



Claim Form and Instructions

Fax to: Claims 1-888-281-8324

From: _____

Fax Number: _____

Date: _____

Number of pages: _____

What can I do to avoid delays?

Missing information is one of the major causes of delay in processing. Please be sure you have:

- Signed the Authorization (page 2) and the Service Release (below).
- Completed the sections that apply to your specific claim.
- Enclosed the information requested.
- Advised your doctor we may be contacting him/her if additional information is needed.

When should I expect a reply?

Mail time is a large contributor to the time it takes for our response to reach you. **Mail may take up to four or five days each way. Typical turnaround time is 21 calendar days from mailbox to mailbox.**

When should I expect a reply?

- You may **fax** your claim to us at 1-888-281-8324. Please allow up to 48 hours for our automated service center to be updated with information confirming receipt of your fax. You may expect a **reply by mail within 14 calendar days, or....**
- You may choose to have your payment returned by **overnight delivery** by initialing the Service Release below. A \$10.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. If you fax your claim and wish us to overnight your check, you may expect a **response in approximately 7 calendar days. We will only overnight payments over \$300.00. Street address is required for overnight delivery, delivery Monday through Friday, time not guaranteed.**

SERVICE RELEASE-Please initial below as indicated.

	I authorize First Unum Life Insurance Company to facilitate processing this claim by discussing its details with a local sales representative if he/she is inquiring on my behalf.
	I authorize First Unum Life Insurance Company to communicate information (other than medical) or the status of this claim through electronic messaging at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/answering machine.
	Yes, please deduct the \$10 fee (cost subject to rate increases) to overnight any applicable benefits from my claim payment. Future payments <i>for this loss</i> will be overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under \$300 will be sent via mail.

- **If you are filing a claim for non-accident related benefits for a loss occurring within the first 6 to 24 months of your policy/certificate (based on policy requirements), we need to confirm if the condition is pre-existing. Please notify your doctor we will be contacting him/her and provide him/her with a copy of your authorization to release information to us.**
- Benefits are payable to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called an assignment. If you wish to assign your benefits, please attach a signed written request.

Claim Fraud Warning Statement

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 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 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

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.

Mail to: First Unum Life Insurance Company
Claims Processing Division
PO Box 100172
Columbia SC 29202
1-800-375-8226

Fax to: 1-888-281-8324
If you fax your claim, please
keep the original for your files.

It's easy, really... This is a multi-purpose form. Complete the general information section on this page. Then, you only need to have those sections that apply to your individual situation and coverage completed. Information does not have to be written on this form, as long as any documentation you send has the information needed to process your claim. Please check the type claim you are filing below:

- ~ **Accidental Injury- Section A** requests specific information from you about the circumstances of your injury.
- ~ **Routine Pregnancy-** Have your doctor complete **Section B** if you are filing for benefits for normal post-delivery disability.
- ~ **Total Disability- Section C** contains parts for both your employer and doctor to complete.

This claim is for: Self Spouse Dependent: if over 18, name of school _____

Has your address changed since we last heard from you? YES NO

Name of Policyholder/Employee _____ Name of Patient _____
(if not self)

Social Security Number: _____ Social Security Number: _____

Date of Birth:(mm/dd/yyyy) _____ Date of Birth: (mm/dd/yyyy) _____

Address _____
Street (Apt. #) _____ City _____ State _____ Zip _____

Home Phone Number: (_____) _____ Work Phone Number: (_____) _____

Fax Number: (_____) _____ Email Address: _____

Please print INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL
Please continue on separate sheet if necessary. Be sure to include any referring physician(s).

Full name of treating doctor _____

Mailing Address _____ City _____ State _____ Zip Code _____
(_____) _____ (_____) _____

Phone number _____ Fax number _____

Full name of treating doctor _____

Mailing Address _____ City _____ State _____ Zip Code _____
(_____) _____ (_____) _____

Phone number _____ Fax number _____

Full name of treating doctor _____

Mailing Address _____ City _____ State _____ Zip Code _____
(_____) _____ (_____) _____

Phone number _____ Fax number _____

AUTHORIZATION

I have checked the above answers and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental conditions, AIDS, AIDS related condition, and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to First Unum Life Insurance Company or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by First Unum Life Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by First Unum Life Insurance Company to any person or organization EXCEPT to reinsuring companies or other persons or organizations performing business or legal service in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one-half years from the date shown below. I certify under penalty of perjury that my correct Social Security number is shown on this form.

