**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).

## 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.

| Type of Coverage Being Claimed | Type of Claim Submitted | Policy Number | Division Number |
|---|---|---|---|
| ☐ Life Insurance | ☐ Employee Death<br>☐ Dependent Death | | |
| ☐ Accidental Death & Dismemberment | ☐ Employee Death<br>☐ Dependent Death | | |

Is this claim also being submitted for Accidental Death & Dismemberment? ☐ Yes ☐ No

### B. Information About the Employer

Employer Name

Employer Street Address

City | State | Zip

Subsidiary/Affiliate/Branch Name | Subsidiary Effective Date (mm/dd/yy)

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

Employee Name (Last Name, Suffix, First Name, MI) | Gender ☐ Male ☐ Female

Employee Street Address

City | State | Zip

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

Home Telephone Number | Cellular Telephone Number

| Date Employee Entered Eligible Class (mm/dd/yy): | Termination & Rehire Dates (mm/dd/yy):<br>Termination: Rehire: | Acquisition Date (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 ☐ Exempt<br>☐ Bargaining ☐ Non-Bargaining ☐ Union ☐ Non-Union ☐ Non-Exempt | Hours Worked Per Week: | If eligibility is not based on hours worked, please describe: |
|---|---|---|
| Salary/Rate of Pay: ☐ Hourly ☐ Salary ☐ Commission ☐ Non-Commission<br>Amount: $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Semi-monthly | Job Title/Class: | |

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 and the last payroll statement for the same year |
| Salary with commissions and/or bonus | • Payroll records<br>• 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:

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## EMPLOYER STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

| Amount of Insurance | Basic | Effective Date of Coverage (mm/dd/yy) | Supplemental | Effective Date of Coverage (mm/dd/yy) |
|---|---|---|---|---|
| Life Insurance | $ | | $ | |
| Accidental Death and Dismemberment | $ | | $ | |

| Changes to the Amount of Insurance | Amount of last change | | Date of last change (mm/dd/yy) |
|---|---|---|---|
| Basic Life | $ | ☐ Increase ☐ Decrease | |
| Supplemental Life | $ | ☐ Increase ☐ Decrease | |
| Basic Accidental Death and Dismemberment | $ | ☐ Increase ☐ Decrease | |
| Supplemental Accidental Death and Dismemberment | $ | ☐ Increase ☐ Decrease | |

**Date the premium payment was paid through for this employee (mm/dd/yy):**

**Was this employee terminated?** ☐ Yes ☐ No
If yes, termination date (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:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

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

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

Relationship to Employee
☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

Dependent Date of Birth (mm/dd/yy) | Dependent Date of Death (mm/dd/yy)

Dependent Social Security Number

Dependent Gender
☐ Male ☐ Female

Dependent Effective Date of Coverage (mm/dd/yy)

| Amount of Insurance | Basic | Effective Date of Coverage (mm/dd/yy) | Supplemental | Effective Date of Coverage (mm/dd/yy) |
|---|---|---|---|---|
| Life Insurance | $ | | $ | |
| Accidental Death and Dismemberment | $ | | $ | |

| Changes to the Amount of Dependent Insurance | Amount of last change | | Date of last change (mm/dd/yy) |
|---|---|---|---|
| Basic Life | $ | ☐ Increase ☐ Decrease | |
| Supplemental Life | $ | ☐ Increase ☐ Decrease | |
| Basic Accidental Death and Dismemberment | $ | ☐ Increase ☐ Decrease | |
| Supplemental Accidental Death and Dismemberment | $ | ☐ Increase ☐ Decrease | |

**Date the premium was paid through for this dependent (mm/dd/yy):**

**Was the employee in active employment at the time of the dependent's death?**
☐ Yes ☐ No

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## EMPLOYER STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

**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.**

| Name, Address & Telephone Number | Relationship | Social Security Number | Date of Birth | Percentage |
|---|---|---|---|---|
| Name | | | | |
| Street | | | | |
| City, State, Zip Telephone # | | | | |
| Name | | | | |
| Street | | | | |
| City, State Zip Telephone # | | | | |
| Name | | | | |
| Street | | | | |
| City, State, Zip Telephone # | | | | |
| | | | | **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.

