**LONG TERM CARE CLAIM FORM**

The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975

Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

For use with policies issued by the following Unum Group ["Unum"] subsidiaries:

Unum Life Insurance Company of America Provident Life and Accident Insurance Company

**OUR COMMITMENT TO YOU**
We understand that a disabling 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

**PLEASE NOTE:** If a legal representative is completing this form or signing any of the documents, please attach a copy of the legal document(s) granting the authority to do so on behalf of the insured.

**Who is responsible for completing this claim form?**
You, as the claimant, or your legal representative should file the claim. The information provided on this claim form will be used to evaluate your eligibility for Long Term Care benefits. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Please enclose any additional information you feel will assist us in the evaluation of your claim.

**Individual Statement** (pages 5 to 10): Please complete this section of the claim form and fax it to 1-800-268-1377.

**Authorization for Additional Contact** - optional (page 11): If you wish to give us permission to share the details of your claim with a third party (such as your spouse, child, sibling or friend, etc.), please sign and date this form and fax it to 1-800-268-1377.

**Individual Authorization** - required (Last page): Please sign and date this form and fax it to 1-800-268-1377. If this authorization is incomplete or not signed appropriately, Unum may not be able to evaluate or administer your claim.

**Attending Physician Statement** (pages 12 to 16): Give this section of the claim form to the physician or treating provider responsible for your care. If they are unable to complete and return to you at that visit, ask him/her to fax the completed form to 1-800-268-1377.

If you do not have access to a fax machine, these forms can be mailed to the address at the top of this form.

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 Monday through Friday from 8 a.m. to 6 p.m. (Eastern Time).

**PLEASE NOTE**: Your claim will not be considered complete and assigned to a claims representative for handling until we have received a signed and valid authorization, completed claim form and completed Attending Physician's Statement from the physician who is treating you for your disabling condition.

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## 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.

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## A Brief Overview of a Long Term Care Policy

In general, an insured's entitlement to benefits for Long Term Care Insurance is based on a loss of independence with Activities of Daily Living (ADLs) and/or the presence of a cognitive impairment requiring another person's assistance/supervision. Assistance with an ADL can mean either the stand-by or hands-on assistance of another individual.

---

### The Activities of Daily Living (ADLs) are generally defined as follows:

**Bathing** - washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.

**Dressing** - putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

**Toileting** - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

**Transferring** - moving into or out of a bed, chair, or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.

**Continence** - the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

**Eating** - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

You will be considered able to perform the above ADLs if the ADLs can be performed by you using equipment or adaptive devices, and you do not require the assistance of another person to perform the ADLs.

---

### Cognitive impairment generally means:

You have suffered a deterioration or loss in your intellectual capacity which requires another person's assistance or verbal cueing to protect yourself or others as measured by clinical evidence and standardized tests which reliably measure your impairment in the following areas:

(a) Your short or long term memory;

(b) Your orientation as to person (such as who you are), place (such as your location) and time (such as day, date and year);

(c) Your deductive or abstract reasoning.

Such loss in intellectual capacity can result from Alzheimer's disease or similar forms of cognitive impairment.

**Note:** If your claim is based on a cognitive impairment and you have not yet had cognitive testing, we recommend you discuss this with your physician as having standardized cognitive testing may expedite our review of your claim.

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## INDIVIDUAL STATEMENT (PLEASE PRINT)

### A. Information About You

Last Name | Suffix | First Name | MI

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

Home Address

City | State | Zip

Home Telephone Number | Cell Phone Number | Policy Number

**Where are you currently residing?**

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

**If other than your home address:**

Name of Facility/Location:_____

Address: _____

Telephone #:_____ Date Entered (mm/dd/yy): _____

Fax #: _____

Are you employed? ☐ Yes ☐ No

If yes, where? _____ How many hours per day/week? _____

### B. Information About the Condition(s) Causing Your Disability

What is your primary medical condition?

What were your first symptoms?

Describe when you first noticed the symptoms.

Date you were first treated by a physician for this condition (mm/dd/yy):

Is this claim related to an injury? ☐ Yes ☐ No If yes, how did the injury occur?

Date the injury occurred (mm/dd/yy):

If related to a motor vehicle accident, was an accident report filed? ☐ Yes ☐ No

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## INDIVIDUAL STATEMENT (Continued)

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

**C. Cognitive Impairment:** Please complete if claim is based on a cognitive impairment (see cognitive impairment definition on page 4 of this form)

When did you begin to need another persons supervision for your health and safety? (mm/dd/yy)

Who provides your supervision?

How often do you receive supervision? Hours per day? Days per week?

Examples of cognitive concerns (i.e. memory loss, disorientation, safety issues):

Please indicate your highest level of education completed.

