HOSPITAL CLAIM FORM

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

Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

Unum Life Insurance Company of America
First Unum Life Insurance Company*
Unum Insurance Company
Provident Life and Accident Insurance Company
Provident Life and Casualty Insurance Company*
The Paul Revere Life Insurance Company*

For use with policies issued by the above Unum Group ["Unum"] subsidiaries.

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.

INSTRUCTIONS

Use this claim form to submit a Supplemental Health Hospital claim to Unum

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The information provided on this claim form will be used to evaluate your eligibility for Supplemental Hospital benefits. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- **Insured/Patient Statement (pages 3-4):** Please complete this section of the claim form and fax the completed form to 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- **Authorization to Share Information with Third Parties (page 5):** 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 fax it to 1-800-447-2498. If you prefer, it may be mailed to the address noted above.
- **Insured/Policyholder/Patient Authorization (last page):** Please sign and date this form, provide a copy to your attending physician, and fax the completed form to 1-800-447-2498. If you prefer, it may be mailed to the address noted above. This form authorizes the release of medical and other types of information needed to evaluate your claim.
- **Attending Physician Statement (pages 6-7):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete. Your physician or treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above. Unum is not responsible for expenses associated with the completion of this form.

Unum Online Services

Unum has developed a secure and easy way for you to submit and manage your claim online via our secure website at www.unum.com/claimant. Our secure web services allow you to access and make changes to your open claims, as well as view updates and available correspondence. Please contact your employer's human resource department to verify online filing is available to you.

Once you have submitted your claim, you may manage it with the Unum Customer App. The Unum Customer App is available for Apple and Android.

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.

* Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this 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.

For your protection:

Alabama law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado law requires the following statement to appear on this 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.

District of Columbia law requires the following statement to appear on this form: 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.

Florida law requires the following statement to appear on this form: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky law requires the following statement to appear on this 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.

Minnesota law requires the following statement to appear on this form: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire law requires the following statement to appear on this 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.

New Jersey law requires the following statement to appear on this 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, subject to criminal prosecution and civil penalties.

New York law requires the following statement to appear on this 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 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.

Pennsylvania law requires the following statement to appear on this 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.

Puerto Rico law requires the following statement to appear on this 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.

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INSURED/PATIENT STATEMENT (PLEASE PRINT)

A. Information About the Employee

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)	Social Security Number	Gender ☐ Male ☐ Female	Policy Number

Home Address

City	State	Zip

Telephone Number	Preferred e-mail address (for confirmation purposes only)

Language Preference ☐ English ☐ Spanish

If known, please check all types of coverage you have with Unum. ☐ Disability ☐ Life ☐ Critical Illness ☐ Accident

While there is no legal requirement for you to provide information regarding other policies you may have with Unum, this information will help us identify any other coverage you have with us for which you may be eligible to file a claim. Failure to provide the requested information may delay claim initiation under the additional policy or policies.

B. Information About the Patient (if different from insured) **Check one:** ☐ **Spouse** ☐ **Domestic Partner** ☐ **Dependent Child**

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)	Social Security Number	Gender ☐ Male ☐ Female	Policy Number

If claim is for a child, please state your relationship to the child

C. Information About Your Well Child Visit Claim. Complete this section for the Well Child Visit claim only, then go to section G

Well Child Visit (if applicable) Please submit proof of visit for up to four well child visits for covered children under the age of 1.

Date(s) of Test(s). _____(for multiple test dates, provide information)

D. Information About Your Condition

What is the medical condition?

If the condition is the result of an accident, how and when did it occur?

Date(s) of Diagnostic Test/Outpatient Surgery

Test/Procedure Performed

Date(s) of Hospital Admission and Discharge Admission: Discharge:

Date(s) of Intensive Care Unit (ICU) Admission and Discharge Admission: Discharge:

E. Information About Your Claim

Please attach any documentation related to your treatment including physician, ambulance, emergency room, hospital admission/discharge, report, etc. Documentation should include diagnosis information (from your medical provider). Additional medical information may be requested to evaluate your claim.

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INSURED/PATIENT STATEMENT (Continued)

Insured's Name (Last Name, Suffix, First Name, MI)	Date of Birth (mm/dd/yyyy)

F. Information About Physicians and Hospitals Please provide the following information about your treating physician and any other physician(s) treating you for this medical condition. If you are being treated by more than one, please share the following information for each physician on a separate sheet of paper and include it with this form.

1. Physician Name _____ Mailing Address _____ Telephone No. _____

Specialty _____ City _____ State _____ Zip _____ Fax No. _____

Date of First Visit (mm/dd/yyyy) _____ Date of Next Visit (mm/dd/yyyy) _____ Diagnosis _____

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.

G. Signature of Insured

I have read and understand the fraud notices listed above and on page 2 of this form. I also understand 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.**

Reminder: Please sign and date the Authorization (last page of this claim form).

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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 leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), 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 any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) with the family members, friends, and/or other third parties listed below:

My Spouse: _____

(Name) (Telephone Number)

Other Family Member: _____

(Name / Relationship) (Telephone Number)

Other person: _____

(Name / Relationship) (Telephone Number)

I understand that information about my claim(s) and/or leave(s) 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(s) and/or leave(s) 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 any of my claim(s) and/or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

_____ _____

Insured Patient 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.

