unum®

CLAIM FOR DISABILITY BENEFITS

P.O. Box 100158
Columbia, SC 29202-3158
Telephone: (800) 858-6843 Fax: (800) 447-2498

INSURED'S STATEMENT

1. Insured's full name _____ Social Security No. _____
   Street and No. _____ City _____ State _____ Zip Code _____
   Birthdate _____ Male ☐ Female ☐ Telephone Number _____
2. Date sickness began or injury occurred _____ Date last worked _____
3. Date of first treatment by a physician for present disability _____
4. State nature of sickness or injury _____
5. If injured, state how and where the injury occurred _____
   _____ Did injury occur on duty? Yes ☐ No ☐
6. From and to what dates were you continuously totally disabled and prevented from performing any work?
   From _____ to _____
7. Date you were first able to do any work? _____
8. Has claim been filed or will claim be filed under any Worker's Compensation Act or similar law? Yes ☐ No ☐

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, in Florida, a felony of the third degree.

I hereby authorize any hospital, physician, or surgeon to furnish the Provident Life and Accident Insurance Company any information desired.

Date _____ (Signed) _____
(Insured)

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name _____ Age _____

1. Nature of sickness or injury (Describe complications if any) _____
   _____ ICD 9 CODE NO. _____
2. Did this sickness or injury arise out of patient's employment? Yes ☐ No ☐
   If "yes", explain _____
3. Is disability due to pregnancy? Yes ☐ No ☐ What is the expected delivery date or actual delivery date? _____
   Type of delivery ☐ cesarean ☐ vaginal Please describe any complications _____
4. Nature of surgical or obstetrical procedure, if any, (describe fully). _____
   _____
   _____
   Date performed _____
5. Give dates of treatments:
   Date of first office visit: _____ Date of last office visit: _____ Frequency of treatment: _____
   Home _____
   Hospital: Admission date: _____ time: _____ Discharge date: _____ time: _____
6. The patient has been continuously disabled (unable to work) from _____ through _____
7. Remarks: _____
   _____

Date	Attending Physician's Signature	Telephone Number SSN or Employers ID No.	
Street Address	City or Town	State	Zip Code

EMPLOYER'S STATEMENT

1. Insured's full name _____ Date of Birth _____
2. Policy No. **498035 Claims Division 003** Date Insured _____ Date Employed _____ SS No. _____
3. Was Insured's premium paid when disability began or loss occurred? _____ To what date have premiums been paid? _____
4. Has claim been filed or is it possible that claim will be filed under any Worker's Compensation Act or similar law? Yes ☐ No ☐
5. Date insured _____ Occupation _____
6. Date Insured last worked _____ A.M. P.M.
   Weekly Earnings $ _____
   Date _____
   REMARKS: _____
   _____
   _____
   _____

   Date resumed work _____ A.M. P.M.
   Name of Company **Northern Arizona University**
   Address **P.O. Box 4113**
   City **Flagstaff** State **AZ** Zip Code **86011-4113**
   Department _____
   (Signed) _____
   My position is _____

NORTHERN ARIZONA UNIVERSITY

Human Resources Dept.
PO Box 4113 Flagstaff, AZ 86001
Phone: 928-523-2223
Fax: 928-523-7486
Email: hr.contact@nau.edu

Unum Provident Life and Accident Insurance Company
Claim for Disability Benefits
P.O. Box 100158
Columbia, SC 29202-3158
FAX: (800) 447-2498

Dear Claims Representative,

This letter is to confirm that the following employee who has submitted a claim for Short Term Disability Benefits was confined in-patient in a hospital for a minimum of 24 hours or had out-patient surgery.

Name: _____ **SSN:** _____

To be complete by the patient's Health Care Provider

Select the type of admission and provide the requested information

	Admission	Discharge
☐ **Hospitalization**	Date: _____ Time: _____ a.m. / p.m.	Date: _____ Time: _____ a.m. / p.m.
☐ **Outpatient Surgery**	Date: _____ Time: _____ a.m. / p.m.	Date: _____ Time: _____ a.m. / p.m.
☐ **Birth of a Child**	Date: _____ Time: _____ a.m. / p.m.	Date: _____ Time: _____ a.m. / p.m.

Baby's Date and Time of Birth: _____

Type of Delivery: ☐ Normal Delivery ☐ C-Section

_____ _____

Signature of Health Care Provider *Date*

Thank you in advance for your prompt attention to this matter. If you have any questions, please contact Human Resources at hr.contact@nau.edu or call 928.523.2223