Are you still driving? ☐ Yes ☐ No

**D. ADL Loss:** Please complete this section if claim is based on ADL loss. (See ADL definitions on page 4 of this form).

| ADL Loss | Reason assistance needed | Begin Date | End Date |
|---|---|---|---|
| Bathing | | | |
| Dressing | | | |
| Toileting | | | |
| Transferring | | | |
| Continence | | | |
| Eating | | | |

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## INDIVIDUAL STATEMENT (Continued)

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

## E. Physicians and Other Medical Treatment Providers:

If you have had more than four, use a separate sheet of paper and include it with this form.

**1.**
Provider First Name Last Name | Mailing Address
Specialty | City State Zip
Telephone No. | Fax No.
Date of First Visit (mm/dd/yy) | Date of Last Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

**2.**
Provider First Name Last Name | Mailing Address
Specialty | City State Zip
Telephone No. | Fax No.
Date of First Visit (mm/dd/yy) | Date of Last Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

**3.**
Provider First Name Last Name | Mailing Address
Specialty | City State Zip
Telephone No. | Fax No.
Date of First Visit (mm/dd/yy) | Date of Last Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

**4.**
Provider First Name Last Name | Mailing Address
Specialty | City State Zip
Telephone No. | Fax No.
Date of First Visit (mm/dd/yy) | Date of Last Visit (mm/dd/yy) | Date of Next Visit (mm/dd/yy)

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## INDIVIDUAL STATEMENT (Continued)

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

### F. Hospitals and Other Facilities:

Please list any recent (within the last 12 months) hospital visits/admissions. If you have had more than four, use a separate sheet of paper and include it with this form.

**1.** _____
Hospital/Facility Telephone Number Fax Number

_____
Address City State Zip

_____ _____
Date of Visit/Admission (mm/dd/yy) Date of Discharge (mm/dd/yy)

_____
Reason for Admission

**2.** _____
Hospital/Facility Telephone Number Fax Number

_____
Address City State Zip

_____ _____
Date of Visit/Admission (mm/dd/yy) Date of Discharge (mm/dd/yy)

_____
Reason for Admission

**3.** _____
Hospital/Facility Telephone Number Fax Number

_____
Address City State Zip

_____ _____
Date of Visit/Admission (mm/dd/yy) Date of Discharge (mm/dd/yy)

_____
Reason for Admission

**4.** _____
Hospital/Facility Telephone Number Fax Number

_____
Address City State Zip

_____ _____
Date of Visit/Admission (mm/dd/yy) Date of Discharge (mm/dd/yy)

_____
Reason for Admission

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## INDIVIDUAL STATEMENT (Continued)

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

## G. Home Care Agencies, Hospice, Inpatient/Outpatient Therapy, and Adult Day Care:

**1.** Name of care provider: _____

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

Address: _____

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 ☐ Physical Therapy ☐ Companionship/supervision
☐ Occupational Therapy ☐ Speech Therapy ☐ Housekeeping/Transportation
☐ Skilled Nursing
☐ Other _____

**2.** Name of care provider: _____

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

Address: _____

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 ☐ Physical Therapy ☐ Companionship/supervision
☐ Occupational Therapy ☐ Speech Therapy ☐ Housekeeping/Transportation
☐ Skilled Nursing
☐ Other _____

**3.** Name of care provider: _____

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

Address: _____

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 ☐ Physical Therapy ☐ Companionship/supervision
☐ Occupational Therapy ☐ Speech Therapy ☐ Housekeeping/Transportation
☐ Skilled Nursing
☐ Other _____

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## INDIVIDUAL STATEMENT (Continued)

Employee/Individual'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.

## H. Signature of Employee/Individual

I have read and understand the fraud notices listed on pages 2 and 3 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**

**Reminder:** Please sign and date the Authorization (last page of this claim form).

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**.

**LONG TERM CARE CLAIM FORM**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## Authorization for Additional Contact

As part of the standard claims review process, a claims representative will be contacting you, the insured, to discuss the details of your claim and policy. If you would like to also name another contact with whom we could share this information, please complete this Authorization for Additional Contact.

Additional Contact Name (first and last): _____

Address: _____

Telephone #: _____ Relationship to Insured: _____

Check if the Additional Contact is also a legal representative:

☐ Power of Attorney (circle medical/financial/both) ☐ Legal Guardian ☐ Conservator

I authorize _____ (Print Name) to act as an additional contact in regard to my claim(s). In doing so, I am giving Unum, 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 may be provided so that my representative may assist me with my claim(s). This information may be provided to my representative in writing or verbally, such as by telephone. I understand the information could be redisclosed by my representative and no longer protected by federal privacy regulations.

I authorize my designated Additional Contact to direct where my benefit payment will be mailed. ☐ Yes ☐ No

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 100158, Columbia, SC 29202-3158.

