CLAIM FOR INCOME PROTECTION BENEFITS
The Benefits Center, P.O. Box 100158
Columbia, SC 29202-3158
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498

Maine Municipal Employees Health Trust

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

Please mail or fax this form to:
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
Toll free 800.858.6843 Fax 800.447.2498

This form should be used for the following types of claims only:
• Short Term Disability (STD)

There is a **90 day timely filing requirement** on this plan. This form must be completed by the Attending Physician, the Employee, and the Employer, and be received by Unum no later than 90 days from your date of disability, or your claim will not be considered for benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

The employee is responsible for completion of all portions of this form without expense to Maine Municipal Employees Health Trust or the Unum subsidiaries.

INSTRUCTIONS:

A. Attending Physician's Statement: This section must be completed by the physician primarily responsible for your care. If your disability is related to a non-complicated pregnancy, your physician should complete the Normal Pregnancy section of the form. For all other disabilities, including complicated pregnancy, your physician should complete the All Other section of the form. Your physician must sign and date the form.

B. Employer Statement: Your employer must complete, sign and date this section of the form.

C. Employee Statement: This section must be completed by you, the employee. Please sign and date the bottom of the form.

Authorization: Sign and date this form. Provide a copy of the signed and dated form to your attending physician.

Please enclose any additional information that you feel will assist us in evaluating this claim.

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A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number ( )	Date of Birth	Social Security Number

Employer Name/Address	Employer Telephone Number ( )

Instructions: The following sections must be completed and signed by the attending physician. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete the normal pregnancy section. **Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, you must complete the signature block at the bottom of this form.**

NORMAL PREGNANCY

a) Expected Delivery Date: b) Actual Delivery Date: c) Delivery Type: ☐ Vaginal ☐ C-Section

Date First Unable to Work: Date Hospitalized:

ALL OTHER CONDITIONS

Patient Information

a) Height: Weight: b) Date of first visit regarding current conditions?

c) Date patient ceased work because of condition? d) Did you advise patient to cease work? ☐ Yes ☐ No If yes, when?

e) Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No If yes, when?

If yes, please describe:

f) Is the patient's condition due to injury or sickness involving the patient's employment? ☐ Yes ☐ No

Diagnosis and Treatment
Primary Diagnosis

a) What is the primary diagnosis preventing your patient from working?

Please include Primary ICD-9 and/or DSM IV Multi-Axial Diagnoses and Codes

b) Date of last examination:

c) Describe Reported Symptoms:

d) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.):

Other Conditions **(Please attach additional information as necessary)**

Are there other conditions that prevent your patient from working? If so, please list with information as follows:

a) Secondary ICD-9s: Diagnosis:

Secondary ICD-9s: Diagnosis:

b) Describe Reported Symptoms:

c) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.):

Treatment

a) Describe the patient's current treatment program (include facilities name/address if applicable):

b) Medications (Please list all medications including dosage and frequency):

c) Has patient been hospitalized? ☐ Yes ☐ No Date Hospitalized: through:

d) Was surgery performed? CPT 4 Code(s): Date Surgery Performed:

Name/Address of facility:

e) Is the patient still under your care? ☐ Yes ☐ No Final Date of Treatment:

Claimant Name: Social Security Number:

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To

Physical Capabilities

a) Patient's ability to: *(Please Check Number of Hours Per Workday and How Often)*

	Number of Hours									How Often			
Sit	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently		
Stand	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently		
Walk	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ Intermittently		

b) Patient's ability to: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☐	☐	☐	☐
Twist/bend/stoop	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate heavy machinery	☐	☐	☐	☐

c) Patient's ability to lift/carry: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐

d) Patient's ability to perform: *(Please Check)*

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
	R	L	R	L	R	L	R	L
Fine Finger movements	☐	☐	☐	☐	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☐ Right ☐ Left

Psychological Features

Are there any cognitive deficits or psychiatric conditions that interfere with the patient's ability to perform his/her occupation? If so, please describe specifically how any identified condition prevents the patient from performing his/her occupation.

Return to Work

a) When do you expect improvement in the patient's capabilities?

b) Have you advised patient to return to work? ☐ Yes ☐ No Expected Return to Work Date: ☐ Full Time ☐ Part Time
If yes, please indicate any ongoing restrictions and limitations in the space provided below.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below.

c) RESTRICTIONS (activities patient should not do)

d) LIMITATIONS (activities patient cannot do)

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

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 and Attending Physician portions of the claim form.

Print or Type Name		Degree	Medical Specialty
Street Address			Telephone Number ( )
City	State	ZIP Code	Fax ( )
Signature of Physician			Date
SSN or Employer's ID Number:		Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship?	

