

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 800-331-1538.

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).

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 Life Insurance Company of America (Unum)
Long Term Care Benefits Center
2211 Congress Street
Portland, ME 04122-2300

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

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

For your protection, the laws of several states require these statements to appear:

Fraud Warning

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Fraud Warning for Alaska Residents

CAUTION: If your answers on this application are untrue, Unum may have the right to deny benefits or rescind coverage. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Fraud warning for California Residents

CAUTION: If your answers on this application are misstated or untrue, Unum may have the right to deny benefits or rescind coverage. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Fraud warning for Colorado Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. 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 producer 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 Regulatory Agencies.

Fraud Warning for District of Columbia Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage.

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

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Warning for Georgia and South Carolina Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage, subject to the Incontestability provision. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Fraud Warning for Kentucky Residents

CAUTION: If your answers on this application, to the best of your knowledge, are incorrect or untrue, Unum has the right to deny benefits or rescind coverage. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 Louisiana, Massachusetts and Utah Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum has the right to deny benefits or rescind coverage. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Fraud Warning for New Jersey Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning for New York Residents

CAUTION: If your answers on this application fail to include all material medical information requested, First Unum Life Insurance Company may have the right to deny benefits or rescind coverage. 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.

Fraud Warning for Oregon Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to prosecution for insurance fraud.

Fraud Warning for Pennsylvania Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. WARNING: 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 Rhode Island Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum has the right to deny benefits or rescind your policy. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Fraud Warning for Texas Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Fraud Warning for Virginia Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud Warning for Washington Residents

CAUTION: If your answers on this application are incorrect or untrue, Unum may have the right to deny benefits or rescind coverage. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits

**SECTION 1 – General Information****Name of Claimant:** (first, middle, last)Ms. ☐ Mrs. ☐Mr. ☐ Miss ☐

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

Policy #:

Telephone #:

Date of Birth (mm/dd/yyyy):

Social Security #:

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

Where are you currently residing?

☐ Your residence☐ Nursing Care Facility (Nursing Home)☐ Hospital☐ Assisted Living Facility☐ Residential Care Facility☐ Other _____

If other than your residence:

Name of Facility/Location: _____

Address: _____

Telephone # _____ Date Entered _____

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)

848-89 (11/08)

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/yyyy) _____ Date discharged: (mm/dd/yyyy) _____

Reason for admission: _____

Name of Hospital/Facility _____

Address: _____

Telephone #: _____ Fax # (if available) _____

Date admitted: (mm/dd/yyyy) _____ Date discharged: (mm/dd/yyyy) _____

Reason for admission: _____

Name of Hospital/Facility _____

Address: _____

Telephone #: _____ Fax # (if available) _____

Date admitted: (mm/dd/yyyy) _____ Date discharged: (mm/dd/yyyy) _____

Reason for admission: _____

Name of Hospital/Facility _____

Address: _____

Telephone #: _____ Fax # (if available) _____

Date admitted: (mm/dd/yyyy) _____ Date discharged: (mm/dd/yyyy) _____

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:

- | | |
|--|--|
| <input type="checkbox"/> Home Health Aid | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> Housekeeping/Transportation |
| <input type="checkbox"/> Companionship/supervision | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Home Health Aid | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> Housekeeping/Transportation |
| <input type="checkbox"/> Companionship/supervision | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Home Health Aid | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> Housekeeping/Transportation |
| <input type="checkbox"/> Companionship/Supervision | <input type="checkbox"/> Other _____ |

Individual completing this form:

Name (first and last): _____

Telephone #: _____ Relationship to Claimant: _____

Date claim form completed _____

Check if individual completing this form is also a legal representative:

☐ Power of Attorney ☐ Legal Guardian ☐ Conservator**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.



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, 2211 Congress Street, Portland, ME 04122. 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, 2211 Congress Street, Portland, ME 04122.

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: _____

Check if primary contact is also a legal representative:

☐ Power of Attorney ☐ Legal Guardian ☐ Conservator

Authorization for Primary Contact

I authorize _____ (Print Name) to act as my representative 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 representative. 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 representative may assist me with my claim(s). This information may be provided to my representative in writing or orally, such as by telephone. I understand the information could be redisclosed by my representative and 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, 2211 Congress Street, Portland, Maine 04122.

This authorization is valid for the duration of my claim 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.