GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-800-445-0402  Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 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
The Paul Revere Life Insurance Company

OUR COMMITMENT
During this difficult time, we are committed to providing responsive, compassionate service.

INSTRUCTIONS
Who is responsible for completing this form?

- **Employer Statement (pages 4-7):** This section of the form should be completed by the employer who should fax it to 1-800-447-2498 or mail it to the address noted above. The following information should also be provided:
  - A copy of the death certificate (a photocopy or fax is acceptable);
  - The original enrollment form and any other enrollment forms indicating any change in coverage; and
  - The most recent beneficiary designation form.

- **Accidental Death Statement (pages 8-10):** If the claim is related to an accidental death, this section of the form should be completed by the employee or beneficiary. The completed form should be faxed to 1-800-447-2498 or mailed to the address noted above.

- **Substitute W-9 Form (page 11):** This form should be completed, signed and dated by the beneficiary. If there are multiple beneficiaries, each beneficiary should complete, sign and date a form. The completed form(s) should be faxed to 1-800-447-2498 or mailed to the address noted above.

- **Authorization (last page):** This form should be signed and dated by the employee or beneficiary and faxed to 1-800-447-2498 or mailed to the address noted above.

Questions?
If you have questions about the claim process or need help to complete this form, please call the above toll-free number. Our Contact Center professionals are available from 8 a.m. to 8 p.m. Eastern Time Monday through Friday.
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

**Fraud Warning for Minnesoan Residents**

**Commission of a Fraudulent Insurance Act, Which is a Crime:**

Any material or false information or concealing the truth of material information concerning any insurance transaction is guilty of a felony of the third degree.

For your protection, Kentucky residents are required to follow the following to appear on this claim form:

**Fraud Warning for Kentucky Residents**

Any person who knowingly and with intent to defraud an insurer of an interest, false statement of claim or an application materially related to a claim was provided by the applicant.

For your protection, Florida residents are required to follow the following to appear on this claim form:

**Fraud Warning for Florida Residents**

Any material information is guilty of a felony of the third degree.

For your protection, the District of Columbia residents are required to follow the following to appear on this claim form:

**Fraud Warning for District of Columbia Residents**

Any material information is guilty of a felony of the third degree.

For your protection, Colorado residents are required to follow the following to appear on this claim form:

**Fraud Warning for Colorado Residents**

Any material information is guilty of a felony of the third degree.

For your protection, California residents are required to follow the following to appear on this claim form:

**Fraud Warning for California Residents**

Any material information is guilty of a felony of the third degree.

For your protection, Wyoming residents are required to follow the following to appear on this claim form:

**Fraud Warning for Wyoming Residents**

Any material information is guilty of a felony of the third degree.

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho,

**Fraud Warning for Other Residents**

Any material information is guilty of a felony of the third degree.

For your protection, Vermont residents are required to follow the following to appear on this claim form:

**Fraud Warning for Vermont Residents**

Any material information is guilty of a felony of the third degree.

For your protection, the laws of several states, including Alabama, Arkansas, Arizona, Delaware, Idaho,

**Fraud Warning for Residents of Several States**

Any material information is guilty of a felony of the third degree.

For your protection, New Hampshire residents are required to follow the following to appear on this claim form:

**Fraud Warning for New Hampshire Residents**

Any material information is guilty of a felony of the third degree.

For your protection, the laws of several states, including Alabama, Arizona, Arkansas, Delaware, Idaho,

**Fraud Warning for Residents of Several States**

Any material information is guilty of a felony of the third degree.

For your protection, Nevada residents are required to follow the following to appear on this claim form:

**Fraud Warning for Nevada Residents**

Any material information is guilty of a felony of the third degree.

For your protection, the laws of several states, including Alabama, Arizona, Arkansas, Delaware, Idaho,

**Fraud Warning for Residents of Several States**

Any material information is guilty of a felony of the third degree.

For your protection, the laws of several states, including Alabama, Arizona, Arkansas, Delaware, Idaho,
Instructions (continued) / Claim Fraud Statements

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.
If yes, please describe the nature of the benefits:

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Amount of Insurance Provided to Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$10,000</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

Reason for Seeking Work:
- Document of commission and business
- Salary with commission under $100,000
- Copy of the policy and the full policy statement for the same year

Employer Statement - To be completed by the Employee (Please Print):

Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time):

Phone: 1-800-443-0420  Fax: 1-800-474-7298

P.O. Box 10015, Columbia, SC 29202-1015

The Benefits Center
**GROUP LIFE AND/OR ACCIDENTAL DEATH CLAIM FORM**
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P.O. Box 100158, Columbia, SC 29202-3158  
Toll-free: 1-800-445-0402  Fax: 1-800-447-2498  
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

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**EMPLOYER STATEMENT (Continued)**

