GROUP CRITICAL ILLNESS 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.

INSTRUCTIONS

When should you use this claim form?

Use this claim form to submit a critical illness/specified disease and/or cancer claim to Unum. This form should be used for the following types of claims only:

- Critical Illness
- Specified Disease

Who is responsible for completing this claim form?

The information provided on this claim form will be used to evaluate your eligibility for critical illness/specified disease benefits. Incomplete or illegible answers may result in a delay of benefit consideration. Please enclose any additional information you feel will assist us in the evaluation of your claim.

- **Employee/Patient Statement (pages 3-5):** Please complete this section of the claim form and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above.
- Please complete the name and date of birth fields at the top of every page for easy identification purposes in case the pages become separated.
- **Authorization to Share Information with Third Parties (page 6):** If you wish to give us permission to share the details of your claim with a third party (such as your spouse, son, daughter, friend, etc.), please sign and date this form and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above.
- **Attending Physician Statement (pages 7-8):** Please give this section of the claim form to the physician or treating provider primarily responsible for your care and ask him/her to complete. Your physician or treating provider should fax the completed form to 1-800-447-2498 or mail it to the address noted above. If you are applying for the Be Well Benefit, this statement is not required. Unum is not responsible for expenses associated with the completion of this form.
- **Insured/Patient Authorization (last page):** Please sign and date this form, provide a copy to your attending physician, and fax it to 1-800-447-2498. If you prefer, you may mail it to the address noted above. This form authorizes the release of medical and other types of information needed to evaluate your 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.

* 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 claim 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.

Alabama: 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: Any person who knowingly presents 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.

Colorado: 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: 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: 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: 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: 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: 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: 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: 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: 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: 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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EMPLOYEE/PATIENT STATEMENT (PLEASE PRINT)

A. Information About the Employee

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female | Policy Number(s)

Home Address

City | State | Zip

Preferred Telephone Number | Preferred E-mail Address

Employer Name

Language Preference ☐ English ☐ Spanish

Please check all types of coverage you have with Unum. ☐ Disability ☐ Life Insurance ☐ Accident Insurance ☐ Hospital Indemnity

Are you currently working? ☐ Yes ☐ No | If no, what was your last date worked?

While there is no legal requirement for you to provide information regarding other policies you may have with Unum, this information will help us identify any other coverage you have with us for which you may be eligible to file a claim. Failure to provide the requested information may delay claim initiation under the additional policy or policies.

B. Information About the Patient - Check One ☐ Self ☐ Spouse ☐ Child If applying for Self and Be Well Benefits only provide the date of the test in Section B.

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female | Date of Test (mm/dd/yy) (Be Well Benefit Only)

C. Information about your or the Patient's Be Well Benefit Claim Complete this section for Be Well Benefit claims. Please indicate the type of screening performed and the date above, examples of the screenings can be found to the right. If the type of test performed is not listed, please indicate test performed.

☐ Cholesterol and Diabetes	**Eligible screenings include, but may not be limited to:** blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C (HbA1c), Serum cholesterol test to determine total HDL and LDL cholesterol levels, two hour post-load plasma glucose.
☐ Cancer	**Eligible screenings include, but may not be limited to:** colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis, dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology (PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing.
☐ Cardiovascular Function	**Eligible screenings include, but may not be limited to:** echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging.
☐ Imaging Studies	**Eligible screenings include, but may not be limited to:** chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound.
☐ Annual Examinations by a Physician	**Eligible examinations include:** sports physicals, annual exams for adults, and well-child visits.
☐ Immunizations	**Eligible immunizations include, but may not be limited to:** HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza.

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EMPLOYEE/PATIENT STATEMENT (Continued)

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

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

D. Information about the illness

Please check the illness for which you are filing this claim. Please Note: Not all conditions are covered on all policies, consult your certificate of coverage or policy for details.

- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Benign Brain Tumor
- ☐ Cancer (Including Non-Invasive and Skin)
- ☐ Coma
- ☐ Coronary Artery Disease
- ☐ Dementia (including Alzheimer's Disease)
- ☐ End Stage Renal (Kidney) Failure
- ☐ Functional Loss
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Infectious Disease
- ☐ Loss of Hearing, Sight or Speech
- ☐ Major Organ Failure (Requiring Transplant)
- ☐ Multiple Sclerosis (MS)
- ☐ Occupational Human Immunodeficiency Virus (HIV) or Hepatitis
- ☐ Parkinson's Disease
- ☐ Permanent Paralysis
- ☐ Stroke

Child Conditions:

- ☐ Cerebral Palsy
- ☐ Cleft Lip or Palate
- ☐ Cystic Fibrosis
- ☐ Down Syndrome
- ☐ Spina Bifida

E. Information About Physicians and Hospitals

Please provide the following information about your current treatment provider(s). If you are being treated by more than two providers, please share the following information for each provider on a separate sheet of paper and include it with this form.

