GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM

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

Toll-free: 1-800-445-0402 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
The Paul Revere Life Insurance Company

OUR COMMITMENT

During this difficult time, we are committed to providing responsive, compassionate service.

INSTRUCTIONS

Who is responsible for completing this form?

- **Employer Statement (pages 4-6):** This section of the form should be completed by the employer who should fax it to 1-800-447-2498 or mail it to the address noted above. If available, the following information should also be provided:
  - A copy of the death certificate (a photocopy or fax is acceptable);
  - The original enrollment form and any other enrollment forms indicating any change in coverage; and
  - The most recent beneficiary designation form.
- **Accidental Death Statement (pages 7-9):** If the claim is related to an accidental death, this section of the form should be completed by the employee or beneficiary. The completed form should be faxed to 1-800-447-2498 or mailed to the address noted above.
- **Authorization (last page):** This form should be signed and dated by the employee or beneficiary and faxed to 1-800-447-2498 or mailed to the address noted above.

Questions?

If you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center professionals are available from 8 a.m. to 8 p.m. Eastern Time Monday through Friday.

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 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.

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.

Instructions (continued) / Claim Fraud Statements

Fraud Warning for New York Residents

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

Fraud Warning for Oregon Residents

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

Fraud Warning for Pennsylvania Residents

For your protection, Pennsylvania law requires the following to appear on this claim form:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Warning for Puerto Rico Residents

For your protection, Puerto Rico law requires the following to appear on this claim form:
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may 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.

GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

EMPLOYER STATEMENT - To be completed by the Employer (PLEASE PRINT)

A. Information About the Type of Claim – Please check all that apply and provide the policy and division numbers.

Type of Coverage	Type of Claim Submitted	Policy Number	Division Number
☐ Life Insurance	☐ Employee Death ☐ Dependent Death		
☐ Accidental Death & Dismemberment	☐ Employee Death ☐ Dependent Death		

B. Information About the Employer

Employer Name

Employer Street Address

City State Zip -

Subsidiary/Affiliate/Branch Name

C. Information About the Employee – The term "employee" refers to employees, members and/or retirees.

Employee Name (Last Name, Suffix, First Name, MI) Gender ☐ Male ☐ Female

Employee Street Address

City State Zip -

Date of Birth (mm/dd/yy) Social Security Number Date of Hire (mm/dd/yy) Date of Death (mm/dd/yy)

If this employee is or has been known by another name(s) (such as a nickname, maiden name, etc.), please provide the name(s).

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired

Hours Worked Per Week:

Salary/Rate of Pay: ☐ Hourly ☐ Salary

Amount: $ _____

Job Title/Class:

Please provide the following salary verification/documentation. This information is necessary to accurately determine the amount of the life insurance benefit.

If the definition of annual earnings is:	**Then provide, as stated in your policy:**
W-2	A copy of the prior year W-2
Salary with commissions and/or bonus	• Payroll records • Documentation of commissions and/or bonuses

Last Date Physically at Work (mm/dd/yy):

Reason for Stopping Work:

Is the employee receiving any company sponsored retirement benefits? ☐ Yes ☐ No

If yes, when did the employee retire (mm/dd/yy)?

If yes, please describe the retirement benefits:

Amount of Insurance	**Basic**	**Effective Date of Coverage (mm/dd/yy)**	**Supplemental**	**Effective Date of Coverage (mm/dd/yy)**
Life Insurance	$ _____	_____	$ _____	_____
Accidental Death and Dismemberment	$ _____	_____	$ _____	_____

GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

EMPLOYER STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

Changes to the Amount of Insurance	Amount of last change		Date of last change (mm/dd/yy)
Basic Life	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Life	$ _____	☐ Increase ☐ Decrease	_____
Basic Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____

Date of last premium payment for this employee (mm/dd/yy):

The Accidental Death and Dismemberment policy may provide an education benefit. Does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled in an institution of higher learning beyond the 12th grade? ☐ Yes ☐ No If yes, please provide the following information for each child:

Name: _____ Age:_____

Name: _____ Age: _____

Name: _____ Age: _____

D. Information About the Dependent – Please complete this section if the claim is for the death of the employee's dependent.