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ATTENDING PHYSICIAN OR PROVIDER OF SERVICE STATEMENT (PLEASE PRINT)

TO BE COMPLETED BY ATTENDING PHYSICIAN OR TREATING PROVIDER
Please complete Section A and D for all claims. Please complete Section B for Emergency Room and Hospital confinement, Section C for Diagnostic Testing and Outpatient Surgery claims

Insured Name (Last Name, Suffix, First Name, MI)	Insured Social Security Number
Patient Name (Last Name, Suffix, First Name, MI)	Patient Social Security Number
Patient Relationship to Employee: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child Patient Gender: ☐ Male ☐ Female	Patient Date of Birth (mm/dd/yyyy)

Please provide copies of all test results, operative reports, pathology reports, and/or your detailed medical statement related to the service provided to the patient.

A. Complete this section for all medical conditions

Date of injury or first symptom (mm/dd/yyyy)	Date patient first consulted you for this condition (mm/dd/yyyy)?	Diagnosis	ICD Code

Accident Description:

Reason for Treatment ☐ Accident ☐ Sickness ☐ Pregnancy

Has the patient been treated for the same or a similar condition by another physician in the past? ☐ Yes ☐ No
If yes, what was the first date of treatment (mm/dd/yyyy)?

Other Providers: In a separate attachment, please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Place of Service Codes

11–Office	26–Military Facility	51–Inpatient Psychiatric Facility	62–Comprehensive Outpatient Rehabilitation Facility
12–Home	31–Skilled Nursing Facility	52–Psychiatric Facility Partial Hospitalization	65–End Stage Renal Disease Treatment Facility
21–Inpatient Hospital	32–Nursing Facility	53–Community Mental Health Center	71–State or Local Public Health Clinic
22–Outpatient Hospital	33–Custodial Care Facility	54–Intermediate Care Facility/Mentally Retarded	72–Rural Health Clinic
23–Emergency Room/Hospital Center	34–Hospice	55–Residential Substance Abuse Treatment Facility	81–Independent Laboratory
24–Ambulatory Surgical	41–Ambulance (Land)	56–Psychiatric Residential Treatment Center	99–Other Unlisted Facility
25–Birthing Center	42–Ambulance (Air or Water)	61–Comprehensive Inpatient Rehabilitation Facility	

B. Complete this section for EMERGENCY ROOM, AMBULANCE, and HOSPITAL CONFINEMENT claims (Please refer to Place of Service codes above)

Date of Admission (mm/dd/yyyy) and Time of Admission	Date of Discharge (mm/dd/yyyy) and Time of Discharge	Place of Service Code	Diagnosis Code Related to the Hospital Confinement (ICD Code)	Name/Address/Phone Number of Facility

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ATTENDING PHYSICIAN OR PROVIDER OF SERVICE STATEMENT (Continued)

Employee's Name (Last Name, Suffix, First Name, MI)	Date of Birth (mm/dd/yyyy)
Patient's Name (Last Name, Suffix, First Name, MI)	Date of Birth (mm/dd/yyyy)

Place of Service Codes

11–Office	26–Military Facility	51–Inpatient Psychiatric Facility	62–Comprehensive Outpatient Rehabilitation Facility
12–Home	31–Skilled Nursing Facility	52–Psychiatric Facility Partial Hospitalization	65–End Stage Renal Disease Treatment Facility
21–Inpatient Hospital	32–Nursing Facility	53–Community Mental Health Center	71–State or Local Public Health Clinic
22–Outpatient Hospital	33–Custodial Care Facility	54–Intermediate Care Facility/Mentally Retarded	72–Rural Health Clinic
23–Emergency Room/Hospital Center	34–Hospice	55–Residential Substance Abuse Treatment Facility	81–Independent Laboratory
24–Ambulatory Surgical	41–Ambulance (Land)	56–Psychiatric Residential Treatment Center	99–Other Unlisted Facility
25–Birthing Center	42–Ambulance (Air or Water)	61–Comprehensive Inpatient Rehabilitation Facility	

C. Complete this section for DIAGNOSTIC TEST/OUTPATIENT SURGERY claims (Please refer to Place of Service codes above)

Surgery Date (mm/dd/yyyy)	Place of Service Code	Procedure Code (CPT Code)	Name/Description of Surgery	Diagnosis Code Related to the Surgery (ICD Code)	Address/Phone Number

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 the Attending Physician portion of the claim form.

D. Signature of Attending Physician or Provider of Service

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, Suffix, First Name, MI) Please Print

Medical Specialty	Degree

Address

City	State	Zip

Telephone Number	Fax Number	Physician's Tax ID Number

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

X
Physician Signature **Date**

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Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Authorization to Collect and Disclose Information

(Not for FMLA Requests)

I authorize the following persons: health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocator Group, Brown & Brown Absence Services Group and other Social Security advocacy vendors, professional licensing bodies, 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 health, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits ("My Information");

To Unum Group and its subsidiaries, Unum Life Insurance Company of America, First Unum Life Insurance Company*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty 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, including providing assistance with return to work. For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits (to include any subsequent financial management and/or benefit recovery review), whichever is shorter. I understand that once My Information is disclosed to Unum, any privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum may then disclose My Information only as permitted by law, including, state fraud reporting laws or as authorized by me.

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

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 or administer my claim(s), which may lead to my 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 Unum requests or discloses prior to Unum receiving my revocation request.

_____ _____
Patient's Signature Date Signed

_____ _____
Printed Name Social Security Number

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

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