



**CANCER CLAIM FORM
CRITICAL ILLNESS/SPECIFIED DISEASE CLAIM FORM**

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

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.

When should you use this claim form?

Use this claim form to submit a critical illness/specified disease and/or cancer claim to Unum. This form should be used for the following types of claims only:

- Voluntary Benefits Critical Illness/Specified Disease
- Voluntary Benefits Cancer
- Group Critical Illness/Specified Disease
- Group Cancer

If you are covered for more than one of these products, you only have to complete this one form.

Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for critical illness/specified disease and/or cancer benefits. Incomplete or illegible answers may result in a delay of benefit consideration. 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 mail or fax the completed form to the address or fax number indicated above. If you are applying for Voluntary Benefits Cancer or Group Cancer benefits, please attach itemized bills indicating the ICD-9 diagnosis code, the CPT-4 procedure code, and the dates of treatment, along with a copy of the pathology report. If you are applying for the Health Screening/Wellness Benefit only, please complete Sections A, B, C, and F.
- Please complete the name and date of birth fields at the top of every page for easy identification purposes in case the pages become separated.
- **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 mail or fax it to the address or fax number indicated above.
- **Attending Physician Statement** (pages 6-7): Please complete Part I of this statement, then give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete Part II. Your physician or treating provider should mail or fax the completed form to the address or fax number indicated above. If you are applying for the Health Screening/Wellness Benefit, this statement is not required. Unum is not responsible for expenses associated with the completion of this form.
- **Insured/Patient Authorization** (last page): Please sign and date this form, provide a copy to your attending physician, and mail or fax the completed form to the address or fax number indicated above. This form authorizes the release of medical information needed to evaluate your 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 Warning for the District of Columbia, 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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INSURED/PATIENT STATEMENT (Continued)

Insured's Name (Last Name, Suffix, First Name, MI)

Date of Birth

Grid for name input

MM DD YY date input boxes

D. Information About the Condition(s) Causing the Illness Complete this section for Critical Illness/Specified Disease claims only.

Please check the illness for which you are filing this claim.

- Benign Brain Tumor, Blindness, Cancer, Carcinoma in Situ, Cerebral Palsy, Cleft Lip or Palate, Coma as the result of severe Traumatic Brain Injury, Coronary Artery Bypass Graft, Cystic Fibrosis, Down Syndrome, End Stage Renal (kidney) Failure, Heart Attack (Myocardial Infarction), Major Organ Failure, Occupational HIV, Permanent Paralysis as the result of a Covered Accident, Spina Bifida, Stroke

Date of first treatment for this condition (mm/dd/yy):

E. Information About Physicians and Hospitals

Please provide the following information about your current treatment provider(s). If you are being treated by more than two providers, please share the following information for each provider on a separate sheet of paper and include it with this form.

1. Primary Care Physician Name, Mailing Address, Telephone No., Specialty, City, State, Zip, Fax No., Date of First Visit (mm/dd/yy), Date of Next Visit (mm/dd/yy)

Please list any recent hospital visits/admissions. If you have had more than two recent hospital visits/admissions, please share the following information for each visit/admission on a separate sheet of paper and include it with this form.

1. Hospital, Address, Date of Visit/Admission (mm/dd/yy), Procedure, City, State, Zip, Date of Discharge (mm/dd/yy)

F. Signature of Insured

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



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OPTIONAL - DISCLOSING INFORMATION TO THIRD PARTIES

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 claim, 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 my claim(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health and financial information relating to my claim with the family members, friends, and/or other third parties listed below:

My Spouse: _____
(Name)

Other Family Member: _____
(Name / Relationship)

Other person: _____
(Name / Relationship)

I authorize Unum to leave messages about my claim on my voicemail / answering machine.
 Yes No

I understand that information about my claim 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 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 my claim. I may request a copy of the Authorization and a copy shall be as valid as the original.

