



REPORTING YOUR LONG-TERM DISABILITY (LTD) CLAIM

WHEN TO REPORT A CLAIM

When you experience an illness or injury — whether it is work-related or not — always follow your sector's procedures for reporting an absence from work due to illnesses or injury. **If you are on an approved medical leave for more than 90 days, you should notify UnumProvident of your disability — you may be eligible for long-term disability benefits.**

Long-term disability benefits are not available until you have been continuously disabled for six consecutive months.

HOW TO REPORT A CLAIM

1. Before you call UnumProvident to report your long-term disability claim, complete the enclosed Authorization form. You must complete this form in order for UnumProvident to obtain your medical records from your physician. Access to your medical records is necessary to process your long-term disability claim.

Please mail or fax your completed form to UnumProvident at the address or fax number below:

Glendale Customer Care Center
655 North Central Ave., Suite 800
Glendale, CA 91203
Fax: 1-877-851-7624

Be sure to give your health care provider a copy of the completed Authorization form, and please also keep a copy for your files.

2. To report your long-term disability claim, call UnumProvident at **1-866-278-4638**. Benefits service representatives are available to assist you with your claim Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time, excluding holidays.

The benefits service representative will ask you to provide the information listed in the "Before You Call..." box below. Please have this information ready before you call.

BEFORE YOU CALL...

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 (in the upper left-hand corner of this page)
- Name and Social Security number (SSN)
- Complete address and phone number
- Date of birth
- Marital status and number of dependents
- Occupation (or job title)
- Supervisor's name and phone number
- Health care 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 health care 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.

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.



UNUMPROVIDENT CORPORATION
 Glendale Customer Care Center
 655 North Central Ave., Suite 800
 Glendale, CA 91203
 Toll-free: 1-866-278-4638
 Fax: 1-877-851-7624

Note: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization to the address or fax number above.

AUTHORIZATION

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). Information about my health may relate 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 understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. 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.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

Signature of Claimant _____ Date Signed _____

Print Name _____

Social Security number _____

I signed on behalf of the claimant as _____

(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, First Unum Life Insurance Company, Provident Life and Casualty Insurance Company, and The Paul Revere Life Insurance Company.

©2003 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.