CONTINUING DISABILITY CLAIM FORM

FAX TO 1-888-281-8324
Questions? Call 1-800-375-8226
Please Allow Two Weeks Processing Time

MAIL TO:
FIRST UNUM LIFE INSURANCE COMPANY
Attn.: DISABILITY BENEFITS
P. O. BOX 100172
COLUMBIA, SOUTH CAROLINA 29202

SECTION 1 TO BE COMPLETED BY POLICYHOLDER

1. Policyholder name ❑ Male ❑ Female
If the address given at left has changed since your last claim please mark box with an "x". ❑

Address (Street) | Claim Number (*see payment letter*) or Policy Number

City State Zip Code | Social Security Number | Birthdate (MM/DD/YYYY)

2. Claim is for: ❑ Accident ❑ Sickness | Home Telephone ( ) | Work Telephone ( )

3. Date and Description of Injury/Sickness | Did your injuries occur while working for wage or profit? ❑ Yes ❑ No

4. List dates (MM/DD/YYYY) unable to work From: To: | If not employed, list dates (MM/DD/YYYY) of house confinement*: From: To:

5. Have you returned to your place of employment? ❑ Yes, ❑ Full-time ❑ Part-time ❑ No | Date Returned to Work (MM/DD/YYYY) | **house confinement means unable to do normal daily activities.*

SECTION 2 TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

6. Dates (MM/DD/YYYY) Employee unable to work From: ❑ a.m. ❑ p.m. To: ❑ a.m. ❑ p.m. | Date Employee returned to his/her primary duties Date (MM/DD/YYYY) ❑ a.m. ❑ p.m. Part-time ❑ Full-time ❑

7. Employee's position and primary duties

8. Signed By | Title | Date (MM/DD/YYYY) | Employer's Telephone Number ( )

SECTION 3 TO BE COMPLETED BY PHYSICIAN

9. What is this patient's current primary disabling condition? _____

Symptoms: | Objective Findings:

10. Are there secondary conditions contributing to the disability? ❑ Yes ❑ No | If yes, what are they and would the patient be disabled without regards to these secondary conditions?

11. List any test(s) performed and submit a copy of the results.

12. List any surgeries performed and submit a copy of the operative reports.

13. Restrictions (What the patient SHOULD NOT do)

14. Limitations (What the patient CANNOT do)

15. What is your prognosis of recovery?

16. How soon do you expect significant improvement in the patient's medical condition? ❑ 1-2 months ❑ 3-4 months ❑ 5-6 months ❑ more than 6 months | Estimated Return to Work Date (MM/DD/YYYY)

17. Is this patient permanently disabled? ❑ Yes ❑ No | Is patient considered to be house confined and/or unable to perform 2 out of 5 activities of daily living*? ❑ Yes ❑ No *dressing, eating, transferring, toileting and meal preparation. | List dates (MM/DD/YYYY) of house confinement.* **house confinement means unable to do normal daily activities.*

18. Dates (MM/DD/YYYY) of Total Disability From: To: | Dates (MM/DD/YYYY) of Partial Disability From: To: | Patient's return to work date (MM/DD/YYYY)

19. Dates (MM/DD/YYYY) of Office visits (Last 3 months) | Dates (MM/DD/YYYY) of Hospitalization (Last 3 months)

20. Is patient currently being treated by any other practitioner or therapist? If so, list name and address. | Name and Address of Hospital

21. Signature of Physician or Supplier | Date (MM/DD/YYYY) | Physician's supplier and group name

Telephone Number ( ) | Tax ID or SSN | Address

21. Doctor's Fax Number | Patient Number | Submit charges with assignment if applicable.

PLEASE SIGN AND RETURN THE ENCLOSED AUTHORIZATION AND CERTIFICATION BELOW TO AVOID DELAY.

CERTIFICATION

Policyholder/Employee's Name _____Social Security Number_____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form.

____/____/____ Date (mm/dd/yyyy) _____ PATIENT SIGNATURE _____ POLICYHOLDER/EMPLOYEE SIGNATURE

Continuing Disability Information Form

Do Not Use This Form If This Is The FIRST Time You Have Filed For Benefits For THIS Injury/Sickness

First Unum Life Insurance Company Processing Center

Attn: Disability Benefits, P. O. Box 100172, Columbia, South Carolina 29202

1-800-375-8226

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