



# Filing

a Leave Request and/or Short Term Disability Claim by Telephone or on the Unum Website



Telephone: 877-247-1290

Fax: 800-447-2498

[www.unum.com](http://www.unum.com)

24 hours a day

7 days a week

## WHEN TO CALL UNUM

- When your health care provider has determined you are unable to work due to illness, injury or pregnancy.
- When you need to be absent from work to care for a family member who has a serious health condition.
- When you need to care for a child due to birth, adoption or foster care placement.
- When you need to be absent from work for a qualifying exigency leave because your spouse, son, daughter or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- When you need to care for your spouse, child, parent or next of kin undergoing medical treatment, recuperation, or therapy, is in outpatient status, or is on the temporary disability retired list for a serious illness or injury incurred or aggravated in the line of duty on active duty in the Armed Forces (includes the National Guard or Reserves). This includes a veteran who was discharged from the Armed Forces for reasons other than dishonorable within the 5 year period before the employee's first day of leave.
- When you need to file for LifePoint Military leave of absence, LifePoint General leave of absence or LifePoint union qualified leave of absence.
- When you need any other type of leave that may be covered by applicable state leave laws.
- Thirty days before a planned leave based on prescheduled medical treatment related to a serious health condition for you or your family member, or the expected birth, adoption or foster care placement of a child.
- Thirty days before a disability based on the expected delivery date of a child or prescheduled medical treatment.

## WHAT TO DO NEXT

- Notify your manager or supervisor of your absence from work.
- To submit your claim and/or leave request via telephone, call the toll-free number listed to the left. Please be prepared with the information requested on page 2 of this brochure.
- To submit your claim and/or leave request via the Unum website, go to [www.unum.com](http://www.unum.com) and follow the claim submission instructions.
- If you are eligible for leave, a certification of health care provider form may be required. If so, it will be mailed in your initial leave packet within 2 business days of filing your leave. You will be provided a minimum of 15 days from the date the leave is requested to complete and return this form.

## FOR SHORT TERM DISABILITY CLAIMS

- Provide your health care provider with a signed and dated copy of the authorization form (last page of brochure). This form authorizes the release of medical information needed to evaluate your disability claim.
- Once you have filed your Short Term Disability claim, please fax a copy of the signed and dated disability authorization to the Unum Benefits Center at the following toll-free number, 800-447-2498. If you prefer, you may sign and submit your authorization electronically at [www.unum.com/claims](http://www.unum.com/claims).

## INFORMATION NEEDED TO SUBMIT A SHORT TERM DISABILITY CLAIM AND/OR REQUEST FOR LEAVE

**Please be prepared to provide the following information when you call to submit your claim/leave. If someone else makes the call on your behalf, he/she may need to provide this information.**

- Name of the company where you work
- Your name and Social Security number or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Supervisor's name and telephone number
- Your last day worked and your first day absent from work due to your claim and/or leave request
- The date you expect to return to work (if you know), or the actual date if you have already returned to work at the time you call

**Please note:** Leave is job protection under federal and state laws whereas a disability is income replacement. In many situations the two coverages overlap when you are missing work due to your own illness or injury.

**In addition, the following information will be needed when submitting a disability claim.**

- Healthcare provider's name, address, fax and telephone number
- A brief description of your medical condition including cause of condition (illness or injury), date of injury or beginning of illness, and whether it's work-related
- The dates of your first visit, your most recent visit, and your next scheduled visit with your healthcare provider for this condition
- Work restrictions or limitations stated by your healthcare provider, if any.

Prompt and complete information from you and your healthcare provider will help assure a timely decision and payment if you are eligible.

Unum may require additional medical information to better understand your disability claim. The timing of the decision depends on how quickly the information is received.

Unum will partner with you to gather all required information for the duration of your disability claim.

## INFORMATION THAT MAY BE IMPORTANT TO YOU

**Check your claim status, correspondence, and updates online – anytime.**

Unum has developed a secure and easy way for you to manage your disability claim online. Our secure web services allow you to access and make changes to your open claims, as well as view updates and correspondence when they become available.

Our secure site helps eliminate delays and is simple to use. Here are a few main features:

- Sign and submit your electronic disability authorization form.
- Upload documents for disability claims from your personal computer.
- Register for direct deposit of your claim payment, when applicable.
- Check claim status, correspondence, and most recent payment information.
- Verify and change personal information and monitor your claim progress.

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**Unum Group**, 1 Fountain Square, Chattanooga, TN 37402

unum.com

## **Claim Fraud Statements**

### **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 Alabama Residents**

For your protection, Alabama law requires the following to appear on this claim form:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents 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.

### **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 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.



Fax or mail a completed copy of this authorization to:  
**Unum Benefits Center**  
 P.O. Box 100158  
 Columbia, SC 29202-3158  
 Fax: 800-447-2498

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, Inc., The Advocator 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, 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, 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 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, 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.

**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 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.

\_\_\_\_\_  
 Insured'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.

Please detach this page and submit to your health care provider