A Brief Overview of a Long Term Care Policy

Claim eligibility under a Long Term Care insurance policy is based on a loss of Activities of Daily Living (ADLs) or the presence of a Cognitive Impairment which causes the insured to require supervision from another individual. Cognitive Impairment generally means changes in mental status which may be associated with conditions like dementia or Alzheimer's disease.

The standard Activities of Daily Living (ADLs) are: bathing, dressing, toileting, transferring, continence and eating. A loss of an ADL means that the insured is no longer able to perform that ADL without assistance from another person.

Please review your Long Term Care policy carefully for explanations and descriptions of the eligibility criteria, definitions of ADLs and Cognitive Impairment, benefits available to you and requirements for payment of benefits should your claim be approved. If you cannot locate your policy, please call our Customer Service department at 800-227-4165.

Instructions for Completing this Long Term Care Claim Form

1. Complete Sections 1 through 5 of this claim form. Your responses should be based on the situation/condition for which you are currently filing a claim. The availability of thorough and complete information on this form will help to expedite your claim.

NOTE: ***Please ensure that the Authorization to Release Information in Section 5 is completed and signed by the claimant or a legal representative. If this authorization is incomplete or not signed appropriately, Unum may not be able to evaluate or administer your claim (s). If Authorization is signed by Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.***

2. When all sections have been completed, you may fax the form to us at 207-575-9741 or mail the form to the following address:

Unum
Long Term Care Benefits Center
P.O. Box 100196
Columbia, SC 29202-9975

3. If you should have any questions about the claims process, please call us at (800) 693-4988.

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.

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, knowingly and with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is relied upon by the insurer and is material to the content of the policy and to the risk assumed by the insurer, may be prosecuted for insurance fraud. There is no time limit on contestability in the event of fraud on the part of the insured.

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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Group Long Term Care Claim Form

SECTION 1 – General Information

Employer/Group Policyholder Name:

Policy #:

Name of Employee/Retiree: (first middle, last)
Ms. ☐ Mrs. ☐
Mr. ☐ Miss ☐

Employee Social Security #:

Name of Claimant if different than employee: (first, middle, last)
Ms. ☐ Mrs. ☐
Mr. ☐ Miss ☐

Relationship to Employee:
☐ Spouse ☐ Parent ☐ Grandparent ☐ Other

Claimant's Social Security #:

Claimant's Home Address: (street, city, state, zip):

Telephone #:

Date of Birth (mm/dd/yyyy):

Please describe the primary diagnosis, event or circumstances which caused the initiation of this claim: _____

_____

_____

_____

Where are you currently residing?

☐ Claimant's residence
☐ Hospital
☐ Residential Care Facility
☐ Nursing Care Facility (Nursing Home)
☐ Assisted Living or Residential Care Facility
☐ Other _____

If other than your residence:
Name of Facility/Location: _____
Address: _____
Telephone # _____ Date Entered _____
Fax # _____

Please provide examples of what ADL assistance you require and/or what supervision is being provided to you for Cognitive Impairment and indicate why this assistance or supervision is needed.

_____

_____

_____

_____

_____

When did you begin to need assistance for ADLs or supervision for Cognitive Impairment? (date or general timeframe)

_____ _____

(mm/dd/yyyy)

SECTION 2 – Physician Information

Primary Care Physician:

First Name: ____________________ Last Name: ______________________________
Address: ____
Telephone Number: ____________________ Fax # (if available): ____________________
Date first seen: (mm/dd/yyyy) ____________ Date last seen: (mm/dd/yyyy) ____________

Other Physicians:

First Name: ____________________ Last Name: ______________________________
Specialty: ____
Address: ____
Telephone Number: ____________________ Fax # (if available): ____________________
Date first seen: (mm/dd/yyyy) ____________ Date last seen: (mm/dd/yyyy) ____________

First Name: ____________________ Last Name: ______________________________
Specialty: ____
Address: ____
Telephone Number: ____________________ Fax # (if available): ____________________
Date first seen: (mm/dd/yyyy) ____________ Date last seen: (mm/dd/yyyy) ____________

First Name: ____________________ Last Name: ______________________________
Specialty: ____
Address: ____
Telephone Number: ____________________ Fax # (if available): ____________________
Date first seen: (mm/dd/yyyy) ____________ Date last seen: (mm/dd/yyyy) ____________

