
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 Policy 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.
-

NOTICES**PLEASE READ THE FOLLOWING NOTICE THAT WE ARE REQUIRED BY LAW TO GIVE YOU.**

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. 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 state and federal tax and regulatory authorities as is appropriate.

Notice to Colorado Residents:

It is unlawful to knowingly provide false, incomplete, or misleading acts 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.

Notice to Florida Residents:

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.

Notice to 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 a 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.

Notice to Virginia Residents:

It may be a crime under state law if you knowingly, and with intent to injure, defraud or deceive any insurance company, file a statement of claim and/or application containing any false, incomplete, or misleading information. Submission of false information in connection with this claim form may also constitute a crime under federal laws. Unum will pursue any appropriate legal remedies in the event of insurance fraud, including prosecution 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 state and federal tax and regulatory authorities as is appropriate.



Individual Long Term Care Claim Form

Name of Claimant: (first, middle, last)

Ms. Miss
Mrs. Mr.

Claimant's Home Address: (street, city, state, zip)

Policy #:	Telephone #: ()	Date of Birth: ___ / ___ / ___	Social Security #:
-----------	-------------------------	-----------------------------------	--------------------

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):



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.



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.