HEALTH SCREENING BENEFIT CLAIM FORM
WELLNESS BENEFIT CLAIM FORM

The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158

Phone: 1-800-635-5597 Fax: 1-800-447-2498
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

Unum Life Insurance Company of America
First Unum Life Insurance Company*
Unum Insurance Company
Provident Life and Accident Insurance Company
Provident Life and Casualty Insurance Company*
The Paul Revere Life Insurance Company*

For use with policies issued by the above Unum Group ["Unum"] subsidiaries.

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 the following types of claims to Unum:

- Voluntary Benefits Health Screening Benefit
- Voluntary Benefits Wellness Benefit

If you are covered for both 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 health screening and/or wellness benefits. Incomplete or illegible answers may result in a delay of benefit consideration.

- **Insured/Patient Statement** (page 3)**:** Please complete this section of the claim form and mail or fax the completed form to the address or fax number indicated above.

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.

* Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this 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.

For your protection:

Alabama law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado law requires the following statement to appear on this 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.

District of Columbia law requires the following statement to appear on this form: 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.

Florida law requires the following statement to appear on this form: 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.

Kentucky law requires the following statement to appear on this 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.

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

New Hampshire law requires the following statement to appear on this 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.

New Jersey law requires the following statement to appear on this 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, subject to criminal prosecution and civil penalties.

New York law requires the following statement to appear on this 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 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.

Pennsylvania law requires the following statement to appear on this 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.

Puerto Rico law requires the following statement to appear on this 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 (PLEASE PRINT)

A. Information About the Insured

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)	Social Security Number	Gender
		☐ Male ☐ Female

Home Address

City	State	Zip

Home Telephone Number	Cellular Telephone Number	Work Telephone Number

Preferred Telephone Number	Preferred E-mail Address

B. Information About the Patient - Check One ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child

Last Name	Suffix	First Name	MI

Date of Birth (mm/dd/yyyy)	Social Security Number	Gender
		☐ Male ☐ Female

Home Address

City	State	Zip

C. Information About Your or the Patient's Health Screening/Wellness Benefit Claim

Complete this section for Health Screening/Wellness Benefit claims.
Please note: If you are submitting this claim request 2 years or more after the date of the test/x-ray, please attach written documentation verifying the date the test/x-ray was performed.

Please check all tests performed for this patient and indicate the date the test was performed.

Test	Date Performed	Test	Date Performed
☐ Blood Test for Triglycerides	_____	☐ Hemocult Stool Analysis	_____
☐ Bone Marrow Aspiration/Biopsy	_____	☐ Mammography	_____
☐ Breast Ultrasound	_____	☐ Pap Smear	_____
☐ CA 15-3 (Blood Test for Breast Cancer)	_____	☐ PSA (Blood Test for Prostate Cancer)	_____
☐ CA 125 (Blood Test for Ovarian Cancer)	_____	☐ Serum Cholesterol Test to Determine Level of HDL and LDL	_____
☐ CEA (Blood Test for Colon Cancer)	_____	☐ Serum Protein Electrophoresis (blood test for myeloma)	_____
☐ Carotid Doppler	_____	☐ Serum Protein Test to Determine Level of HDL and LDL	_____
☐ Chest X-Ray	_____	☐ Skin Cancer Biopsy	_____
☐ Colonoscopy	_____	☐ Stress Test on Bicycle or Treadmill	_____
☐ Echocardiogram	_____	☐ Skin Cancer Biopsy	_____
☐ Electrocardiogram	_____	☐ Thermography	_____
☐ Fasting Blood Glucose Test	_____	☐ Thin Prep Pap Test	_____
☐ Fasting Plasma Glucose (FPG)	_____	☐ Virtual Colonoscopy	_____
☐ Two Hour Post-Load Plasma Glucose (2 Hour PG)	_____	☐ _____	_____
☐ Hemoglobin A1C (HbA1c)	_____		
☐ Flexible Sigmoidoscopy	_____		

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D. Tax Considerations

Benefit payments under this policy could be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Unum reports taxable income to you and the IRS as required on form 1099-MISC. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.

Fraud Warning: For your protection, Arizona law requires the following 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 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.

E. Signature of Insured

I have read and understand the fraud notices listed above and 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.**