First Name: ____________________ Last Name: ______________________________
Specialty: ____
Address: ____
Telephone Number: ____________________ Fax # (if available): ____________________
Date first seen: (mm/dd/yyyy) ____________ Date last seen: (mm/dd/yyyy) ____________

First Name: ____________________ Last Name: ______________________________
Specialty: ____
Address: ____
Telephone Number: ____________________ Fax # (if available): ____________________
Date first seen: (mm/dd/yyyy) ____________ Date last seen: (mm/dd/yyyy) ____________

SECTION 3 – Facility/Hospital Information

If you have been hospitalized or confined to any other type of facility as a result of the circumstances/ condition for which this claim has been filed, please complete this section:

Name of Hospital/Facility ______________________________
Address: ______________________________
____
Telephone #: ______________ Fax # (if available) ______________
Date admitted: (mm/dd/yyyyy) __________ Date discharged: (mm/dd/yyyyy) __________
Reason for admission: ______________________________

Name of Hospital/Facility ______________________________
Address: ______________________________
____
Telephone #: ______________ Fax # (if available) ______________
Date admitted: (mm/dd/yyyyy) __________ Date discharged: (mm/dd/yyyyy) __________
Reason for admission: ______________________________

Name of Hospital/Facility ______________________________
Address: ______________________________
____
Telephone #: ______________ Fax # (if available) ______________
Date admitted: (mm/dd/yyyyy) __________ Date discharged: (mm/dd/yyyyy) __________
Reason for admission: ______________________________

Name of Hospital/Facility ______________________________
Address: ______________________________
____
Telephone #: ______________ Fax # (if available) ______________
Date admitted: (mm/dd/yyyyy) __________ Date discharged: (mm/dd/yyyyy) __________
Reason for admission: ______________________________

If you require additional space to complete this or any section of this form, please feel free to attach additional pages to this form.

SECTION 4 – Caregiver Information

For the period of time you are claiming to have a loss of ADLs or a Cognitive Impairment, who provides (provided) assistance? Please check all that apply.

- ☐ Facility staff provides care
- ☐ State licensed home health care agency
- ☐ State licensed home health care professional (i.e. Registered Nurse)
- ☐ Privately hired individual and/or non-licensed home health care provider
- ☐ Adult Day Care provider
- ☐ Informal caregivers (family/friends)
- ☐ Other (explain): _____

Home Care Information: (Only complete this section if you have received care in the home or have received outpatient therapy)

1. Name of care provider: _____

Telephone #: _____ Fax # (if available): _____

Frequency: _____ days per week _____ hours per day

Start date of care: (mm/dd/yyyy) _____ End date of care:(mm/dd/yyyy) _____

Services provided:

- ☐ Home Health Aid
- ☐ Occupational Therapy
- ☐ Skilled Nursing
- ☐ Companionship/supervision
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Housekeeping/Transportation
- ☐ Other _____

2. Name of care provider: _____

Telephone #: _____ Fax # (if available): _____

Frequency: _____ days per week _____ hours per day

Start date of care: (mm/dd/yyyy) _____ End date of care:(mm/dd/yyyy) _____

Services provided:

- ☐ Home Health Aid
- ☐ Occupational Therapy
- ☐ Skilled Nursing
- ☐ Companionship/supervision
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Housekeeping/Transportation
- ☐ Other _____

3. Name of care provider: _____

Telephone #: _____ Fax # (if available): _____

Frequency: _____ days per week _____ hours per day

Start date of care: (mm/dd/yyyy) _____ End date of care:(mm/dd/yyyy) _____

Services provided:

- ☐ Home Health Aid
- ☐ Occupational Therapy
- ☐ Skilled Nursing
- ☐ Companionship/Supervision
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Housekeeping/Transportation
- ☐ Other _____

Individual completing this form:

Name (first and last): _____

Telephone #: _____ Relationship to Claimant: _____

Date claim form completed _____

Does the claimant have a designated representative that is authorized to act on his/her behalf? Check all that apply:

☐ Medical POA ☐ Financial POA ☐ Legal Guardian ☐ Conservator ☐ Other: _____

Please list the name(s) and telephone number(s) for the designated representatives here if different than, or in addition to, the above individual completing this form.