This authorization is valid for one year, or for the length of time otherwise permitted by law. I know that I have the right to receive a copy of this authorization or to revoke this authorization at any time. A photographic or electronic copy of this authorization is as valid as the original.

_____ _____
Claimant Signature Date Signed

_____ _____
Print Claimat's Name Social Security Number

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

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

**LONG TERM CARE**
**ATTENDING PHYSICIAN STATEMENT**

The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

**A. Patient Information**

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

Social Security Number

Date of Birth (mm/dd/yy)

Home Telephone Number

Height

Weight

**Instructions:** Please complete, sign and date this form. The purpose of this form is to assist us in making a disability determination. Please complete all questions on this form and provide copies of supporting reports, such as office notes, medical records, medication logs, consultations and/or testing. Be sure to sign and date this form in Section F.

What is the primary diagnosis that may impact your patient's functional capacity?

ICD Code:

Is your patient still working? ☐ Yes ☐ No ☐ N/A

Date of first visit for this current condition(s) (mm/dd/yy):

Date of last office visit (mm/dd/yy):

Date of next office visit (mm/dd/yy):

Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yy): From Through

Please list any other diagnoses that may impact your patient's functional capacity.

Secondary Diagnosis:

ICD Code:

Secondary Diagnosis:

ICD Code:

Has the patient been hospitalized? ☐ Yes ☐ No

If yes, please provide most recent date hospitalized (mm/dd/yy): through (mm/dd/yy):

Has the patient had any surgeries in the past 12 months? ☐ Yes ☐ No

If yes, what procedure was performed?

CPT Code:

Date Surgery Performed (mm/dd/yy):

**LONG TERM CARE**
**ATTENDING PHYSICIAN STATEMENT**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

**ATTENDING PHYSICIAN STATEMENT (Continued)**

Patient's Name | Date of Birth (mm/dd/yy)

**B. Functional Capacity**

In general, an insured's entitlement to benefits for Long Term Care Insurance is based on a loss of independence with Activities of Daily Living (ADLs) and/or the presence of a cognitive impairment requiring another person's assistance/supervision. Assistance with an ADL can mean either the stand-by or hands-on assistance of another individual.

Please provide your opinion below as to what ADL loss, if any, your patient has experienced and indicate when this loss began and how long you anticipate this loss will last. We have provided general definitions of ADLs at the end of this packet for your reference.

| ADL | When did the loss begin? (mm/yy) | Based on the date of loss noted when do you anticipate recovery of the ability to perform the ADL? |
|---|---|---|
| Bathing<br>☐ No Loss | | ☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater<br>☐ Not Anticipated<br>☐ Independent as of (mm/yy) _____ |
| Dressing<br>☐ No Loss | | ☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater<br>☐ Not Anticipated<br>☐ Independent as of (mm/yy) _____ |
| Toileting<br>☐ No Loss | | ☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater<br>☐ Not Anticipated<br>☐ Independent as of (mm/yy) _____ |
| Transferring<br>☐ No Loss | | ☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater<br>☐ Not Anticipated<br>☐ Independent as of (mm/yy) _____ |
| Continence<br>☐ No Loss | | ☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater<br>☐ Not Anticipated<br>☐ Independent as of (mm/yy) _____ |
| Eating<br>☐ No Loss | | ☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater<br>☐ Not Anticipated<br>☐ Independent as of (mm/yy) _____ |
| Ambulating/ mobility<br>☐ No Loss | | ☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater<br>☐ Not Anticipated<br>☐ Independent as of (mm/yy) _____ |

Is your opinion based on: ☐ Clinical Observation ☐ Functional Evaluation/Testing ☐ Patient/Family Report

If you have indicated your patient requires/required assistance with ADLs, please check the causes below for the ADL loss:

☐ Balance
☐ Strength
☐ Deconditioning
☐ Cognitive/Perceptual
☐ Paralysis
☐ Fine motor control
☐ Weakness/numbness explain: _____
☐ ROM Limitation explain: _____
☐ Gait
☐ Other: _____

**LONG TERM CARE**
**ATTENDING PHYSICIAN STATEMENT**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name | Date of Birth (mm/dd/yy)

### C. Cognitive Capacity

Please provide your opinion below as to what cognitive impairment, if any, your patient has experienced. We have provided a general Long Term Care definition of cognitive impairment at the end of this packet for your reference.

Does your patient have a cognitive impairment? ☐ Yes ☐ No

**If NO, please proceed to Section D.**

What is the cognitively impairing diagnosis (please be specific): _____

When was your patient first seen for cognitive issues and by whom? (mm/dd/yy) _____

Has any cognitive testing been completed? ☐ Yes ☐ No If yes, please attach testing with this completed form.