1. Primary Care Physician Name | Mailing Address | Telephone No.
   Specialty | City | State | Zip | Fax No.
   Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)
2. Treating Physician Name | Mailing Address | Telephone No.
   Specialty | City | State | Zip | Fax No.
   Date of First Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

Please list any recent hospital visits/admissions. If you have had more than two recent hospital visits/admissions, please share the following information for each visit/admission on a separate sheet of paper and include it with this form.

1. Hospital | Address | Date of Visit/Admission (mm/dd/yy)
   Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)
2. Hospital | Address | Date of Visit/Admission (mm/dd/yy)
   Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

F. 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. Every tax situation is unique. You should seek independent advice if you have questions about your personal tax situation.

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EMPLOYEE/PATIENT STATEMENT (Continued)

Insured's 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.

F. Signature of Insured

I have read and understand the fraud notices listed above and on pages 2 and 5 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.**

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You are not required to sign this Optional Authorization. However, if you would like us to communicate with a family member, friend or other third party about your leave(s) and/or claim(s), which could include, but not be limited to, accident, disability, American's with Disability Act (ADA), we recommend completing the information below. Please sign and date the form as indicated and mail or fax it to the address or fax number indicated above.

Optional Authorization to Disclose Information to Third Parties

To assist in the evaluation or administration of any of my claim(s) and/or leave(s), I authorize Unum Group, its subsidiaries and duly authorized representatives ("Unum") to share personal health information, financial information, and/or information relating to any accommodations in verbal or written format relating to my claim(s) and/or leave(s) with the family members, friends, and/or other third parties listed below:

My Spouse: _____

(Name) (Telephone Number)

Other Family Member: _____

(Name / Relationship) (Telephone Number)

Other person: _____

(Name / Relationship) (Telephone Number)

I understand that information about my claim(s) and/or leave(s) may include information about my health and that such information about my health may be related to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I do not wish the following information about my claim(s) and/or leave(s) to be shared (leave blank if not applicable):

_____

I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

I may revoke this authorization in writing at any time except to the extent Unum or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this Authorization by sending written notice to the address above.

This authorization is valid for the shorter of two (2) years or the duration of any of my claim(s) and/or leave(s). I may request a copy of the Authorization and a copy shall be as valid as the original.

_____ _____

Insured Patient Signature Date

_____ _____

Printed Name Social Security Number

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

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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

TO BE COMPLETED BY ATTENDING PHYSICIAN OR TREATING PROVIDER
Instructions: Please complete all applicable questions and provide copies of supporting reports, such as office notes, medical records, consultations, and/or testing. Please sign and date the form.

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

Employee Social Security Number

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

Patient Social Security Number

Patient Relationship to Employee: ☐ Self ☐ Spouse ☐ Child

Patient Gender: ☐ Male ☐ Female

Patient Date of Birth (mm/dd/yy)

Complete these questions for all medical conditions

Diagnosis Information

Diagnosis:	ICD Code:
Date of Diagnosis:	Date you were first consulted for this condition (mm/dd/yy):

