for any referrals you have made to other providers including other physicians, therapist or clinical programs.

Name	Specialty	City, State

F. 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	Physician's tax ID number:	
Address	City	State	Zip

Telephone number	Fax number	Are you related to this patient? ☐Yes ☐No If yes, what is the relationship?

Signature of Physician **X**	Date

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Authorization for Additional Contact

As part of the standard claims review process, a claims representative will be contacting you, the insured, to discuss the details of your claim and policy. If you would like to also name another contact with whom we could share this information, please complete this Authorization for Additional Contact.

Additional Contact Name (first and last):_____

Address: _____

Telephone #: _____Relationship to Insured:_____

Check if the Additional Contact is also a legal representative:
☐ Power of Attorney (circle medical/financial/both) ☐ Legal Guardian ☐ Conservator

I authorize _____ (Print Name) to act as an additional contact in regard to my claim(s). In doing so, I am giving 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 duly authorized representatives ("Unum") the right to discuss all aspects of my coverage and claim(s) with my representative. This may include information regarding benefits, medical conditions (including, but not limited to, HIV and AIDS, mental illness and drug and alcohol abuse), medical providers, caregivers and locations of care. This information may be provided so that my representative may assist me with my claim(s). This information may be provided to my representative in writing or verbally, such as by telephone. I understand the information could be redisclosed by my representative and no longer protected by federal privacy regulations.

I authorize my designated Additional Contact to direct where my benefit payment will be mailed. ☐ Yes ☐ No

I understand I am not required to sign this authorization and Unum may not condition payment of my claim(s) on whether I sign 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. I may revoke this authorization by sending written notice to: Long Term Care Benefits Center, P.O. Box 100196, Columbia, SC 29202-9975.

This authorization is valid for two (2) years, or for the length of time otherwise permitted by law. I know that I have the right to receive a copy of this authorization or to revoke this authorization at any time. A photographic or electronic copy of this authorization is as valid as the original.

_____ _____
Insured Signature Date Signed

_____ _____
Print Insured's Name Social Security Number

*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.)

The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377

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, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies, 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. 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 person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum. 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

_____ _____
Insured's Printed Name Insured's Social Security Number

I _____ (print name) signed on behalf of the Insured as:

☐ Power of Attorney, ☐ Guardian, ☐ Conservator.

If signing on behalf of the insured, you must include a copy of the legal document granting authority. If you have already sent us this legal document in the past, you would not need to send it again.

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