Name (first and last): _____

Telephone #: _____

Name (first and last): _____

Telephone #: _____

When returning this claim form, please include a copy of any document(s) granting the legally designated representative the authority to act on behalf of the claimant.

SECTION 5 – Authorizations

The Authorization to Disclose Information (required)
The Authorization to Disclose Information is a HIPAA (Health Insurability Portability and Accountability Act of 1996) compliant form which should be signed and dated by the claimant or their legal representative. This form allows us to obtain documentation from medical and care providers, and others as provided, to assist with our review of this claim. ***Without this authorization,Unum may not be able to evaluate or administer your claim (s).***

The Primary Contact Authorization (optional)
The Primary Contact Authorization is optional. Completing this authorization indicates that you, the claimant, designate another individual to be the primary contact with regards to the claim. This means that the primary contact will receive all written and verbal correspondence related to the claim with the exception of benefit payments, if payment is approved. Benefit payments are made directly to the claimant unless otherwise directed in writing from the claimant or a legally designated representative who has the authority to make such a request.

If no primary contact is assigned, the claimant or their legal representative will be the primary contact.

Special Authorizations for Release of Information (as needed)
On occasion certain medical or care providers may require that their own, specific authorization be completed in addition to the Authorization to Disclose Information included with this form. When we are informed that a special authorization is required to obtain documentation, we will forward that authorization to the claimant or their legal representative for completion. Since the authorization will be required to obtain the documentation needed for our review of the claim, completing and returning the form as soon as possible will help to expedite our decision.

Claimant representation: A representative for the claimant may complete and sign the attached authorizations provided that a copy of the document(s) granting his/her legal authority to do so is received with the claim form. If there are multiple legally designated representatives with varying authority, we recommend that this be disclosed in the section above and a copy of all associated document(s) be included with the claim form. We will review the documents once received to establish the authority granted (i.e. medical/health, financial, insurance affairs) and to ensure that we share information regarding this claim in an appropriate manner.

NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to: Long Term Care Benefits Center, P.O. Box 100196, Columbia, SC 29202-9975. This authorization complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Authorization to Disclose Information

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; health plan; rehabilitation professional; insurance company; reinsurer; insurance service provider; third party administrator; producer; government organization; and employer that has information about my health, employment information, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for Unum Group, its insurance subsidiaries* and duly authorized representatives ("Unum"). Information about my health may relate 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 understand that any information Unum obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits. 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.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to: Long Term Care Benefits Center, P.O. Box 100196, Columbia, SC 29202-9975.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____

(Claimant Signature) (Date Signed)

_____

(Print Name)

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

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America and Provident Life and Accident Insurance Company.

Primary Contact Information
(Optional: If no primary contact is assigned, the claimant or their legal representative will be the primary contact.)

Primary Contact Name (first and last): _____

Address: _____

Telephone #: _____ Relationship to Claimant: _____

Authorization for Primary Contact

I authorize the above noted individual to act as my primary contact in regard to my claim(s). In doing so, I am giving Unum Group, its insurance subsidiaries* and duly authorized representatives ("Unum") the right to discuss all aspects of my coverage and claim(s) with my primary contact. This may include information regarding benefits, medical conditions (including, but not limited to, HIV and AIDS, mental illness and drug and alcohol abuse), medical providers, caregivers and locations of care. This information will be provided so that my primary contact may assist me with my claim(s). This information may be provided to my primary contact in writing or orally, such as by telephone. I understand the information once redisclosed by my primary contact could be no longer protected by federal privacy regulations.

I understand I am not required to sign this authorization and Unum may not condition payment of my claim(s) on whether I sign this authorization. I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation. I may revoke this authorization by sending written notice to: Long Term Care Benefits Center, P.O. Box 100196, Columbia, SC 29202-9975.

I authorize Unum to leave a message about my claim on my voicemail/answering machine.
☐ Yes ☐ No

This authorization is valid for two years, or the duration of my claim, whichever comes first unless it is revoked in writing. I know that I have a right to request a copy of this authorization. A photographic or electronic copy of this authorization is as valid as the original.

_____ _____
(Claimant Signature) (Date Signed)

_____
(Print Name)

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America and Provident Life and Accident Insurance Company.