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## EMPLOYER STATEMENT (Continued)

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

**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.
- The entire account balance can be accessed by the use of one draft.
- Drafts can be written for a minimum of $250 up to the full account balance at any time. There is no limit on the number of withdrawals that can be made from the account.
- No charges will be made to the Unum Retained Asset Account for writing drafts or ordering a new supply of drafts.
- The following charges will be made to the Unum Retained Asset Account for any request for:
  - A copy of a draft or statement ($5);
  - A stop payment of a draft ($15);
  - A draft returned as unpaid, requests for additional statements, and requests for additional copies of IRS Form 1099-INT ($10); and
  - Draft book rush orders ($25).
- 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. To learn more about the protections provided by these associations, the beneficiary may contact the National Organization of Life and Health Insurance Guaranty Associations at nolhga.com or 703-481-5206.
- The beneficiary may leave the money in the Unum Retained Asset Account for as long as he/she wishes. If there is no account activity or any contact with the beneficiary for two years, we will attempt to contact him/her. If we are unable to contact the beneficiary, we could be required to surrender the account balance to the state of his/her last known residence.

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 should consult a tax advisor, an investment advisor, or another financial advisor with any questions. For further information, the beneficiary should contact his/her state insurance department.

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

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

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

Name of Person Completing Form

| Title of Person Completing Form | Telephone Number | Fax Number |
|---|---|---|
| | | |

**Signature**
**X**

**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

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

Date of Birth (mm/dd/yy)

Employer Name

Employer Telephone Number

## B. Information About the Deceased

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

Deceased Social Security Number

Deceased Date of Birth (mm/dd/yy)

Date of Death (mm/dd/yy)

Relationship to the Employee ☐ Self ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

## C. Information About the Accident

Date of the accident (mm/dd/yy):

Time of the accident:

Where did the accident happen?

Describe how the accident happened.

## D. Information About the Responding Authorities

| Names of Public Agencies (Fire Dept., Police Dept., EMS, etc.) | Telephone Number |
|---|---|
| Other: Name/Title | Telephone Number |
| Other: Name/Title | Telephone Number |
| Other: Name/Title | Telephone Number |
| Other: Name/Title | Telephone Number |

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## ACCIDENTAL DEATH STATEMENT (Continued)

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

Date of Birth (mm/dd/yy)

## E. 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.

| Physician/Hospital Name | Mailing Address | Telephone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## F. 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.

| Physician Name, Specialty, Address and Telephone Number | Medical Condition Treated |
|---|---|
| | |
| | |
| | |
| | |
| | |

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**ACCIDENTAL DEATH STATEMENT (Continued)**

Employee Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

**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.

**G. Signature**

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

Language Preference: ☐ English ☐ Spanish

| Print Name | Telephone Number |
|---|---|
| **Signature** X | **Date Signed** |

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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. You are entitled to receive a copy of this authorization.

## Authorization – Life or Accidental Death Claim

**I authorize the following persons:** 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, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, 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) ("Information");

**To 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");

**So that Unum may evaluate and administer the claim(s).** For such evaluation and administration of claims, this authorization is valid for two years, or the duration of the claim, whichever is shorter. I understand that once Information is disclosed to Unum, privacy protections established by HIPAA may not apply to the Information, but other privacy laws continue to apply. Unum may then disclose the Information only as permitted by law, including, state fraud reporting laws, or as authorized by me.

**I also authorize Unum to disclose Information to the following persons** (for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative, or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purpose of these disclosures by Unum, this authorization is valid for one year, or for the length of time otherwise permitted by law.

**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, except as specified, 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.

_____ _____
Signature of Beneficiary or Personal Representative Date Signed

_____ _____
Printed Name Deceased's Social Security Number

I signed on behalf of the Beneficiary or Personal Representative as _____(print relationship). If Guardian, Conservator, or court-appointed guardian of the minor's property/estate for a Minor Beneficiary, please attach a copy of the document granting authority.

Form **W-9**
Substitute
(Rev. August 2013)

# Request for Taxpayer Identification Number and Certification

**Give Form to the requester. Do not send to the IRS.**

Print or type

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN).

**For further instructions, see http://www.irs.gov/pub/irs-pdf/fw9.pdf**

**Social security number**

| | | | – | | – | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

**Employer identification number**

| | | – | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. **For further instructions, see http://www.irs.gov/pub/irs-pdf/fw9.pdf**

| **Sign Here** | **Signature of U.S. person ▶** | **Date ▶** |
|---|---|---|

Please return this substitute W-9 form as soon as possible to the address below; otherwise the IRS may require us to withhold taxes from the interest we pay you to ensure that the tax will be collected. For more information on withholdings, please refer to the IRS website at http://www.irs.gov.

**Return address:**
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158