GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM

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

Toll-free: 1-800-445-0402  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
The Paul Revere Life Insurance Company

OUR COMMITMENT
During this difficult time, we are committed to providing responsive, compassionate service.

INSTRUCTIONS
Who is responsible for completing this form?

• Employer Statement (pages 4-6): This section of the form should be completed by the employer who should fax it to 1-800-447-2498 or mail it to the address noted above. If available, the following information should also be provided:
  - A copy of the death certificate (a photocopy or fax is acceptable);
  - The original enrollment form and any other enrollment forms indicating any change in coverage; and
  - The most recent beneficiary designation form.

• Accidental Death Statement (pages 7-9): If the claim is related to an accidental death, this section of the form should be completed by the employee or beneficiary. The completed form should be faxed to 1-800-447-2498 or mailed to the address noted above.

• Authorization (last page): This form should be signed and dated by the employee or beneficiary and faxed to 1-800-447-2498 or mailed to the address noted above.

Questions?

If you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center professionals are available from 8 a.m. to 8 p.m. Eastern Time Monday through Friday.
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 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.

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.
Instructions (continued) / Claim Fraud Statements

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 Oregon Residents
For your protection, Oregon law requires the following to appear on this claim form:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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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EMPLOYER STATEMENT - To be completed by the Employer (PLEASE PRINT)

A. Information About the Type of Claim – Please check all that apply and provide the policy and division numbers.

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Type of Claim Submitted</th>
<th>Policy Number</th>
<th>Division Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Information About the Employer

Employer Name

Employer Street Address

City

State

Zip

Subsidiary/Affiliate/Branch Name

C. Information About the Employee – The term “employee” refers to employees, members and/or retirees.

Employee Name (Last Name, Suffix, First Name, M)  Gender  □ Male  □ Female

Employee Street Address

City

State

Zip

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

If this employee is or has been known by another name(s) (such as a nickname, maiden name, etc.), please provide the name(s).

Employment Status:  □ Full-time  □ Part-time  □ Retired  Hours Worked Per Week:

Salary/Rate of Pay:  □ Hourly  □ Salary  Job Title/Class:

Amount: $

Please provide the following salary verification/documentation. This information is necessary to accurately determine the amount of the life insurance benefit.

If the definition of annual earnings is:  Then provide, as stated in your policy:

W-2  A copy of the prior year W-2

Salary with commissions and/or bonus

• Payroll records
• Documentation of commissions and/or bonuses

Last Date Physically at Work (mm/dd/yy):  Reason for Stopping Work:

Is the employee receiving any company sponsored retirement benefits?  □ Yes  □ No  If yes, when did the employee retire (mm/dd/yy)?

If yes, please describe the retirement benefits:

Amount of Insurance

<table>
<thead>
<tr>
<th></th>
<th>Basic</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
<th>Supplemental</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

CL-1091 (03/11)
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### EMPLOYER STATEMENT (Continued)

<table>
<thead>
<tr>
<th>Employee Name (Last Name, Suffix, First Name, Mi)</th>
<th>Date of Birth (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes to the Amount of Insurance</th>
<th>Amount of last change</th>
<th>Date of last change (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
<tr>
<td>Supplemental Life</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
<tr>
<td>Supplemental Accidental Death and Dismemberment</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
</tbody>
</table>

Date of last premium payment for this employee (mm/dd/yy):

The Accidental Death and Dismemberment policy may provide an education benefit. Does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled in an institution of higher learning beyond the 12th grade?  [ ] Yes  [ ] No  If yes, please provide the following information for each child:

1. **Name:** ____________________________   **Age:** ______
2. **Name:** ____________________________   **Age:** ______
3. **Name:** ____________________________   **Age:** ______

### D. Information About the Dependent – Please complete this section if the claim is for the death of the employee's dependent.

<table>
<thead>
<tr>
<th>Dependent Name (Last Name, Suffix, First Name, Mi)</th>
<th></th>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Employee</th>
<th>Dependent Date of Birth (mm/dd/yy)</th>
<th>Dependent Date of Death (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Spouse</td>
<td>[ ] Civil Union Partner</td>
<td>[ ] Domestic Partner</td>
</tr>
<tr>
<td>[ ] Spouse</td>
<td>[ ] Domestic Partner</td>
<td>[ ] Child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent Social Security Number</th>
<th>Dependent Gender</th>
<th>Dependent Effective Date of Coverage (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Male</td>
<td>[ ] Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount of Insurance</th>
<th>Basic</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
<th>Supplemental</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes to the Amount of Dependent Insurance</th>
<th>Amount of last change</th>
<th>Date of last change (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
<tr>
<td>Supplemental Life</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
<tr>
<td>Supplemental Accidental Death and Dismemberment</td>
<td>$ ________</td>
<td>[ ] Increase [ ] Decrease</td>
</tr>
</tbody>
</table>

Date of last premium payment for this dependent (mm/dd/yy):

Was the employee in active employment at the time of the dependent's death?
[ ] Yes  [ ] No
E. Information About the Employee’s Beneficiary(ies) – If the claim is for the death of the employee, please complete this section. If there are more than three, please provide the following information for each additional beneficiary on a separate sheet of paper and include it with this form. The first beneficiary listed will receive the Life Planning Resources, if the services are provided by this policy.

<table>
<thead>
<tr>
<th>Name, Address &amp; Telephone Number</th>
<th>Relationship</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Total Must Equal 100%

A copy of the most recent beneficiary designation form is enclosed. ☐ Yes ☐ No If no, please explain:

F. Information About Minor Beneficiary – If any of the above beneficiaries are minor children, please complete this section. If there is more than one, please provide the following information for each additional minor beneficiary on a separate sheet of paper and include it with this form.