<table>
<thead>
<tr>
<th>Employee Name (Last Name, Suffix, First Name, MI)</th>
<th>Date of Birth (mm/dd/yy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Amount of Insurance</th>
<th>Basic</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
<th>Supplemental</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes to the Amount of Insurance</th>
<th>Amount of last change</th>
<th>Date of last change (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
<tr>
<td>Supplemental Life</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
<tr>
<td>Supplemental Accidental Death and Dismemberment</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
</tbody>
</table>

Date the premium payment was paid through for this employee (mm/dd/yy):  
Was this employee terminated?  □ Yes  □ No  
If yes, termination date (mm/dd/yy):

The Accidental Death and Dismemberment policy may provide an education benefit. Does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled in an institution of higher learning beyond the 12th grade?  □ Yes  □ No  
If yes, please provide the following information for each child:

Name: ___________________________  Age: _____________

Name: ___________________________  Age: _____________

Name: ___________________________  Age: _____________

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**D. Information About the Dependent**  Please complete this section if the claim is for the death of the employee’s dependent.

<table>
<thead>
<tr>
<th>Dependent Name (Last Name, Suffix, First Name, MI)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship to Employee</th>
<th>Dependent Date of Birth (mm/dd/yy)</th>
<th>Dependent Date of Death (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Spouse □ Civil Union Partner □ Domestic Partner □ Child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent Social Security Number</th>
<th>Dependent Gender</th>
<th>Dependent Effective Date of Coverage (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Male □ Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount of Insurance</th>
<th>Basic</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
<th>Supplemental</th>
<th>Effective Date of Coverage (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes to the Amount of Dependent Insurance</th>
<th>Amount of last change</th>
<th>Date of last change (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
<tr>
<td>Supplemental Life</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
<tr>
<td>Supplemental Accidental Death and Dismemberment</td>
<td>$</td>
<td>Increase □ Decrease □</td>
</tr>
</tbody>
</table>

Date the premium was paid through for this dependent (mm/dd/yy):  
Was the employee in active employment at the time of the dependent’s death?  □ Yes  □ No
C. Information About Payment - Advise the beneficiary that if the claim is approved the benefit will be paid by check if it is less than $10,000. The benefit will be paid through a lump sum account or a benefit account at the Bank of America. The beneficiary may request the benefit be paid by check. Thereafter the account will be closed and all monies in the account will be distributed to the beneficiary. The amount of the benefit will be paid by check. The payment of the benefit will be made in accordance with the terms of the group policy. The bank account will be closed and the group policy will be terminated. The amount of the benefit will be paid by check.

<table>
<thead>
<tr>
<th>Telephone Number of Adult Responsible:</th>
<th>ZIP:</th>
</tr>
</thead>
</table>

D. Address of Adult Responsible: (Last Name, First Name, Middle Initial)

E. Information About Minor Beneficiary - If any of the above beneficiaries are minor children, please complete this section. If there is more than one, please provide the following information for each additional minor beneficiary on a separate sheet of paper and include it with this form. If there are no beneficiaries, please check "No" if no, please explain.

<table>
<thead>
<tr>
<th>Name of Minor Child (Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Phone Number</td>
</tr>
</tbody>
</table>

F. Information About Recent Beneficiary Designation Form is enclosed. Yes or No. If no, please explain.

G. Employment Statement (Continued)
G. Information About Unum Retained Asset Accounts – By placing the funds in a Unum Retained Asset Account the beneficiary will have the time needed to decide how to best manage the insurance proceeds so as not to put his/her investment decisions at risk. Here’s how it works:

- When the claim is approved, a personalized book of bank drafts and an opening account statement will be mailed to the beneficiary.
- He/She will have unlimited access to the balance in the account.
- The entire account balance can be accessed by the use of one draft.
- Drafts can be written for a minimum of $250 up to the full account balance at any time. There is no limit on the number of withdrawals that can be made from the account.
- No charges will be made to the Unum Retained Asset Account for writing drafts or ordering a new supply of drafts.
- The following charges will be made to the Unum Retained Asset Account for any request for:
  - A copy of a draft or statement ($5);
  - A stop payment of a draft ($15);
  - A draft returned as unpaid, requests for additional statements, and requests for additional copies of IRS Form 1099-INT ($10); and
  - Draft book rush orders ($25).
- A quarterly statement is provided, detailing the account balance, interest rate, accrued interest and account transactions for the statement period.
- Funds in the Unum Retained Asset Account are fully guaranteed by Unum Group. The funds are not protected by the FDIC, but are protected by state Guaranty Associations. To learn more about the protections provided by these associations, the beneficiary may contact the National Organization of Life and Health Insurance Guaranty Associations at nolha.com or 703-481-5206.
- The beneficiary may leave the money in the Unum Retained Asset Account for as long as he/she wishes. If there is no account activity or any contact with the beneficiary for two years, we will attempt to contact him/her. If we are unable to contact the beneficiary, we could be required to surrender the account balance to the state of his/her last known residence.