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B. EMPLOYER STATEMENT (PLEASE PRINT)

Type of Coverage: (CHECK ALL THAT APPLY TO THIS EMPLOYEE)

☐ **Short Term Disability** ☐ **Long Term Disability**

Policy Number (for this claim)	Division Number	Department Name
574031		

1. Employer Name | Employer's Phone Number

General Employee Information

2. Employee Name | Social Security Number

Employee Address

3. Has employee returned to work? ☐ Yes ☐ No If yes, date: ☐ Full Time ☐ Part Time Hours Per Week

4. Date of Hire	Effective Date of Insurance	Date Last Worked	Number of Hours Worked on Date Last Worked

Employee's Work Status ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-exempt ☐ Bargaining ☐ Non-bargaining

Has the employee's employment been terminated? ☐ Yes ☐ No If yes, please provide termination date

5. Job Title/Major Job Duties

6. Annual Base Salary (not including overtime)

7. How was the STD premium paid for the plan year in which the disability occurred?

Percentage paid by Employer _____ Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No

Percentage paid by Employee _____ ☐ Pre-tax ☐ Post-tax

8. Check off regular work days ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

9. Date paid through For ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick Pay ☐ Other

10. If this is a Flexible Benefits Plan, indicate which option of coverage this employee has chosen.

Previous Plan Year - Date of Open Enrollment _____ Option _____ Current Plan Year - Date of Open Enrollment _____ Option _____

11. Is the claim the result of a work related injury or sickness? ☐ Yes ☐ No If yes, has Workers' Compensation claim been filed? Yes ☐ No ☐

If yes, name and address of Workers' Compensation carrier

If Workers' Compensation claim has been denied, a copy of the denial is required.

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

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 and Attending Physician portions of the claim form.

Name of Person Completing Form		Telephone Number and Extension
Title of Person Completing Form	E-mail Address	Fax Number
Signature		Date Signed

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C. EMPLOYEE'S STATEMENT (PLEASE PRINT)

1. Employee's Name (as printed on your Social Security Card) | Home Telephone Number | Date of Birth | Social Security Number

☐ Male ☐ Female

Home Address (Street, City, State, ZIP)

The state in which you work | Preferred e-mail address where you can be reached

2. Employer Name | Policy Number 574031

3. Disability claim due to:

Accident
- ☐ motor vehicle
- ☐ work-related
- ☐ non-work related
- ☐ other _____

Sickness
- ☐ work-related
- ☐ non-work related
- ☐ pregnancy

Other Reason
- ☐ other _____

4. Please provide reason for disability claim

For any accident related claim, was another party at fault? ☐ Yes ☐ No If so, have you filed a claim against that party? ☐ Yes ☐ No

5. Date Last Worked | Number of Hours Worked on Date Last Worked

6. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.
If you have been approved or denied for any of these benefits, please send a copy of Award or Denial Notification.

Social Security/Retirement ☐ Yes ☐ No	Social Security/Disability ☐ Yes ☐ No	Canada Pension Plan ☐ Yes ☐ No	State Disability ☐ Yes ☐ No
Worker's Compensation ☐ Yes ☐ No	Pension/Retirement ☐ Yes ☐ No	Pension/Disability ☐ Yes ☐ No	Unemployment ☐ Yes ☐ No
No-Fault Insurance ☐ Yes ☐ No	Short Term Disability ☐ Yes ☐ No – Ins. Co. Name and Policy #		
Other (Include Individual Disability or Group Disability Benefits) ☐ Yes ☐ No – Ins. Co. Name and Policy #			

7. If your request for benefits is approved, do you want Federal Income Tax withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ _____ (Note: Minimum withholding is $20.00 per week)
Do you want State Income Tax withheld from your check? ☐ Yes ☐ No
If yes, please indicate dollar amount $ _____ (Note: The amount indicated must be a whole dollar increment)

Claim Fraud Warning Statements

Fraud Warning for Maine 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.

Fraud Warning for New Hampshire Residents 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.

Signature of Employee

I have read and understand the fraud notices listed on this form. The above statements are true and complete to the best of my knowledge and belief.

_____ _____
Signature Date

INCOME PROTECTION CLAIM
EMPLOYEE'S AUTHORIZATION
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FOR EMPLOYEE TO COMPLETE

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 The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for Maine Municipal Employees Health Trust (MMEHT) or 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 MMEHT or Unum obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. 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 MMEHT or 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, MMEHT or 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 the address above.

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) (Social Security Number)

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, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.