Check type of testing completed:

☐ CT/MRI date _____
☐ MMSE date/score _____
☐ MOCA date/score _____
☐ Neurology consultation
☐ Speech Therapy
☐ Neuro-psychological evaluation

**If no cognitive testing has been performed, please attach clinical findings that support a cognitive impairment.**

Has there been a work up for reversible causes of cognitive impairment? ☐ Yes ☐ No If yes, please attach this workup

Is your patient's cognitive impairment to the degree that it puts him/her at risk for health and safety? ☐ Yes ☐ No
If YES, when did the cognitive impairment begin to impair your patient to the degree that it put him/her at risk for his/her health and safety? (mm/dd/yy) _____

If YES, please indicate why supervision is needed as well as what activities your patient needs assistance/supervision with? (check all that apply)

**Why:**

☐ Short term memory loss
☐ Long term memory loss
☐ Poor Judgment
☐ Impaired executive function
☐ Wandering behavior
☐ Confusion
☐ Impaired orientation to person/place/time

**What activities:**

☐ Managing Finances
☐ Managing Medications
☐ Using the telephone/devices
☐ Handling Transportation
☐ Shopping
☐ Preparing Meals
☐ Housework/home management

Do you know whether or not your patient is still driving? ☐ Yes ☐ No, not driving ☐ Unknown

If your patient is currently driving, do you agree that he/she should be driving? ☐ Yes ☐ No

Is your patient **currently** receiving supervision to protect his/her self or others due to cognitive impairment? ☐ Yes ☐ No
How many hours per day _____ and days per week _____ do you recommend supervision be provided?

When did supervision begin? (mm/dd/yy) _____ Who provides the supervision? _____

**LONG TERM CARE**
**ATTENDING PHYSICIAN STATEMENT**

The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

## ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name

Date of Birth (mm/dd/yy)

### D. Plan of Care

Date care to begin (mm/dd/yy) _____

Date care to be reassessed (mm/dd/yy)_____

Please check type of medical care to be provided by a skilled agency or licensed professional and indicate frequency to be provided.

- ☐ Skilled Nursing Visits _____
- ☐ Physical Therapy _____
- ☐ Occupational Therapy _____
- ☐ Speech Therapy _____
- ☐ Respiratory Therapy _____
- ☐ Hospice _____
- ☐ Other _____

Please check type of non-medical care that can be provided by an unskilled, non-licensed agency or individual and indicate frequency to be provided.

- ☐ Personal Care/HHA _____
- ☐ Companion Care _____
- ☐ Respite Care _____
- ☐ Homemaker Services _____

### E. Other Treating Providers, Facilities or Hospitals

Please provide complete name, contact information and specialty for any other treating providers your patient is seeing for his/her disabling condition(s) or for any referrals you have made to other providers including other physicians, therapist or clinical programs.

| Name | Specialty | City, State |
|---|---|---|
| | | |
| | | |
| | | |

### F. Signature of Attending Physician

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

Physician Name (Last Name, First Name, MI, Suffix) 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?

**Signature of Physician** | **Date**

**X**

**LONG TERM CARE**
**ATTENDING PHYSICIAN STATEMENT**
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

**A Brief Overview of a Long Term Care Policy**

In general, an insured's entitlement to benefits for Long Term Care Insurance is based on a loss of independence with Activities of Daily Living (ADLs) and/or the presence of a cognitive impairment requiring another person's assistance/supervision. Assistance with an ADL can mean either the stand-by or hands-on assistance of another individual.

---

**The Activities of Daily Living (ADLs) are generally defined as follows:**

**Bathing** - washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.

**Dressing** - putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

**Toileting** - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

**Transferring** - moving into or out of a bed, chair, or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.

**Continence** - the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

**Eating** - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

**Mobility** – is the ability to move from one location to another, indoors and outdoors, even if you must use the support of equipment such as a walker, a mechanical or motorized wheelchair or artificial limbs.

**Ambulating** – is the ability to walk from one location to another, indoors or outdoors, with or without the use of supportive equipment such as a walker, crutches or artificial limbs without the standby assistance of another person.

You will be considered able to perform the above ADLs if the ADLs can be performed by you using equipment or adaptive devices, and you do not require the assistance of another person to perform the ADLs.

---

**Cognitive impairment generally means:**

An insured has suffered a deterioration or loss in their intellectual capacity which requires another person's assistance or verbal cueing to protect them or others as measured by clinical evidence and standardized tests which reliably measure impairment in the following areas:

(a) short or long term memory;

(b) orientation as to person (such as who they are), place (such as their location) and time (such as day, date and year);

(c) deductive or abstract reasoning.

Such loss in intellectual capacity can result from Alzheimer's disease or similar forms of cognitive impairment.

The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

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

**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, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies employers, attorneys, 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 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.** 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 person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim. 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.

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