Signed this _____ day of _____, _____

Signature of Patient _____ Signature of Policyholder _____

A. ACCIDENTAL INJURY- please complete and attach itemized copies of any related bills including doctor, emergency room, and hospital. Bills should include diagnosis information (from your medical provider).

Date of accident(mm/dd/yyyy): _____ Time of accident: _____ am/ pm (circle one)

Tell us how your accident happened: (If you need more space, you may attach on a separate piece of paper.)

Were you at work, working for wage or profit, at the time of your accident? Yes No

Have you ever had a similar injury? _____ If so, please tell us when (mm/dd/yyyy): _____

If you are claiming disability, please have your employer and doctor complete SECTION C.

B. ROUTINE PREGNANCY (6 weeks for vaginal delivery, or 8 weeks for c-section)

First Date of Treatment(mm/dd/yyyy): _____ Date of Delivery: (mm/dd/yyyy) _____

Type delivery: Vaginal/ C-Section (circle one) Dates of Hospital Confinement (mm/dd/yyyy): _____

Name of Hospital: _____ Hospital Phone Number: (____) _____

Doctor's Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

_____ Tax Identification Number: _____

Treating Doctor's Signature: _____ Date(mm/dd/yyyy): _____

Referring Physician: _____ Phone number: (____) _____

Mailing address

If disabled due to complications of pregnancy, before or after delivery, complete *Section C*.

C. DISABILITY BENEFITS:

To be completed and signed by your *EMPLOYER*:

Name of Employer: _____ Phone Number: (____) _____

Fax Number:(____) _____

Employee's Job Title: _____

Dates this employee has been unable to work:

From: ___/___/___ am/pm To: ___/___/___ am/pm From: ___/___/___ am/pm To: ___/___/___ am/pm

Date employee returned to main or principal duties: ___/___/___ Date employee returned to light duty: ___/___/___

Did the accident occur while working for wage/profit? ___ yes ___ no

Name and address of Workers Compensation carrier, if applicable:

Signed: _____ Title: _____ Date (mm/dd/yyyy): _____

(To be signed by your employer)

To be completed and signed by the DOCTOR treating you for this disability:

Diagnosis/ primary disabling condition: _____

Is this condition the result of an accidental injury? ___ Yes ___ No If yes, please provide us with the date and description.

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment:

Dates of Inpatient Hospital Confinement: From: ___/___/___ To: ___/___/___

Hospital: _____

Name

Address

List any surgeries performed and submit a copy of the operative report. _____

How soon do you expect significant improvement in the patient's medical condition? # weeks/months (circle one)

If due to complications of pregnancy prior to delivery, what is EDC? _____

Dates unable to work: From: ___/___/___ To: ___/___/___

From: ___/___/___ To: ___/___/___

Anticipated return to work/release date: _____ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

Dates of treatment(mm/dd/yyyy): _____

Is this patient considered to be house confined or unable to perform 2 or more activities of daily living? (If not working at time of accident or when disability begins.) Yes/ No (circle one) If so, date (mm/dd/yyyy) from: _____ to _____ (This information will be used in accordance with state regulations and policy provisions.)

Restrictions/Limitations _____

Secondary conditions contributing to this disability: _____

Would the patient be disabled without regards to these secondary conditions? ___ yes ___ no

Is this patient permanently disabled? ___ Yes ___ No If yes, what is recommended frequency of treatment? _____

Does this patient have permanent restrictions/limitations? If so, list: _____

Signature of doctor: _____ Date (mm/dd/yyyy): _____ Patient #: _____

Name of doctor: _____ Phone: _____ Fax: _____

Address: _____

Email address: _____ Tax ID or SSN: _____

Referring physician: _____

Full name of treating doctor _____

Mailing Address _____ City _____ State _____ Zip Code _____

() _____ () _____
Phone number _____ Fax number _____

NOTE: Please make a copy of the patient's signed authorization to release information for your records.