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

Fraud Warning

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, New Mexico, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, Washington, and West Virginia require the following statement to appear on this claim form:

Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly 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 Alabama Residents

For your protection, Alabama law requires the following to appear on this claim form:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 District of Columbia Residents

For your protection, the District of Columbia requires the following to appear on this claim form:
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

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 insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Warning for Kentucky Residents

For your protection, Kentucky 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 a 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.

Fraud Warning for Minnesota Residents

For your protection, Minnesota law requires the following to appear on this claim form:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Fraud Warning for New Hampshire Residents

For your protection, New Hampshire law requires the following to appear on this claim form:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

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CLAIM FRAUD STATEMENTS

Fraud Warning for New Jersey Residents

For your protection, New Jersey law requires the following to appear on this claim form:
Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and civil penalties.

Fraud Warning 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 Warning for Pennsylvania Residents

For your protection, 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 Warning 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 dollars ($5,000) and not more than ten thousand dollars ($10,000), 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 _____
If divorced, please provide the division of property documents from your divorce decree.

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 _____
If divorced, please provide the division of property documents from your divorce decree.

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.

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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)

Information About the Unum Retained Asset Account

If approved benefits are payable to a minor and no financial guardian is appointed, payment will be made through a Unum Retained Asset Account set up in the minor's name and payable through the Bank of New York Mellon. Payment through a retained asset account will satisfy Unum's claim payment obligation. The funds may not be withdrawn from the account until the minor becomes an adult (typically age 18, but this may vary by state). The money may be withdrawn earlier by a court appointed conservator or guardian of the minor's estate. We must receive copies of the court documents appointing the conservator or guardian of the minor's estate. These documents can be provided to Unum by mailing them to the address listed on this form.

Please review the features of the Unum Retained Asset Account:

- A quarterly statement is provided, detailing the account balance, interest rate, accrued interest and account transactions for the statement period.
- Funds in the Unum Retained Asset Account are fully guaranteed by Unum Group. The funds are not protected by the FDIC, but are protected by state Guaranty Associations. You may contact the National Organization of Life and Health Insurance Guaranty Associations at nolhga.com or (703) 481-5206 to learn more about the protections provided.
- The beneficiary may leave the money in the Unum Retained Asset Account for as long as he/she wishes.
- Unum will retain the funds and invest them in its general account for as long as they remain in the Unum Retained Asset Account. Unum guarantees the account balance and will pay a competitive interest rate regardless of the investment performance of Unum's general account. Unum may derive income from the total gains received on the investment of the balance of the funds in the retained asset account.
- The interest rate is determined by monitoring rates of interest offered on similar types of accounts (i.e. checking, savings and money market accounts). Any changes to the interest rate will be disclosed via a quarterly account statement.

The interest earned on the Unum Retained Asset Account may be taxable. The beneficiary's guardian should consult a tax advisor, an investment advisor, or another financial advisor with any questions. For further information, please contact your state insurance department. You may contact us at the telephone number listed on this form.

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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Please sign and return this authorization to The Benefits Center at the address above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Authorization – Life or Accidental Death Claim

I authorize health care professionals, hospitals, clinics, laboratories, pharmacies, emergency medical service agencies, and all other medical or medically related providers, facilities or services, medical examiner's offices, coroner's offices, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, law enforcement agencies, consumer reporting agencies, employers, attorneys, financial institutions and/or banks, and governmental entities;

To disclose information, whether from before, during or after the date of this authorization, about the deceased's health, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, death, earnings, financial or credit history, professional licenses, employment history, autopsy reports and findings, laboratory test results and findings, toxicology results, police reports, accident reports, or incident reports of any kind, photographs, blood, urine, or other specimens, insurance claims and benefits, and all other claims and benefits of _____ (print name of deceased):

To the following persons: Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies ("Unum"), employee benefit plans sponsored by the deceased's employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, the deceased's employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about the deceased to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to the deceased's benefit plans.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

_____ _____
Signature of Beneficiary or Personal Representative Date Signed

_____ _____
Printed Name Social Security Number

I signed on behalf of the Beneficiary or Personal Representative as _____(print relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.