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

Relationship to Employee
☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

Dependent Date of Birth (mm/dd/yy) | Dependent Date of Death (mm/dd/yy)

Dependent Social Security Number

Dependent Gender
☐ Male ☐ Female

Dependent Effective Date of Coverage (mm/dd/yy)

Amount of Insurance	Basic	Effective Date of Coverage (mm/dd/yy)	Supplemental	Effective Date of Coverage (mm/dd/yy)
Life Insurance	$ _____	_____	$ _____	_____
Accidental Death and Dismemberment	$ _____	_____	$ _____	_____

Changes to the Amount of Dependent Insurance	Amount of last change		Date of last change (mm/dd/yy)
Basic Life	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Life	$ _____	☐ Increase ☐ Decrease	_____
Basic Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____
Supplemental Accidental Death and Dismemberment	$ _____	☐ Increase ☐ Decrease	_____

Date of last premium payment for this dependent (mm/dd/yy):

Was the employee in active employment at the time of the dependent's death?
☐ Yes ☐ No

GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

EMPLOYER STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

E. Information About the Employee's Beneficiary(ies) – If the claim is for the death of the employee, please complete this section. If there are more than three, please provide the following information for each additional beneficiary on a separate sheet of paper and include it with this form. **The first beneficiary listed will receive the Life Planning Resources, if the services are provided by this policy.**

Name, Address & Telephone Number	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

A copy of the most recent beneficiary designation form is enclosed. ☐ Yes ☐ No If no, please explain:

F. Information About Minor Beneficiary – If any of the above beneficiaries are minor children, please complete this section. If there is more than one, please provide the following information for each additional minor beneficiary on a separate sheet of paper and include it with this form.

Name of Minor Child (Last Name, Suffix, First Name, MI):

Adult Representative of Minor Child (Last Name, Suffix, First Name, MI):

Mailing Address of Adult Representative:

City: State: Zip: | Telephone Number of Adult Representative:

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civilpenalties. This includes Employer portions of the claim form.

G. Information About and Signature of Benefit Administrator (Please Print)

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form

Title of Person Completing Form | Telephone Number | Fax Number

Signature
X

Date Signed

GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

ACCIDENTAL DEATH STATEMENT (PLEASE PRINT)

To be completed by:
- **the beneficiary or next of kin, if the claim is related to the accidental death of the employee**
- **the employee, if the claim is related to the accidental death of a dependent**

Please attach copies of any police and/or emergency medical services reports.

A. Information About the Employee

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

Date of Birth (mm/dd/yy)

Employer Name

Employer Telephone Number

B. Information About the Deceased

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

Deceased Social Security Number

Deceased Date of Birth (mm/dd/yy)

Date of Death (mm/dd/yy)

Relationship to the Employee ☐ Self ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

C. Information About the Accident

Date of the accident (mm/dd/yy):	Time of the accident:

Where did the accident happen?

Describe how the accident happened.

D. Information About the Witnesses to the Accident

Please provide the following information about all witnesses to the accident. If there were more than three, please share the following information for each additional witness on a separate sheet of paper and include it with this form.

Witness Name	Mailing Address	Telephone Number

E. Information About the Investigating Authorities

Name/Title of Investigating Officer:	Telephone Number
Other: Name/Title	Telephone Number

GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

ACCIDENTAL DEATH STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

F. Information About Physicians/Hospitals

Please provide the following information about all the physicians/hospitals who attended the deceased for injuries sustained in this accident. If there were more than three, please share the following information for each additional physician/hospital on a separate sheet of paper and include it with this form.

Physician/Hospital Name	Mailing Address	Telephone Number

G. Information About Previous Medical Conditions

Please provide the following information about all physicians who treated the deceased for any medical condition in the last five years. If there were more than five, please share the following information for each additional physician on a separate sheet of paper and include it with this form.

Physician Name, Specialty, Address and Telephone Number	Medical Condition Treated

GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

ACCIDENTAL DEATH STATEMENT (Continued)

Employee 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

The above statements are true and complete to the best of my knowledge and belief.

Language Preference: ☐ English ☐ Spanish

Print Name	Telephone Number
Signature **X**	**Date Signed**

GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

Please sign and return this authorization to The Benefits Center at the address above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Authorization – Life or Accidental Death Claim

I authorize health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies, and all other medical or medically related providers, facilities or services, medical examiner's offices, coroner's offices, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, law enforcement agencies, 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 the deceased's 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, death, earnings, financial or credit history, professional licenses, employment history, autopsy reports and findings, laboratory test results and findings, toxicology results, police reports, accident reports, or incident reports of any kind, photographs, blood, urine, or other specimens, insurance claims and benefits, and all other claims and benefits of _____ (print name of deceased):

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 the deceased's 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, the deceased's employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about the deceased to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to the deceased's 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.

_____ _____
Signature of Beneficiary or Personal Representative Date Signed

_____ _____
Printed Name Social Security Number

I signed on behalf of the Beneficiary or Personal Representative as _____(print relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.