Condition	Medical Documentation and Other Pertinent Information
Amyotrophic Lateral Sclerosis (ALS)	Clinical Diagnosis – Please send supporting medical documentation Has the patient lost two or more activities of Daily Living ☐ Yes ☐ No Is the patient Cognitively Impaired? ☐ Yes ☐ No
Benign Brain Tumor	Tissue Biopsy with neurological deficits resulting from tumor
Cancer (Including Non-Invasive and Skin)	Pathology Report with staging
Coma	Clinical Diagnosis Has the patient experienced a continuous state of unconsciousness for 7 or more consecutive days? ☐ Yes ☐ No Did the patient require intubation? ☐ Yes ☐ No
Coronary Artery Disease	Diagnosis and type of surgery recommended
Dementia (including Alzheimer's Disease)	Clinical Diagnosis – Please send supporting medical documentation Has the patient lost two or more activities of Daily Living ☐ Yes ☐ No Is the patient Cognitively Impaired? ☐ Yes ☐ No
End Stage Renal (Kidney) Failure	Is the patient on the UNOS list for a kidney transplant? ☐ Yes ☐ No Does patient have chronic irreversible function of both kidneys? ☐ Yes ☐ No Does the patient require regular hemodialysis or peritoneal dialysis? ☐ Yes ☐ No Did the patient have a kidney transplant? ☐ Yes ☐ No
Functional Loss	Clinical Diagnosis – Please send supporting medical documentation Has the patient lost two or more activities of Daily Living for a period of at least 90 days? ☐ Yes ☐ No
Heart Attack (Myocardial Infarction)	Medical Records, surgical records, elevation of biochemical markers, and imaging studies
Infectious Disease	Clinical Diagnosis – Hospitalization of 14 or more consecutive days
Loss of Hearing	Medical Documentation of Loss, NOTE: Use of device or aide will not correct loss.
Loss of Sight	Medical documentation of loss – Snellen or E-Chart Acuity, NOTE: Use of device or aid will not correct loss
Loss of Speech	Medical Documentation of Loss, NOTE: Use of device or aide will not correct loss.
Major Organ Failure Requiring Transplant	Is the patient on the UNOS list for organ transplant? ☐ Yes ☐ No If yes, date added to UNOS list:
Multiple Sclerosis (MS)	Clinical Diagnosis – Please send supporting medical documentation Has the patient lost two or more activities of Daily Living ☐ Yes ☐ No
Occupational Human Immunodeficiency Virus (HIV) or Hepatitis	Clinical Diagnosis, medical documentation along with accident report from employer
Parkinson's Disease	Clinical Diagnosis – Please send supporting medical documentation Has the patient lost two or more activities of Daily Living ☐ Yes ☐ No
Permanent Paralysis	Clinical Diagnosis – Radiological tests, severed spinal cord, verification of continuous loss of two or more limbs for 90 days or more.
Stroke	Documented neurological deficits post 30 days from diagnosis
Cerebral Palsy, Cleft Lip or Palate, Cystic Fibrosis, Down Syndrome and Spina Bifida	Clinical diagnosis made or confirmed after birth.

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ATTENDING PHYSICIAN STATEMENT (Continued)

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

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

Return to Work Assessment

Did you advise the patient to stop work?	If yes, when (mm/dd/yy)?	Have you advised patient to return to work?	If yes, expected return to work date (mm/dd/yy):
☐ Yes ☐ No		☐ Yes ☐ No	☐ Full Time ☐ Part Time

If yes, please indicate any ongoing restrictions and limitations in the space provided.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided.

CURRENT RESTRICTIONS (activities patient should not do) Please be specific.

CURRENT LIMITATIONS (activities patient cannot do) Please be specific.

Hospitalizations and Other Treating Providers

Has the patient been treated for the same or similar condition by another physician in the past? ☐ Yes ☐ No ☐ Unknown If yes, list below.

Other Providers: Please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To

Has patient been hospitalized? ☐ Yes ☐ No If yes, date hospitalized (mm/dd/yy): through (mm/dd/yy):

Facility Name

Address

City | State | Zip

Was surgery performed? ☐ Yes ☐ No | If yes, CPT 4 code(s): | Date Surgery Performed (mm/dd/yy):

Is the patient still under your care? ☐ Yes ☐ No | If no, final date of treatment (mm/dd/yy):

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 Attending Physician portions of the claim form.

Signature of Attending Physician

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

Physician Name (Last Name, Suffix, First Name, MI) Please Print

Medical Specialty | Degree

Address

City | State | Zip

Telephone Number | Fax Number | Physician's Tax ID Number

Are you related to this patient? ☐ Yes ☐ No If yes, what is the relationship?

X

Physician Signature **Date**

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

Authorization to Collect and Disclose Information

(Not for FMLA Requests)

I authorize the following persons: health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocator Group, Brown & Brown Absence Services Group and other Social Security advocacy vendors, professional licensing bodies, 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 my health, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits ("My Information");

To Unum Group and its subsidiaries, 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* and persons who evaluate claims for any of those companies ("Unum");

So that Unum may evaluate and administer my claims, including providing assistance with return to work. For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits (to include any subsequent financial management and/or benefit recovery review), whichever is shorter. I understand that once My Information is disclosed to Unum, any privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum may then disclose My Information only as permitted by law, including, state fraud reporting laws or as authorized by me.

I also authorize Unum to disclose My 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; or, the Social Security Administration. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purposes of these disclosures by Unum, this authorization is valid for one year or for the length of time otherwise permitted by law.

If I do not sign this authorization or if I alter or revoke it, except as specified above, Unum may not be able to evaluate or administer 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 Unum requests or discloses prior to Unum receiving my revocation request.

_____ _____
Patient's Signature Date Signed

_____ _____
Printed Name Social Security Number

I signed on behalf of the Insured as _____ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

*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.