



**HEALTH SCREENING BENEFIT CLAIM FORM
WELLNESS BENEFIT CLAIM FORM**

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

Toll-free: 1-800-635-5597 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

OUR COMMITMENT TO YOU

We understand an illness or injury creates emotional, physical and financial challenges and we want to do whatever we can to help you. You have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during the claim process.

When should you use this claim form?

Use this claim form to submit the following types of claims to Unum:

- Voluntary Benefits Health Screening Benefit
- Voluntary Benefits Wellness Benefit

If you are covered for both of these products, you only have to complete this one form.

Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for health screening and/or wellness benefits. Incomplete or illegible answers may result in a delay of benefit consideration.

- **Insured/Patient Statement** (page 3): Please complete this section of the claim form and mail or fax the completed form to the address or fax number indicated above.
- **Authorization to Share Information with Third Parties** (page 4): If you wish to give us permission to share the details of your claim with a third party (such as your spouse, son, daughter, friend, etc.), please sign and date this form and mail or fax it to the address or fax number indicated above.

Questions?

If, at any time, you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center is staffed with experienced professionals who can be contacted from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday.



**HEALTH SCREENING BENEFIT CLAIM FORM
WELLNESS BENEFIT CLAIM FORM**

The Benefits Center

P.O. Box 100158, Columbia, SC 29202-3158

Toll-free: 1-800-635-5597 Fax: 1-800-447-2498

Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

CLAIM FRAUD STATEMENTS

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

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 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 Notice for District of Columbia Residents

For your protection, the District of Columbia requires the following to appear on this claim form:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 Maine, Tennessee and Virginia Residents

For your protection, Maine, Tennessee and Virginia law requires the following to appear on this claim form:

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

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 insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

For your protection, New Jersey, New Mexico and 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 Statement 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 Statement 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 (5,000) dollars and not more than ten thousand (10,000) dollars, 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.



HEALTH SCREENING BENEFIT CLAIM FORM
WELLNESS BENEFIT CLAIM FORM

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-635-5597 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

INSURED/PATIENT STATEMENT (PLEASE PRINT)

A. Information About the Insured

Form for Insured information including Last Name, First Name, MI, Date of Birth, Social Security Number, Gender, Home Address, City, State, Zip, Home Telephone Number, Cellular Telephone Number, Work Telephone Number, Policy Number(s), and Preferred e-mail address.

B. Information About the Patient - Check One [] Self [] Spouse [] Domestic Partner [] Child

Form for Patient information including Last Name, First Name, MI, Date of Birth, Social Security Number, Gender, Home Address, City, State, Zip.

C. Information About Your or the Patient's Health Screening/Wellness Benefit Claim Complete this section for Health Screening/Wellness Benefit claims. It is not necessary to provide proof that the test/x-ray was performed.

Please check all tests performed for this patient and indicate the date the test was performed.

Table with 4 columns: Test, Date Performed, Test, Date Performed. Lists various medical tests such as Blood Test for Triglycerides, Bone Marrow Aspiration/Biopsy, Breast Ultrasound, etc.

D. Tax Considerations

Benefit payments under this policy could be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Unum reports taxable income to you and the IRS as required on form 1099-MISC. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.

E. Signature of Insured

I have read and understand the fraud notices listed on page 2 of this form. I also acknowledge that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

X
Signature Date

I signed on behalf of the insured, as (indicate relationship). If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.



**HEALTH SCREENING BENEFIT CLAIM FORM
WELLNESS BENEFIT CLAIM FORM**

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-635-5597 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

OPTIONAL - DISCLOSING INFORMATION TO THIRD PARTIES

You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your claim, we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of my claim(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health and financial information relating to my claim with the family members, friends, and/or other third parties listed below:

My Spouse: _____
(Name)

Other Family Member: _____
(Name / Relationship)

Other person: _____
(Name / Relationship)

I authorize Unum to leave messages about my claim on my voicemail / answering machine.
 Yes No

I understand that information about my claim may include information about my health and that such information about my health may be related 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 do not wish the following information about my claim to be shared (leave blank if not applicable):

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.

I may revoke this authorization in writing at any time except to the extent Unum or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of my claim. I may request a copy of the Authorization and a copy shall be as valid as the original.

Claimant Signature _____
Date

Printed Name _____
Social Security Number

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