Unum will retain the funds and invest them in its general account for as long as they remain in the Unum Retained Asset Account. Unum guarantees the account balance and will pay a competitive interest rate regardless of the investment performance of Unum’s general account. Unum may derive income from the total gains received on the investment of the balance of the funds in the retained asset account.

The interest rate is determined by monitoring rates of interest offered on similar types of accounts (i.e., checking, savings and money market accounts). Any changes to the interest rate will be disclosed via a quarterly account statement.

The interest earned on the Unum Retained Asset Account may be taxable. The beneficiary should consult a tax advisor, an investment advisor, or another financial advisor with any questions. For further information, the beneficiary should contact his/her state insurance department.

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer portions of the claim form.

I. Information About and Signature of Benefit Administrator (Please Print)

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

Name of Person Completing Form

Title of Person Completing Form

Telephone Number

Fax Number

Email Address

Signature

Date Signed

CL-1091 (04/18)
## Information About the Claimant

<table>
<thead>
<tr>
<th>Name of Claimant</th>
<th>Relationship to the Employee</th>
<th>Date of Birth (mm/dd/yy)</th>
<th>Date of Death (mm/dd/yy)</th>
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## Information About the Dependent

<table>
<thead>
<tr>
<th>Name of Dependent</th>
<th>Relationship to the Employee</th>
<th>Date of Birth (mm/dd/yy)</th>
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</table>

## Information About the Employee

<table>
<thead>
<tr>
<th>Name of Employee</th>
<th>Date of Birth (mm/dd/yy)</th>
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## Information About the Responding Authorities

Describe how the accident happened.

Where did the accident happen?

<table>
<thead>
<tr>
<th>Time of the Accident</th>
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## Information About the Employee

- Call toll-free Monday through Friday, 6 a.m. to 5 p.m. (Eastern Time): 1-800-449-4040, TTY: 1-800-447-2493
- P.O. Box 100186, Columbia, SC 29202-3158
- The Benefit Center

Group Life and/or Accidental Death Claim Form
ACCIDENTAL DEATH STATEMENT (Continued)

<table>
<thead>
<tr>
<th>Employee Name (Last Name, Suffix, First Name, MI)</th>
<th>Date of Birth (mm/dd/yy)</th>
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</thead>
</table>

E. Information About Physicians/Hospitals

Please provide the following information about all the physicians/hospitals who attended the deceased for injuries sustained in this accident. If there were more than three, please share the following information for each additional physician/hospital on a separate sheet of paper and include it with this form.

<table>
<thead>
<tr>
<th>Physician/Hospital Name</th>
<th>Mailing Address</th>
<th>Telephone Number</th>
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F. Information About Previous Medical Conditions

Please provide the following information about all physicians who treated the deceased for any medical condition in the last five years. If there were more than five, please share the following information for each additional physician on a separate sheet of paper and include it with this form.

<table>
<thead>
<tr>
<th>Physician Name, Specialty, Address and Telephone Number</th>
<th>Medical Condition Treated</th>
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<tbody>
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</tbody>
</table>
Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

1. Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2. Business name/described entity name, if different from above.

3. Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.
   - Individual/sole proprietor or single-member LLC
   - C Corporation
   - S Corporation
   - Partnership
   - Trust/estate
   - Limited liability company. Enter the tax classification (C, S corporation, or P=Partnership). Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.
   - Other (see instructions)

4. Exemptions (check only one of the following):
   - Exempt payee code (if any)
   - Exemption from FATCA reporting code (if any) (Applies to accounts maintained outside the U.S.)

5. Address (number, street, and apt. or suite no.) See instructions. Requester's name and address (optional)

6. City, state, and ZIP code

7. List account number(s) here (optional)

Part I  Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this generally is your social security number (SSN). However, if you are a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see What Name and Number To Give The Requestor for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II  Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here

Signature of U.S. person

date

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1098-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1088-E (student loan interest), 1098-T (tuition)
- Form 1098-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN. If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What Is Backup Withholding, later.
This is a legal document that provides information about the notification of the death of a beneficiary. It includes the following sections:

- **Authorization of Personal Representative or Guardian**: This section outlines the responsibilities and authorization of the personal representative or guardian.
- **Disclosure of Information**: This section details the information that needs to be disclosed to the insurance company.
- **Authorization for Accidental Death Claim**: This section provides the authorization to claim for accidental death.

The document contains various legal terms and acronyms, including HIPAA (Health Insurance Portability and Accountability Act). It is important to read and understand this document thoroughly before taking any action.