How To File A Claim

1. Please complete all portions of this form. We cannot process your claim without a completed form.
2. Please review the “Benefits” section of your Summary of Benefits carefully for explanations and descriptions of which benefits you may be eligible for.
3. When all sections of this form have been completed, submit the form to the following address:

   Unum Life Insurance Company of America (UnumProvident)
   Long Term Care Customer Care
   2211 Congress Street
   Portland, Maine 04122-2300

4. If you have any questions about the claims process, please call us at 800-693-4988.

For your protection, the laws of several states, including Alaska, Georgia, Louisiana, Massachusetts, Oregon, Rhode Island, South Carolina, Texas, Utah and others require this statement to appear:

Fraud Warning

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Fraud Warning for California Residents

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. In addition, submission of false information in connection with this claim form may also constitute a crime under federal laws. UNUMProvident will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to the state and federal tax and regulatory authorities as appropriate.

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 producer 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 Regulatory Agencies.

Fraud Warning for District of Columbia Residents

WARNING: 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.

Fraud Warning for Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurer, 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 Kentucky Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Fraud Warning for New Jersey Residents

Any person who includes any false or misleading information on an application for an insurance policy 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 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 Warning for Pennsylvania Residents

WARNING: 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 Virginia Residents

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud Warning for Washington 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 include imprisonment, fines and denial of insurance benefits

UNUMPROVIDENT®

Group Long Term Care Claim Form

Employer/Group Policyholder Name:		Group ID#:
Name of Employee/Retiree: (first, middle, last)		Social Security #:
Name of Claimant: (if different than employee/retiree): (first, middle, last) Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐		Claimant's Social Security #:
Relationship to Employee: ☐ Spouse ☐ Parent ☐ Grandparent	Date of Birth: ___ /___ /_____	Telephone #: ( )

Address: (street, city, state, zip):

Where are you currently residing?

☐ Your Residence ☐ Nursing Care Facility (Nursing Home) ☐ Residential Care Facility
☐ Hospital ☐ Assisted Living Facility ☐ Other (explain)_____

If other than your Residence:
Name of Facility/Location: _____
Address: _____
Telephone #: _____ Date Entered: ___ /___ /_____

What is your primary diagnosis? _____

_____

Are there other conditions contributing to your need for assistance? _____

_____

_____

_____

_____

What assistance do you need and why? _____

_____

_____

_____

When did you first begin to need assistance? ___ /___ /_____

Who provides this assistance? _____

_____

If you have been hospitalized or confined to any other type of facility within the last year, please complete this section:

Name of Hospital/Facility: ______________________________

Address: ______________________________

____

Telephone #: (   ) ______________ Date Admitted: ___ /___ /______ Date Discharged: ___ /___ /______

Reason for admission: ______________________________

____

Name of Hospital/Facility: ______________________________

Address: ______________________________

____

Telephone #: (   ) ______________ Date Admitted: ___ /___ /______ Date Discharged: ___ /___ /______

Reason for admission: ______________________________

____

Name of Hospital/Facility: ______________________________

Address: ______________________________

____

Telephone #: (   ) ______________ Date Admitted: ___ /___ /______ Date Discharged: ___ /___ /______

Reason for admission: ______________________________

____

Please list the physicians you see on a regular basis and those with whom you have consulted with for your current condition.

Primary Care Physician's Name: ______________________________

Physician's Address: ______________________________

Telephone #: (   ) ______________ Date 1st Seen: ___ /___ /______ Date Last Seen: ___ /___ /______

Physician's Name: ______________________ Specialty: ______________

Physician's Address: ______________________________

Telephone #: (   ) ______________ Date 1st Seen: ___ /___ /______ Date Last Seen: ___ /___ /______

Physician's Name: ______________________ Specialty: ______________

Physician's Address: ______________________________

Telephone #: (   ) ______________ Date 1st Seen: ___ /___ /______ Date Last Seen: ___ /___ /______

Physician's Name: ______________________ Specialty: ______________

Physician's Address: ______________________________

Telephone #: (   ) ______________ Date 1st Seen: ___ /___ /______ Date Last Seen: ___ /___ /______

Physician's Name: ______________________ Specialty: ______________

Physician's Address: ______________________________

Telephone #: (   ) ______________ Date 1st Seen: ___ /___ /______ Date Last Seen: ___ /___ /______

Are you currently, or have you recently, received any of the following services?

☐ Home Health Services ☐ Physical Therapy ☐ Occupational Therapy ☐ Other Services

If you checked any of the above, please provide the information requested below:

Name of Provider/Agency: _____

Address: _____

Telephone #: (_____) _____ Start of Services: ___ /___ /_____ Discharge Date: ___ /___ /_____

Type of Service and Frequency: _____

_____

Name of Provider/Agency: _____

Address: _____

Telephone #: (_____) _____ Start of Services: ___ /___ /_____ Discharge Date: ___ /___ /_____

Type of Service and Frequency: _____

_____

Name of Provider/Agency: _____

Address: _____

Telephone #: (_____) _____ Start of Services: ___ /___ /_____ Discharge Date: ___ /___ /_____

Type of Service and Frequency: _____

_____

Individual completing form:

Name: _____

Address (city, state, zip): _____

Telephone #: (_____) _____ Relationship to Claimant: _____

Check here if Power of Attorney (POA): ☐

Primary Contact (if different than claimant):

Name: _____

Address (city, state, zip): _____

Telephone #: (_____) _____ Relationship to Claimant: _____

Check here if Power of Attorney (POA): ☐

UnumProvident

Authorization for Primary Contact

(Optional: If no primary contact is assigned, the claimant or their legal representative will be the primary contact.)

I authorize _____ (Print Name) to act as my representative in regard to my claim(s). In doing so, I am giving UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident") the right to discuss all aspects of my coverage and claim(s) with my representative. This may include information regarding benefits, medical conditions (including, but not limited to, HIV and AIDS, mental illness and drug and alcohol abuse), medical providers, caregivers and locations of care. This information will be provided so that my representative may assist me with my claim(s). This information may be provided to my representative in writing or orally, such as by telephone. I understand the information could be redisclosed by my representative and no longer protected by federal privacy regulations.

I understand I am not required to sign this authorization and UnumProvident may not condition payment of my claim(s) on whether I sign 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. I may revoke this authorization by sending written notice to: Long Term Care Customer Care, 2211 Congress Street, Portland, Maine 04122.

This authorization is valid for the duration of my claim unless it is revoked in writing. I know that I have a right to request a copy of this authorization. A photographic or electronic copy of this authorization is as valid as the original.

_____ _____

(Claimant Signature) (Date Signed)

_____

(Print Name)

* This authorization is valid for the following UnumProvident insurance subsidiaries: Unum Life Insurance Company of America and Provident Life and Accident Insurance Company.

UnumProvident

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: Long Term Care Customer Care, 2211 Congress Street, Portland, ME 04122.

Authorization to Disclose Information

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; health plan; rehabilitation professional; insurance company; reinsurer; insurance service provider; third party administrator; producer; government organization; and employer that has information about my health, employment information, 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. 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: Long Term Care Customer Care, 2211 Congress Street, Portland, ME 04122.

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).

_____ _____
(Claimant Signature) (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 and Provident Life and Accident Insurance Company.