Filing

a Disability Claim by Telephone, on the Unum Website, or on the mobile app

University of Minnesota

Voluntary Short Term Disability Policy #: 471837-001

Voluntary Long Term Disability Policy #: 471837-002

Academic Long Term Disability Policy #: 471835

www.unum.com

Telephone: 800-986-3239 Fax: 800-447-2498

Monday-Friday

7:00 a.m. to 7:00 p.m. Central

Contact UReturn - Employees are encouraged to call for assistance with return to work or stay at work. 612-624-3316.

WHEN TO CALL UNUM

- If you are injured at work notify your manager or supervisor immediately. Do not use this toll-free number for work-related injuries.
- When you are unable to work due to illness, injury or pregnancy.
- Thirty days before a disability based on the expected delivery date of a child or prescheduled medical treatment.
- When you know you will be out for more than seven days in a row for voluntary short term disability.
- When you know you will be out for more than two weeks for the Academic Long Term Disability.
- Please contact us no later than these timeframes so we can begin reviewing your claim.

WHAT TO DO NEXT

- Notify your your manager or supervisor of your absence from work.
- To submit your claim via telephone, call the toll-free number listed to the left. Please be prepared with the information requested on page 2 of this brochure.
- To submit your claim via the Unum website, go to http://www.unum.com/claimant and follow the claim submission instructions.
- To submit your claim via your Apple or Android device, download the Unum Customer App and follow the claim submission instructions.
- Provide your health care provider with a signed and dated copy of the disability authorization form (last page of brochure). This form authorizes the release of medical information needed to evaluate your disability claim. Confirm with your doctor that they will accept the authorization form from Unum. If not, ask your doctor what needs to be done to release the information to Unum.
- Fax a copy of the signed and dated disability authorization to the Unum Benefits Center at the following toll-free fax number, 800-447-2498. If you prefer, you may mail a copy to the address at the top of the authorization, or you may sign and submit your authorization electronically at http://www.unum.com/claimant.

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.

Submit your claim via your Apple or Android device by downloading the Unum Customer App and following the claim submission instructions.

ADR-1651103 (06/23)

INFORMATION NEEDED TO SUBMIT A DISABILITY CLAIM

Please be prepared to provide the following information when you call to submit your claim. 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: 471837-001, 471837-002, 471835
- Your name and Social Security number or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Supervisor's name and telephone number
- Your last day worked and your first day absent from work due to your claim
- 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
- Healthcare provider's name, address, fax and telephone 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 healthcare provider for this condition
- Work restrictions or limitations stated by your healthcare provider, if any.

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

Unum may require additional medical information to better understand your claim. The timing of the decision depends on how quickly the information is received.

Unum will partner with you to gather all required information for the duration of your claim.

INFORMATION THAT MAY BE IMPORTANT TO YOU

Check your claim status, correspondence, and updates – anytime.

Unum has developed a secure and easy way for you to manage your disability claim online at http://www.unum.com/claimant or through the Unum Customer App.
Our secure web and mobile services allow you to access and make changes to your open claims, as well as view updates and correspondence when they become available.

Our secure site and mobile app help eliminate delays and is simple to use. Here are a few main features:

- Sign and submit your electronic disability authorization form.
- Upload documents for disability claims from your personal computer.
- Register for direct deposit of your claim payment, when applicable.
- Check claim status, correspondence, and most recent payment information.
- Verify and change personal information and monitor your claim progress.

You may also manage your claim with the Unum Customer App. The Unum Customer App is available for Apple™ (and Android™ devices.

For Informational Purposes Only.

unum.com

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unum® The Benefits Center

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming require the following statement to appear on this form.

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 your protection:

Alabama law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California law requires the following statement to appear on this form: Any person who knowingly presents 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.

Colorado law requires the following statement to appear on this 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.

District of Columbia law requires the following statement to appear on this form: 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.

Florida law requires the following statement to appear on this form: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky law requires the following statement to appear on this 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.

Minnesota law requires the following statement to appear on this form: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire law requires the following statement to appear on this 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.

New Jersey law requires the following statement to appear on this 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, subject to criminal prosecution and civil penalties.

New York law requires the following statement to appear on this 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 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.

Pennsylvania law requires the following statement to appear on this 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.

Puerto Rico law requires the following statement to appear on this 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 (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.

The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
Phone: 1-800-858-6843 Fax: 1-800-447-2498
www.unum.com

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

(Not for FMLA Requests)

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, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocator Group, Brown & Brown Absence Services Group and other Social Security advocacy vendors, 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, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, 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 ("My Information");

To Unum Group and its subsidiaries, Unum Life Insurance Company of America, First Unum Life Insurance Company*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty 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, including providing assistance with return to work. For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits (to include any subsequent financial management and/or benefit recovery review), 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 employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum; or, the Social Security Administration. 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.

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.

*Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.