CLAIM FOR INCOME PROTECTION BENEFITS

Human Resources Management/Benefits
Northeastern University
716 Columbus Avenue, Suite 250
Boston, MA 02120

This form is to be completed for absences for medical reasons exceeding five days.

For use with policies issued by the following UnumProvident Corporation ["UnumProvident"] 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:

Human Resources Management/Benefits
Northeastern University
716 Columbus Avenue, Suite 250
Boston, MA 02120
Phone: 617-373-2230
Fax: 617-373-7610

This form should be used for the following types of claims only:

- Interim Disability/Salary Continuation - To be completed for absences exceeding 5 days.
- Long Term Disablity (LTD)

This form must be completed by the Attending Physician, the Employee, and the Employer, and be returned promptly for consideration of 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 Northeastern University and the UnumProvident Corporation 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. **The HRM/Benefits Department will complete the Employer Statement.**

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

D. 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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INCOME PROTECTION 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	Employer Telephone Number
Northeastern University	

Instructions: If this claim is related to normal pregnancy, complete the Normal Pregnancy section. For all other claims, including complicated pregnancy, complete the All Other Conditions section. **In all situations, you must complete the signature block at the bottom of this form.**

Normal Pregnancy

1. Expected Delivery Date:	If Delivered, Actual Delivery Date:	Type of Delivery ☐ Vaginal ☐ C-Section

2. Date First Unable to Work	Date Hospitalized

3. Has patient been released to work in her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No Release Date:
If not, when should the patient be able to return to work? Full Time Part Time

All Other Conditions

1. Diagnosis - Please include the primary diagnosis and list any secondary conditions.

Diagnosis (including any complications) include **ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number**

2. Date First Unable to Work	Date Hospitalized

3. Has patient been released to work in his/her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No Release Date:
If not, when should the patient be able to return to work? Full Time Part Time

4. Is this disability related to the patient's employment? ☐ Yes ☐ No ☐ Unknown

5. If complicated pregnancy	Expected Delivery Date:	If Delivered, Actual Delivery Date:	Type of Delivery ☐ Vaginal ☐ C-Section

6. Date of first visit for this illness or injury

7. Nature of treatment (including surgery and medications prescribed)	Date of Surgical Procedure	CPT Code

8. If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

RESTRICTIONS (What the patient should not do)

LIMITATIONS (What the patient cannot do)

Date restrictions and limitations began.

9. Referring physician or other treating physicians (names, addresses, telephone numbers):

Please include copies of all applicable office notes and test results.

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** ☐ **Individual Income Protection** ☐ **Waiver of Premium (Life Insurance)**

Policy Number (for this claim)	Division Number / Class Number	Division Description / Class Description
570537		

1. Employer Name	Employer's Phone Number
Northeastern University	

General Employee Information

2. Employee Name	Social Security Number

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. Occupational Classification ☐ Sedentary 1-10 lbs. ☐ Light 11-20 lbs. ☐ Medium 21-50 lbs. ☐ Heavy >50 lbs.

7. How was employee paid? (please check one)

☐ Hourly ☐ Commissions ☐ Salary ☐ Salary and Bonus ☐ Commissions Only ☐ Salary and Commissions

Salary/Wage prior to date last worked ***(refer to Earnings definition in your contract)***

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	Bonuses (per week)	Overtime (prior year)	Commissions (per week)	W-2 Earnings
$	$	$	$	$

If this policy provides New York DBL or New Jersey TDB coverage, please provide the earnings for the 8 weeks prior to disability (including the week in which the disability began).

Week Ending						Week Ending					
	Mo.	Day	Yr.	No. Days Worked	Amount		Mo.	Day	Yr.	No. Days Worked	Amount
1						5					
2						6					
3						7					
4						8					

8. 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

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

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

11. 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 _____

12. 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
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 ☐ Male ☐ Female	Social Security Number

Home Address (Street, City, State, ZIP)

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

2. Employer Name: Northeastern University — Policy Number: 570537

3. Is this disability due to ☐ Motor Vehicle Accident ☐ Other Accident ☐ Sickness ☐ Work-related Injury/Sickness ☐ Pregnancy

For any accident related claim, describe the injury including how, where and when it occurred.

4. Date Last Worked	Number of Hours Worked on Date Last Worked

5. 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 #			

CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

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.

Fraud Warning for California Residents

For your protection, California law requires the following to appear:

Any person who knowingly presents a 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.

Fraud Warning for Colorado Residents

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.

Fraud Warning for District of Columbia, Maine, Tennessee and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

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

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

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 Statement for New York Residents

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 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.

The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

Signature _____ Date _____

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INCOME PROTECTION CLAIM EMPLOYEE'S AUTHORIZATION

Northeastern University
716 Columbus Avenue, Suite 250
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Northeastern UNIVERSITY

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, Northeastern University and UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization to the address 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 Northeastern University and UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). 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 Northeastern University and UnumProvident obtain 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 Northeastern University and UnumProvident have 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, Northeastern University and UnumProvident 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, Northeastern University and UnumProvident 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 UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.