GROUP LIFE ACCELERATED BENEFIT 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?

This claim form consists of the following sections to be completed by the person indicated:

- **Employer Statement (pages 4-5):** 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. The employer should also provide the original enrollment form and any other enrollment forms indicating any change in coverage.
- **Employee Statement for Accelerated Life Insurance Benefits (pages 6-7):** This section of the form should be completed by the employee who should fax it to 1-800-447-2498 or mail it to the address noted above.
- **Attending Physician Statement (pages 8-9):** The employee should complete Part I of this section of the form and give it to the physician primarily responsible for the patient's care to complete Part II. The completed form should be faxed to 1-800-447-2498 or mailed to the address noted above.
- **Substitute W-9 Form (page 10):** This form should be completed, signed and dated by the beneficiary. If there are multiple beneficiaries, each beneficiary should complete, sign and date a form. The completed form(s) 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 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 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.

Instructions (continued) / Claim Fraud Statements

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.

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.

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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 Claim Submitted	Policy Number	Division Number
☐ Employee Accelerated Benefit ☐ Dependent Accelerated Benefit		

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)

Employee Street Address

City | State | Zip

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

Date Employee Entered Eligible Class (mm/dd/yy):	Termination & Rehire Dates (mm/dd/yy): Termination: Rehire:	Acquisition Date (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 ☐ Exempt ☐ Non-Exempt ☐ Bargaining ☐ Non-Bargaining ☐ Union ☐ Non-Union	Hours Worked Per Week:	If eligibility is not based on hours worked, please describe:

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 and the last payroll statement for the same year.
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 benefit:

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

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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	_____

Date the premium was paid through for this employee (mm/dd/yy):

D. Information About the Dependent – Please complete this section if the claim is for an accelerated life insurance benefit for 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 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	$ _____	_____	$ _____	_____

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	_____

Date the premium was paid through for this dependent (mm/dd/yy):

Is the employee currently in active employment? ☐ **Yes** ☐ **No**

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.

E. 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

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EMPLOYEE STATEMENT FOR ACCELERATED LIFE INSURANCE BENEFITS (PLEASE PRINT)

A. Information About the Employee

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

Date of Birth (mm/dd/yy)

Employer's Name

Employer's Telephone Number

B. Information About the Patient

Individual's Name (Last Name, Suffix, First Name, MI)

Telephone Number

Individual's Social Security Number

Individual's Date of Birth (mm/dd/yy)

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

C. Information About the Patient's Medical Condition

Medical Condition:	Date symptoms of the medical condition were first noticed (mm/dd/yy):	Date first treated (mm/dd/yy):

Describe the first symptoms of the medical condition:

Has the patient ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, please explain:

D. Information About Physicians/Hospitals

Please provide the following information about all the physicians/hospitals who treated the patient for this medical condition. If there are more than four, 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

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EMPLOYEE STATEMENT FOR ACCELERATED LIFE INSURANCE BENEFITS (Continued)

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

E. Special Notice to New York Employees

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents. Receipt of accelerated death benefits may be taxable. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor. This application is voluntary and without coercion on the part of any third party. No health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility. Within 5 days of receipt of this claim form, Unum will provide a disclosure statement to you containing information related to the payment of the accelerated death benefits as specified in New York Insurance Law §3230(d). New York Insurance Law §3230(c) prohibits Unum from paying accelerated death benefits for a period of 14 days from the date on which the disclosure statement is provided to you.

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.

F. 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**

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ATTENDING PHYSICIAN STATEMENT FOR ACCELERATED LIFE INSURANCE BENEFITS (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT OR EMPLOYEE

A. Information About the Patient

Name of Patient (Last Name, Suffix, First Name, MI)

Patient Social Security Number | Patient Date of Birth (mm/dd/yy) | Patient Home Telephone Number

B. Information About the Employee

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

Name of Employer | Employer Telephone Number

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: The purpose of this statement is to provide information to assist in our evaluation of the patient's claim for payment of accelerated life insurance benefits for terminal illness. Please complete all applicable sections and provide copies of all supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, please complete the signature section at the end of this statement.

A. Information About the Medical Condition

Diagnosis: | Date Diagnosed (mm/dd/yy):

Date of First Visit (mm/dd/yy): | Date of Most Recent Visit (mm/dd/yy): | Frequency of Visits: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

When did the symptoms first appear?

Has the patient ever had the same or a similar condition? ☐ Yes ☐ No If yes, please describe:

During the last six months, has the patient: ☐ Recovered ☐ Improved ☐ Retrogressed ☐ Unchanged

The patient currently is: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined ☐ Hospice Confined As of: _____

Other Providers: Are you aware of or have you referred your patient to other treating providers? If yes, please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Telelphone #

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ATTENDING PHYSICIAN STATEMENT FOR ACCELERATED BENEFITS (Continued)

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

B. Information About Life Expectancy

Have you diagnosed this patient as terminally ill? ☐ Yes ☐ No | If yes, date the condition became terminal (mm/dd/yy):

What is the patient's life expectancy?
☐ Less than 6 months ☐ 6-12 months ☐ 12-24 months ☐ Greater than 24 months

C. Information About Cancer – Please complete this section if the patient has been diagnosed with cancer.

Please check the current stage: ☐ I ☐ II ☐ III ☐ IV

Date of Distant Metastasis(es): | Location of Metastasis(es):

D. Information About Heart Disease – Please complete this section if the patient has been diagnosed with heart disease.

Functional Capacity (American Heart Association)
☐ Class 1 (no limitation)
☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation)
☐ Class 4 (complete limitation)

Therapeutic Class (Activity)
☐ A. No restrictions
☐ B. Slight restrictions
☐ C. Moderate restrictions
☐ D. Marked restrictions
☐ E. Complete restrictions

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 portions of the claim form.

E. 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 Tax ID Number:

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

Signature of Physician | **Date**

X

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	**Signature of U.S. person** ▶	**Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

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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.