



WHEN TO REPORT A CLAIM

- When you have an absence from work due to illness or injury or
 - Up to 2 weeks in advance of a planned disability absence (such as childbirth or prescheduled surgery).
- Under most circumstances, you will have seen a healthcare provider and provided a signed copy of the **Authorization** to your

healthcare provider before you report a claim.

TO REPORT A CLAIM

1. Notify your supervisor to report your absence.
2. See your healthcare provider. Bring your **Reference Card** with you, and:
 - Have your healthcare provider make a **copy** of the Authorization.
 - You should sign and date the copy of the Authorization. You or your healthcare provider must return a copy of the signed and dated Authorization to UnumProvident immediately by faxing it to the Customer Care Representative designated to review your claim or by returning it to UnumProvident with a copy of your medical records. Ask your healthcare provider to keep a signed copy on file at his/her office. Remember that a signed copy of the Authorization is required for processing your claim. UnumProvident must be able to obtain medical information about your claim in order to process any benefit for which you may be eligible.
 - **Hold on to your original Authorization. Don't sign or date the original** — you may have to use it more than once.

BEFORE YOU CALL THE TOLL-FREE NUMBER

Be prepared to provide the following information. If someone else makes the call on your behalf, he or she will need to provide this information.

- Company's name
- Policy Number (on your Reference Card)
- Name and Social Security Number
- Complete address and phone number
- Date of birth
- Marital status and number of dependents
- Occupation (or job title)
- Supervisor's name and phone number
- Healthcare provider's name, address and phone number
- A brief description of your medical condition
- Date and description of injury (if applicable)
- The cause of your medical condition (illness, injury, whether it's work-related)
- The dates of your first visit, your most recent visit, and your next scheduled visit with your healthcare provider for this condition
- Your last day worked and your first day absent from work due to this condition
- The date you expect to return to work (if you know), or the actual date if you have already returned to work at the time you call.

3. Call the toll-free number: **X-XXX-XXX-XXXX**.

Our hours of operation are Monday-Friday, 8 a.m. to 8 p.m., **Generic** Time.

Prompt and complete information from you and your healthcare provider will help assure a timely decision and payment if you are eligible.

Claim Fraud Warning Statements

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma and others require the following statement to appear:

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.

Fraud Warning for California Residents

For your protection, California law requires the following to appear:

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

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 Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning for Maine and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for New Jersey Residents

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Warning for New Mexico and Pennsylvania Residents

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 New York Residents

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 each such violation.

Telephone Claim Easy Reference Card

Detach this card and keep it available for easy access.

TO REPORT A CLAIM

1. Notify your supervisor to report your absence.
2. See your healthcare provider. Bring this Reference Card with you, and:
 - Make a copy of the **Authorization** (see below).
 - Sign and date the copy.
 - Fax signed and dated copy to your UnumProvident Customer Care Representative.
 - Keep signed, dated copy on file at your healthcare provider's office.
 - UnumProvident will contact your healthcare provider to obtain necessary medical information about your claim.
 - **Hold on to this reference card. Don't sign or date this original.**
3. Call the toll-free number: **X-XXX-XXX-XXXX**. Hours of operation are Monday-Friday, 8 a.m. to 8 p.m., **Generic** Time. You should call:
 - When you have an absence from work due to illness or injury or
 - Up to 2 weeks in advance of a planned disability absence (such as childbirth or prescheduled surgery).

POLICY #: XXXXXX

Authorization

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medically-related facility, insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation, other organization, institution, or person that has any records or knowledge of me, my health (including any disorder of the immune system including HIV or AIDS, any information relating to the use of drugs and alcohol, and any information relating to mental and physical history, condition, advice or treatment), financial or credit information, earnings, employment history or other insurance benefits, to release this information to any of the UnumProvident Corporation subsidiaries or their duly authorized representatives. I also authorize the UnumProvident Corporation subsidiaries to request a report from the Medical Information Bureau (MIB), and the association of life insurance companies which operates the Health Claims Index (HCI) and the Disability Income Record

(continued on back)



System (DIRS). I understand that the dates of my past and present claims with any of the UnumProvident Corporation subsidiaries, excluding medical or personal information, may be reported to MIB and that an HCI or DIRS report may reflect this information including the identity of other insurance companies to which I have submitted claims. I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering a claim for benefits.

I further authorize the UnumProvident Corporation subsidiaries or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

I further authorize the UnumProvident Corporation subsidiaries or other authorized representatives to release all information (including information pertaining to HIV or AIDS, mental illness, and drug and alcohol abuse) related to any insurance claims arising out of my injury or illness to insurance companies, third party administrators, health care providers, rehabilitation professionals, vocational evaluators, employers, my insurance agent, and any institution or person on a need to know basis for the purpose of verifying, evaluating, analyzing, negotiating, or other pertinent uses with respect to my claims for benefits.

I, or my authorized representative, may revoke this authorization in writing at any time except to the extent it has been relied on prior to notice of revocation. This authorization may be revoked by sending written notice to:

UNUMPROVIDENT CORPORATION
Customer Care Location
Street Address
City, State, Zip

This authorization is valid for two years from the date below unless it is revoked in writing. I know that I, or my authorized representative, have a right to request a copy of this authorization. A copy of this authorization shall be as valid as the original.

The statements made by me on this claim are true and complete.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney, or Conservator. I know that if I make any representation which I know is false to obtain information from federal records, I could be punished by fine or imprisonment or both.

Signature of Claimant _____

Print Name _____

Date Signed _____

Social Security Number _____

I signed on behalf of the claimant as _____
(indicate relationship).

If Power of Attorney, Guardian or Conservator, attach a copy of document granting authority.

**Claims administered by:
UnumProvident Customer Care Center**

UNUMPROVIDENT CORPORATION
Customer Care Location
Street Address
City, State, Zip
www.unumprovident.com

© 2002 UnumProvident Corporation. The name and logo combination is a servicemark of UnumProvident Corporation. All rights reserved.

Insurance products are underwritten and sold and services provided by the subsidiaries of UnumProvident Corporation. Not all companies do business in all jurisdictions. In New York, insurance products are offered by First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company.

Short Term Income Protection



*Reporting Your Short
Term Disability Claim
by Telephone*

**Important Information for Reporting
a Claim for Employees of:**

ABC Company

Policy #: XXXXXX