Claimant Signature _____
Date

Printed Name

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 STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY INSURED/PATIENT

Insured Name (Last Name, Suffix, First Name, MI)

Grid for Insured Name

Insured Social Security Number

Grid for Insured Social Security Number

Patient Name (Last Name, Suffix, First Name, MI)

Grid for Patient Name

Patient Social Security Number

Grid for Patient Social Security Number

Patient Relationship to Insured: Self Spouse Domestic Partner Child

Patient Gender: Male Female

Patient Date of Birth

MM DD YY date grid

PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete all applicable questions and provide copies of supporting reports, such as office notes, medical records, consultations, and/or testing. Please sign and date the form.

Complete these questions for all medical conditions

Diagnosis Information

Diagnosis: _____ ICD-9 Code: _____
Date of Diagnosis: _____ Date you were first consulted for this condition (mm/dd/yy): _____

Please check the condition(s) that applies to this patient and provide the test results, operative reports, pathology reports, and/or your detailed medical statement as required for the condition(s) indicated below (check all that apply):

Condition	Medical Documentation	Other Pertinent Information
<input type="checkbox"/> Benign Brain Tumor	Tissue Biopsy	
<input type="checkbox"/> Blindness	Metric Acuity or Snellen/E-Chart Acuity Measurements	Visual Acuity after correction L____ R____ Visual Field Restriction L____ R____
<input type="checkbox"/> Cancer	Pathology Report and/or Clinical Diagnosis	Stage: _____ Grade: _____
<input type="checkbox"/> Carcinoma in Situ	Pathology Report and/or Clinical Diagnosis	
<input type="checkbox"/> Cerebral Palsy	Clinical Diagnosis	
<input type="checkbox"/> Cleft Lip or Palate	Clinical Diagnosis	
<input type="checkbox"/> Coma (resulting from severe traumatic brain injury)	Clinical Diagnosis	Has patient experienced a continuous state of unconsciousness for 14 or more consecutive days? <input type="checkbox"/> Yes <input type="checkbox"/> No Did patient require intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Coronary Artery Bypass Surgery	Surgical report	
<input type="checkbox"/> Cystic Fibrosis	Clinical Diagnosis	
<input type="checkbox"/> Down Syndrome	Clinical Diagnosis	
<input type="checkbox"/> End Stage Renal Failure	Clinical Diagnosis	Does patient have chronic irreversible function of both kidneys? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient require regular hemodialysis or peritoneal dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Heart Attack	Any of the following: Electrocardiograph (EKG), cardiac enzymes, thallium scans, MUGA scans, stress echocardiogram	
<input type="checkbox"/> Major Organ Transplant/Failure	Surgical Report	Is the patient on the UNOS list? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date added to UNOS list: _____
<input type="checkbox"/> Occupational HIV	Clinical Diagnosis	
<input type="checkbox"/> Permanent Paralysis	Clinical Diagnosis	
<input type="checkbox"/> Spina Bifida	Clinical Diagnosis	
<input type="checkbox"/> Stroke	Documented neurological deficits and/or neuroimaging studies	

Return to Work Assessment

Did you advise the patient to stop work? Yes No If yes, when (mm/dd/yy)? _____ Have you advised patient to return to work? Yes No If yes, expected return to work date (mm/dd/yy): _____
 Full Time Part Time

If yes, please indicate any ongoing restrictions and limitations in the space provided on the next page.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided on the next page.



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INSURED/PATIENT AUTHORIZATION

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

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; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; professional licensing body; and employer that has information about my health, financial or credit history, professional license, earnings, employment history, or other insurance claims and benefits, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum Group, its insurance subsidiaries* and duly authorized representatives ("Unum"), and, where applicable, to persons or entities that may assist me with or provide services related to my claim(s) for Social Security or other government-sponsored benefits. 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 Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. 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 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 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 if I revoke this authorization, Unum 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 the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

(Patient/Guardian Signature)

(Date Signed)

(Print Name)

(Social Security Number)

I signed on behalf of the patient 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, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.