REASSESSMENT INFORMATION FORM - Attachment C

Instructions:

1. Claimant Statement: Provide an update of certain personal information as indicated in this section.
2. Employment Statement: Provide details regarding any work activity from the date your claim was closed through the present. Depending on the terms of your policy, to qualify for benefits you may need to demonstrate a loss of functional duties and/or a loss in income. In order to properly assess your claim we will need to have information regarding all work you have performed. If you are claiming a loss in income while working, provide all supporting documentation available including tax returns and related IRS Forms W-2 and/or 1099; otherwise, this financial information is not needed to reassess your claim.
3. Medical Information Details: Provide all details regarding medical treatment received since your claim was closed. This enables us to obtain any additional medical information we may need from your medical treatment providers. To assist us in the Claim Reassessment Process, enclose any medical records or information you may have in your possession.
4. Other Income Benefits: Provide us with details concerning any other income benefits you may have received or are receiving. Please complete this section of the form and attach any supporting information you may have, including benefit awards, summaries etc.

   You must sign and date each of the following sections of the form in order for us to begin the Claim Reassessment Process.

5. Certification: Sign and date this form.
6. Conditional Waiver and Release: Sign and date this form.
7. Authorization: Sign and date this form.

Also please enclose any additional information that you feel will assist us in reassessing your claim.

The completed form should be sent to:

UnumProvident
Claim Reassessment Unit
PO Box XXXX
Portland, Maine 04104-5028

A. CLAIMANT'S PERSONAL INFORMATION (PLEASE PRINT)			
Claimant's Name (as printed on your Social Security Card)	Home Telephone Number Including Area Code	Date of Birth _____ Male Female	Social Security Number ____-____-_____

Home Address (Street, City, State, Zip)	
Policy Number:	Claim Number:
Preferred e-mail address where you can be reached	
Explain why you believe that our previous decision to deny or terminate your claim was incorrect.	

B. CLAIMANT'S EMPLOYMENT INFORMATION (PLEASE PRINT)	
Name of Employer A.	Employer's Telephone Number
Dates of Employment	
Employer's Address (Street, City, State, Zip)	
Your occupation and work schedule with this employer	
Weekly or Monthly Earned Income Before Taxes $ (please provide documentation of earnings)	

Name of Employer B.	Employer's Telephone Number
Dates of Employment	
Employer's Address (Street, City, State, Zip)	
Your occupation and work schedule with this employer	
Weekly or Monthly Earned Income Before Taxes $ (please provide documentation of earnings)	

Name of Employer C.	Employer's Telephone Number
Dates of Employment	
Employer's Address (Street, City, State, Zip)	
Your occupation and work schedule with this employer	
Weekly or Monthly Earned Income Before Taxes $ (please provide documentation of earnings)	

C. CLAIMANT'S MEDICAL INFORMATION (PLEASE PRINT)

Please provide full and complete responses, indicating "none" where applicable. If more space is needed, please attach lists as necessary.

1. Name(s) and complete address(es) of any medical care provider you consulted for any condition since your claim was closed.

Name of Doctor Complete Address (Street, City, State, Zip) Dates of Treatment Telephone/Fax#

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2. Indicate the name(s) and complete addresses of any hospital/clinic where you received medical treatment, consultation, care or services (including diagnostic measures) since your claim was closed.

Name of Hospital/Clinic Complete Address (Street, City, State, Zip) Dates Treated Telephone/Fax#

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3. List any medications and prescribed drugs taken since your claim was closed.

Name of drug or medicine Prescription Number Pharmacy Date Physician

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4. Please provide the complete address of any pharmacy listed in response to Question#3.

Name of Pharmacy Complete Address(Street, City, State, Zip) Telephone/Fax #

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D. CLAIMANT'S OTHER INCOME BENEFITS (PLEASE PRINT)

Check the other income benefits you have received, or are receiving, or are eligible to receive as a result of your disability and complete the information requested.

Please also report any changes to previously reported benefits.
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
Workers' Compensation	Pension/Retirement	Pension/Disability	Unemployment

Yes No	Yes No	Yes No	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, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio, 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 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 fraud in 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 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.

E. The information which I have provided on this Reassessment Information Form is true and complete to the best of my knowledge and belief.

Signature _____ Date_____

F. **Conditional Waiver and Release**

By choosing to participate in the Claim Reassessment Process, I hereby agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, I will not pursue any legal action to the extent (and only to the extent) such action is based on any aspect of the prior denial or termination that is reversed or changed. If I receive any additional benefits as a result of this reassessment, I hereby waive and release any right to sue UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives, for their prior failure to pay those same benefits to me. If I have already commenced legal action relating to my prior claim(s) decision, I will take such action as is necessary to stay such litigation pending the reassessment process, if the court will agree to such a stay, and I

agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, then I will withdraw any litigated claim, including any extra-contractual claims, to the extent (and only to the extent) such claims are based on any aspect of the prior denial or termination that is reversed or changed. To the extent that following the reassessment there remains a complete or partial denial of benefits, my right to initiate or continue litigation regarding that portion of the prior denial that has not been reversed or changed is not waived. In addition, any applicable statute of limitations is tolled during the pendency of the reassessment of my claim; however, I understand that my participation in the Claim Reassessment Process will not revive or reinitiate the statute of limitations with respect to the previous claim decision.

This waiver and release will not apply to the extent that any prior decision is not reversed as a result of the Claim Reassessment Process.

Signature _____
Date_____

* This waiver and release is valid for the following UnumProvident subsidiaries: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, The Paul Revere Life Insurance Company.

G. NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization with the completed Reassessment Information Form.

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 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 information on financial or credit history or earnings will not be sought from an employer if it is not relevant to evaluating my claim(s) for benefits.

I understand that any information UnumProvident 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 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 UnumProvident 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, 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 Company.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claims(s) and this may be the basis for denying my claim(s).

Signature _____
Date_____

Print Name _____ Social Security Number _____

If signed on behalf of the claimant as personal representative, please indicate relationship here _____. If signed on behalf of the claimant as designee under power of attorney, as guardian, or as conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following UnumProvident subsidiaries: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, The Paul Revere Life Insurance Company.