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. You are entitled to receive a copy of this authorization.

Authorization – Accelerated Benefit or Dismemberment Claim

I authorize the following persons: health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies, and all other medical or medically related providers, facilities or services, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, 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 my or my dependent insured'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, earnings, financial or credit history, professional licenses, employment history, 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 insured or dependent insured) ("Information"):

To 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");

So that Unum may evaluate and administer my claims. For evaluation and administration of claims, this authorization is valid for two years or the duration of my or my dependent insured's claim, whichever is shorter. I understand that once Information is disclosed to Unum, privacy protections established by HIPAA may not apply to information, but other privacy laws continue to apply. Unum may then disclose the Information only as permitted by law, including state fraud reporting laws, or as authorized by me.

I also authorize Unum to disclose 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. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purpose of these disclosures by Unum, this authorization is valid for one year, or for the length of time otherwise permitted by law.

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, except as specified above, Unum may not be able to evaluate my or my dependent insured's claim(s), which may lead to my or my dependent insured's 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.

_____ _____
Insured or Dependent Insured's Signature Date Signed

_____ _____
Printed Name Social Security Number

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