



**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	To

Physical Capabilities

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

	Number of Hours								How Often		
Sit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently
Stand	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently
Walk	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently

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

	Never	Occasionally	Frequently	Continuously
	0%	1-33%	34-66%	67-100%
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist/bend/stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate heavy machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Never	Occasionally	Frequently	Continuously
	0%	1-33%	34-66%	67-100%
Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Never		Occasionally		Frequently		Continuously	
	0%		1-33%		34-66%		67-100%	
	R	L	R	L	R	L	R	L
Fine Finger movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand/eye coordinated movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dominant Hand	<input type="checkbox"/> Right		<input type="checkbox"/> 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
Signature of Physician	Fax ( )	
	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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 Employees Health Trust

**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) 574031	Division Number	Department Name
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1. Employer Name	Employer's Phone Number
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**General Employee Information**

2. Employee Name	Social Security Number
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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
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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. How was employee paid? (check one)  Hourly  Salary

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

Weekly  Bi-Weekly  Semi-Monthly

\$ \_\_\_\_\_

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.

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Name of Person Completing Form	Telephone Number
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Title of Person Completing Form	E-mail Address	Fax Number
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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
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Home Address (Street, City, State, ZIP)

The state in which you work	Preferred e-mail address where you can be reached
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2. Employer Name	Policy Number 574031
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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.

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

4. Date Last Worked	Number of Hours Worked on Date Last Worked
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Canada Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No
No-Fault Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No – Ins. Co. Name and Policy #		
Other (Include Individual Disability or Group Disability Benefits) <input type="checkbox"/> Yes <input type="checkbox"/> No – Ins. Co. Name and Policy #			

6. For Fully-Insured Plans – 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)

**For Self-Insured Plans** – Attach a copy of your completed W-4 for accurate calculation of Federal and State income taxes. If not provided, we will withhold 25% of your benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.

**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 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 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.

Signature \_\_\_\_\_

Date \_\_\_\_\_



**INCOME PROTECTION CLAIM  
EMPLOYEE'S AUTHORIZATION**  
The Benefits Center, P.O. Box 100158  
Columbia, SC 29202-3158  
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498



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Employees Health Trust

**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.