



Reporting

a Long Term Disability Claim by Telephone

The Emory Clinic, Inc.

LTD Policy #: 602907

Phone: 866-224-9402

Fax: 800-447-2498

Monday-Friday

8 a.m.

to

8 p.m.

Eastern

WHEN TO REPORT A CLAIM

- When you are injured at work notify your manager immediately, unless it is an emergency. Do not use this toll-free number for work-related injuries.
- When your physician has determined you are unable to work due to illness, injury or pregnancy.
- Sixty days in advance of a planned medical absence, such as prescheduled surgery or an expected pregnancy leave.

HOW TO REPORT A CLAIM

- Notify your manager of your absence from work.
- Call the toll-free number listed to the left to initiate your claim. Refer to "Information Needed to Submit a Claim" on page 2 of this brochure for a list of the information that is required to initiate a claim.
- See your physician and provide him/her with a signed and dated copy of the authorization form (attached). This form authorizes the release of medical information needed to evaluate your claim.
- Fax or mail a copy of the signed and dated authorization to the Unum Benefits Center.

OUR COMMITMENT TO YOU

Unum understands 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.

INFORMATION NEEDED TO SUBMIT A CLAIM

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

- Name of the company where you work
- Policy number (printed on the front of this brochure)
- Physician's name, address, fax and phone number
- Your name and Social Security or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Supervisor's name and phone 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 physician for this condition
- Your last day worked and your first day absent from work due to this condition
- 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
- Work restrictions or limitations advised by your physician, if any

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

Claim Fraud Warning Statements

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma and others require the following statement to appear:

Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

For California Residents

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.

For Colorado Residents

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

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Maine, Tennessee and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For New Jersey, New Mexico and Pennsylvania Residents

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.

For New York Residents

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.

For Puerto Rico Residents

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Unum Group

1 Fountain Square
Chattanooga, TN 37402

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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

I authorize 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, credit bureaus, the MIB Group, Inc., GENEX Services Inc., The Advocator Group and other Social Security advocacy vendors, The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), 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;

To the following persons: 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"), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims, including assistance with return to work. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

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, Unum may not be able to evaluate 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 is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

Please detach this page here. Submit to your health care provider.

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.