NOTICE OF LIFE INSURANCE CLAIM
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

You have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during this difficult time.

When should you use this claim form?

Use this claim form to submit a Voluntary Benefits Life Insurance claim to Unum.

Who is responsible for completing this claim form?

- The beneficiary(s) is responsible for completing this form.
- If the beneficiary is a minor child, the minor's guardian/custodian needs to complete and sign section D.

How to Complete the Beneficiary Statement

- Please provide complete and legible responses to ensure the claim is processed as quickly as possible.
- If there is more than one beneficiary, only one form signed by all beneficiaries is needed. However, if it is more convenient, each beneficiary may complete a separate form.
- Please provide the policy owner name and date of birth at the top of page 4. This will be important for identification purposes if the pages of the form become separated.
- **Please include a certified death certificate with the form.**

How to Complete the Authorization (last page of this form)

- Please sign and date this form.
- Mail or fax it to the address or fax number indicated at the top of the page.

This form authorizes the release of medical information needed to evaluate this claim.

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.

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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, the District of Columbia, 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.

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BENEFICIARY STATEMENT (PLEASE PRINT)

A. Information About the Policy Owner

Policy Owner's Last Name | Suffix | Policy Owner's First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Policy Number

B. Information About the Deceased - Check One ☐ Policy Owner ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Grandchild

Deceased's Last Name | Suffix | Deceased's First Name | MI

Date of Birth (mm/dd/yy) | Date of Death (mm/dd/yy) | Social Security Number

C. Information About The Beneficiary(s): Complete Section D for minor beneficiaries.

Beneficiary #1 (Please print clearly)

Beneficiary Last Name | Suffix | Beneficiary First Name | MI

Home Address

City | State | Zip

Home Telephone Number (including area code) | Cellular Telephone Number (including area code) | Work Telephone Number (including area code)

Date of Birth (mm/dd/yy) | Relationship to Deceased ☐ Parent ☐ Child ☐ Spouse ☐ Domestic Partner ☐ Other _____

Social Security Number or Estate Identification Number

Language Preference ☐ English ☐ Spanish

X
Signature of Beneficiary **Date**

Beneficiary #2 (Please print clearly)

Beneficiary Last Name | Suffix | Beneficiary First Name | MI

Home Address

City | State | Zip

Home Telephone Number (including area code) | Cellular Telephone Number (including area code) | Work Telephone Number (including area code)

Date of Birth (mm/dd/yy) | Relationship to Deceased ☐ Parent ☐ Child ☐ Spouse ☐ Domestic Partner ☐ Other _____

Social Security Number or Estate Identification Number

Language Preference ☐ English ☐ Spanish

X
Signature of Beneficiary **Date**

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MINOR BENEFICIARY STATEMENT (Please Print)

Policy Owner's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

D. Information About Minor Beneficiary(s): For all minor beneficiaries, please provide the following information.

Minor Beneficiary #1 (Please print clearly)

Minor Beneficiary Name (Last Name, First Name, MI)	Date of Birth (mm/dd/yy)	Minor Beneficiary Social Security Number
Legal Guardian/Custodian Last Name / Suffix	Legal Guardian/Custodian First Name / MI	
Legal Guardian/Custodian Home Address	Relationship to Minor Beneficiary ☐ Parent ☐ Other _____	
City	State	Zip
Home Telephone Number (including area code)	Cellular Telephone Number (including area code)	Work Telephone Number (including area code)

Minor Beneficiary #2 (Please print clearly)

Minor Beneficiary Name (Last Name, First Name, MI)	Date of Birth (mm/dd/yy)	Minor Beneficiary Social Security Number
Legal Guardian/Custodian Last Name / Suffix	Legal Guardian/Custodian First Name / MI	
Legal Guardian/Custodian Home Address	Relationship to Minor Beneficiary ☐ Parent ☐ Other _____	
City	State	Zip
Home Telephone Number	Cellular Telephone Number	Work Telephone Number

X
Signature of Legal Guardian/Custodian **Date**

Please include copies of minor beneficiary's birth certificate and legal documentation regarding guardianship.

E. Information About the Claim if Related to an Accident

If the cause of death was the result of an accident, please describe the accident in detail and provide a copy of the official accident report.

F. Information About the Deceased's Primary Care Physician

Primary Care Physician Name	Mailing Address	Telephone No. ( )
Specialty	City State Zip	Fax No.

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AUTHORIZATION

Note: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other applicable federal and state privacy laws. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process this claim. Please sign and return this authorization to the address at the top of this page.

AUTHORIZATION

I have filed a claim for life insurance benefits with Unum on account of the death of _____ (name of deceased).

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 provider, health plan, rehabilitation professional, drug and/or alcohol rehabilitation facility, vocational evaluator, banking or financial institution, insurer or reinsurer, third party administrator, producer, consumer reporting agency, governmental agency, including the Social Security Administration, the Medical Information Bureau, law enforcement agencies, medical examiners, the Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), employers and other persons or institution; to provide Unum Group, its insurance subsidiaries*, and its duly authorized representatives ("Unum"), data or records they may have regarding the employment , medical history and treatment, and income of the deceased. The information regarding the medical history of the deceased 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 understand that any information provided pursuant to this authorization will be used to evaluate this claim and may be transferred to any agency, insurance support organization or person employed by Unum to assist with this purpose. I further understand that when information that is covered by HIPAA is disclosed to an entity that is not subject to HIPAA, the information may be redisclosed by the recipient and may no longer be subject to the protections of HIPAA. However, I also understand that such information may be redisclosed only in accordance with other applicable federal and state privacy laws.

This authorization is valid for two (2) years from the date below or the duration of this claim, whichever period is shorter. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photographic or electronic copy of this form will be as valid as the original.

I may revoke this authorization in writing at any time except to the extent that Unum 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 that if I revoke this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer this claim and this may be the basis for denying this claim.

_____ _____

Beneficiary Date

_____ _____

Print Name Policy Owner Social Security Number

I signed on behalf of the beneficiary 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 Unum insurance subsidiaries: Unum Life Insurance Company of America and Provide Life and Accident Insurance Company.