Name of Minor Child (Last Name, Suffix, First Name, MI):

Adult Representative of Minor Child (Last Name, Suffix, First Name, MI):

Mailing Address of Adult Representative:

City: ______________________ State: ______ Zip: ______ Telephone Number of Adult Representative: ______________________

G. Information About Payment – Advise the beneficiary that if the claim is approved the benefit will be paid by check if it is less than $10,000. The benefit will be paid through a Unum Retained Asset Account if it is $10,000 or more and the group policy calls for this method of payment. If the group policy does not call for this method of payment, the benefit will be paid by check. The beneficiary may request the benefit be paid by check regardless of the amount of the benefit by contacting The Benefits Center at the telephone number listed on this form. More information about the Unum Retained Asset Account can be found in section H.

H. Information About Unum Retained Asset Accounts – By placing the funds in a Unum Retained Asset Account the beneficiary will have the time needed to decide how to best manage the insurance proceeds so as not to put his/her investment decisions at risk. Here’s how it works:

- When the claim is approved, a personalized book of bank drafts and an opening account statement will be mailed to the beneficiary.
- He/She will have unlimited access to the balance in the account.
- Drafts can be written for a minimum of $250 up to the full account balance at any time.
- No charges will be made to the Unum Retained Asset Account for writing drafts or ordering a new supply of drafts.
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### EMPLOYER STATEMENT (Continued)

<table>
<thead>
<tr>
<th>Employee Name (Last Name, Suffix, First Name, Mi)</th>
<th>Date of Birth (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

- A small charge will be made to the Unum Retained Asset Account for any request for:
  - A copy of a draft or statement;
  - A stop payment of a draft; and
  - A draft returned as unpaid.
- 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; they are not protected by the FDIC.
- The beneficiary may leave the money in the Unum Retained Asset Account for as long as he/she wishes.

Unum will invest the funds in its general account for as long as it remains 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. The current interest rate will be disclosed via a quarterly account statement.

The interest earned on the Unum Retained Asset Account may be taxable. The beneficiary should consult a tax advisor with any questions.

### FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer portions of the claim form.

### I. Information About and Signature of Benefit Administrator (Please Print)

<table>
<thead>
<tr>
<th>Name of Person Completing Form</th>
</tr>
</thead>
</table>

The above statements are true and complete to the best of my knowledge and belief.

<table>
<thead>
<tr>
<th>Title of Person Completing Form</th>
<th>Telephone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
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</table>

Signature: 

Date Signed: 

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ACCIDENTAL DEATH STATEMENT (PLEASE PRINT)
To be completed by:  • the beneficiary or next of kin, if the claim is related to the accidental death of the employee
• the employee, if the claim is related to the accidental death of a dependent
Please attach copies of any police and/or emergency medical services reports.

A. Information About the Employee

<table>
<thead>
<tr>
<th>Employee Name (Last Name, Suffix, First Name, Ml)</th>
<th>Date of Birth (mm/dd/yy)</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Employer Telephone Number</th>
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</table>

B. Information About the Deceased

<table>
<thead>
<tr>
<th>Deceased Name (Last Name, Suffix, First Name, Ml)</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Deceased Social Security Number</th>
<th>Deceased Date of Birth (mm/dd/yy)</th>
<th>Date of Death (mm/dd/yy)</th>
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</table>

<table>
<thead>
<tr>
<th>Relationship to the Employee</th>
<th>☐ Self ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

C. Information About the Accident

<table>
<thead>
<tr>
<th>Date of the accident (mm/dd/yy):</th>
<th>Time of the accident:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Where did the accident happen?

Describe how the accident happened.

D. Information About the Witnesses to the Accident

Please provide the following information about all witnesses to the accident. If there were more than three, please share the following information for each additional witness on a separate sheet of paper and include it with this form.

<table>
<thead>
<tr>
<th>Witness Name</th>
<th>Mailing Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

E. Information About the Investigating Authorities

<table>
<thead>
<tr>
<th>Name/Title of Investigating Officer:</th>
<th>Telephone Number</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Other: Name/Title</th>
<th>Telephone Number</th>
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</table>

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### ACCIDENTAL DEATH STATEMENT (Continued)

<table>
<thead>
<tr>
<th>Employee Name (Last Name, Suffix, First Name, MI)</th>
<th>Date of Birth (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

### F. Information About Physicians/Hospitals

Please provide the following information about all the physicians/hospitals who attended the deceased for injuries sustained in this accident. If there were more than three, please share the following information for each additional physician/hospital on a separate sheet of paper and include it with this form.

<table>
<thead>
<tr>
<th>Physician/Hospital Name</th>
<th>Mailing Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### G. Information About Previous Medical Conditions

Please provide the following information about all physicians who treated the deceased for any medical condition in the last five years. If there were more than five, please share the following information for each additional physician on a separate sheet of paper and include it with this form.

<table>
<thead>
<tr>
<th>Physician Name, Specialty, Address and Telephone Number</th>
<th>Medical Condition Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
**ACCIDENTAL DEATH STATEMENT (Continued)**

<table>
<thead>
<tr>
<th>Employee Name (Last Name, Suffix, First Name, Mi)</th>
<th>Date of Birth (mm/dd/yy)</th>
</tr>
</thead>
</table>

**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.

**H. Signature**

The above statements are true and complete to the best of my knowledge and belief.

Language Preference:  ☐ English  ☐ Spanish

Print Name

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Telephone Number
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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.

CL-1091-AUTH (03/11)