BE WELL BENEFIT CLAIM FORM

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

Toll-free: 1-800-858-6843 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 Unum Insurance Company

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.

When should you use this claim form?

Use this claim form to submit the following types of claims to Unum:

- Be Well Benefit

Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for Be Well Benefits. Incomplete or illegible answers may result in a delay of benefit consideration.

- **Employee/Patient Statement** (page 4)**:** Please complete this section of the claim form and mail or fax the completed form to the address or fax number indicated above.
- **Authorization to Share Information with Third Parties** (page 5)**:** 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 mail or fax it to the address or fax number indicated above**.**

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.

BE WELL BENEFIT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

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.

BE WELL BENEFIT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

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.

BE WELL BENEFIT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

EMPLOYEE/PATIENT STATEMENT (PLEASE PRINT)

A. Information About the Employee

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female | Policy Number(s)

Home Address

City | State | Zip

Preferred Telephone Number | Preferred E-mail Address

Employer Name

B. Information About the Patient - Check One ☐ Self ☐ Spouse ☐ Child If applying for Self only provide the date of the test in Section B.

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female | Date of Test

C. Information about your or the Patient's Be Well Benefit Claim Complete this section for Be Well Benefit claims. Please indicate the type of screening performed and the date above, examples of the screenings can be found to the right. If the type of test performed is not listed, please indicate what test was performed.

☐ **Cholesterol and Diabetes**	**Eligible screenings include, but may not be limited to:** blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C(HbA1c), Serum cholesterol test to determine total, HDL and LDL cholesterol levels, two hour post-load plasma glucose.
☐ **Cancer**	**Eligible screenings include, but may not be limited to:** colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis, dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology (PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing.
☐ **Cardiovascular Function**	**Eligible screenings include, but may not be limited to:** echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging.
☐ **Imaging Studies**	**Eligible screenings include, but may not be limited to:** chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound.
☐ **Annual Examinations by a Physician**	**Eligible examinations include** sports physicals, annual exams for adults, and well-child visits.
☐ **Immunizations**	Eligible immunizations include, but may not be limited to: HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza.

D. Tax Considerations

Benefit payments under this policy could be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.

E. Signature of Insured

I have read and understand the fraud notices listed on page 2 and page 3 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 _____ _____

Signature **Date**

I signed on behalf of the insured, as _____ (indicate relationship). **If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.**

BE WELL BENEFIT CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

OPTIONAL - DISCLOSING INFORMATION TO THIRD PARTIES

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)

Authorized Person 1: _____

(Name / Relationship) (Telephone Number)

Authorized Person 2: _____

(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.

_____ _____

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.