

**UNUM
Disability Claim Form**

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

TO BE COMPLETED BY THE INSURED:

Policy No. _____

1. Name of Insured _____ Date of Birth _____ S.S. # _____
2. Address _____ City _____ State _____ Zip _____ Phone # () _____
3. Name of Employer _____ Address _____ City _____ State _____ Zip _____
4. Occupation _____ Duties _____
5. Date sickness began or accident occurred _____ Date you last worked _____
6. Nature of sickness or injury _____
7. Have you had the same or similar sickness before? _____ If yes, explain _____
8. If injured, how, and where did the accident occur? _____
9. First treating physician: Full name _____ Address _____ Date _____
10. Date disability began: Month _____ Day _____ Year _____ A.M. _____ P.M. _____
11. On what date did you (or do you) expect to resume any part of your work? _____

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give Unum, or its representatives, any such information.

A photographic copy of this authorization shall be as valid as the original.

APPROVED BY: _____

DATED _____

SIGNED _____

Attending Physician

Claimant's Signature

TO BE COMPLETED BY ATTENDING PHYSICIAN: FAILURE TO PROVIDE ALL INFORMATION REQUIRED BELOW MAY DELAY PAYMENT

1. Name of Patient _____ Age _____
 2. How long have you been Insured's physician _____
 3. Nature of sickness or injury, describe complications, if any _____
 4. When did the patient first consult you for this condition? _____
 5. List all treatment for this condition _____
 6. If patient hospitalized, give name and address of hospital _____
Date admitted _____
 7. Was surgery performed? _____ If so, procedure and date performed _____
 8. Has the claimant had the same or similar illness before? _____ If yes, when? _____
 9. How Long Was Or Will Patient Be Continuously Totally Disabled? FROM _____ TO _____
 10. How Long Was Or Will Patient Be Partially Disabled? FROM _____ TO _____
 11. Was the patient referred to another doctor? _____ if so, whom? _____
 12. Confining Date _____ Thru _____ Non Confining Date _____ Thru _____
- Typewritten name of Physician _____ Address _____ Degree _____
Signature _____ Date _____ Phone No. _____

TO BE COMPLETED BY THE EMPLOYER:

1. Employer Name _____ Address _____ Zip _____
2. Employer's Phone # () _____ Workmen's Comp Claim Filed ? _____
3. Name of Compensation carrier _____
4. Between what dates did employee give up all duties: TOTAL DISABILITY FROM _____ TO _____

Date _____ Title _____ Signature _____

Form No. 701

No faxed claims accepted



Unum
P. O. Box 2728
Houston, TX 77252-2728

**COMPLETE AND RETURN
THIS FORM PROMPTLY**
Please fold in half, then fold in half again
so that the address is showing thru the
window in the enclosed envelope