MEDICAL TREATMENT BENEFIT CLAIM FORM
2008 EDUCATOR SELECT PLANS
Mail Completed Claim Form to:
Mass Group Marketing, Inc.
2121 N. Glenville Drive, Richardson, TX 75082
Phone: (800) 527-4572 Fax: (972) 881-2251

Once your completed claim form has been received, normal turn around time is 2 weeks to process the claim and mail a response back to you.

If you receive treatment from a Physician for a NON-DISABLING INJURY (for which no other benefits are paid under the policy) or if you receive treatment from a Physician for a SICKNESS (for which no other benefits are paid under the policy) and incurred an expense, Unum will provide a benefit (according to the terms of the policy) for the actual physician's charges. **In order for your claim to be handled in a timely manner, please attach copies of your physician(s) and/or hospital bill(s) with diagnosis, date of treatment and charges.**

BENEFIT LIMITATIONS:

A Medical Treatment Benefit will be paid when you receive treatment by a doctor as a result of a sickness or injury, provided no other benefits are payable under the plan as a result of the condition for which the treatment was rendered.

The Medical Treatment Benefit will be the doctor's actual charge for services rendered, up to a maximum benefit of $50 for sickness or $100 for injury. In addition, the charges must be for medically necessary care and treatment and in keeping with the extent of the sickness or injury.

No benefit will be paid unless you are personally seen and treated by a doctor and the treatment is not for routine medical examinations or dental work.

Note: No more than one Medical Treatment Benefit will be paid for the same or related condition(s) unless the treatment dates are separated by at least 14 consecutive days. In addition, no more than one benefit will be paid for treatment during any 24 hour period and the benefit will not be paid more than 4 times per calendar year.

The laws of some states require us to furnish you with the following notice: Any person who, knowingly and with the intent to defraud an insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a crime.

SECTION A: EMPLOYEE'S STATEMENT

Name of Employee	Employed by (School District, Parish, BOE, County, etc.)		
Home Address	Telephone	Social Security Number	Date of Birth
City State Zip	Nature of sickness or injury		

Date accident or sickness began	How and where did accident happen? ☐ A.M. ☐ P.M.
Date(s) you were first treated for your sickness or injury	Treated by: Hospital: ____________________ Doctor: ____________________
Have you ever had the same or similar condition in the past? ☐ Yes ☐ No	Treated by: Hospital: ____________________ Doctor: ____________________

I hereby request and authorize any hospital, physician, or other person who has attended or examined me to furnish to Unum of Portland, Maine, or its representative, any and all information concerning any illness or injury I may have suffered, medical history, consultations, prescriptions, or treatments including X-rays and copies of all hospital and medical records. A copy of this authorization shall be considered as effective and valid as the original for the duration of the claim.

Employee's Signature	Date Completed

SECTION B: ATTENDING PHYSICIAN'S STATEMENT

This claim cannot be processed if a diagnosis is not provided by the physician on the Attending Physician's Statement or on the hospital bill.

Patient's Name	Date(s) of hospital confinement (if applicable) ☐ Inpatient ☐ Outpatient
Nature of sickness or injury	Was the claimant unable to work due to this condition? ☐ Yes ☐ No If Yes, List Date(s)
When did symptoms first appear or accident happen?	When did patient consult you for this condition?

Describe any other disease or infirmity affecting present condition

Has patient ever had the same or related condition? ☐ Yes ☐ No
If yes, list date(s) and describe

Name and address of referring physician(s)

Give date(s) of treatment	Office
	Hospital
Signature of Attending Physician	Date signed Telephone
	Street Address: City State Zip

FINAL CHECKLIST - ARE THE FOLLOWING ITEMS ENCLOSED?

✔ SECTION A - EMPLOYEE'S STATEMENT
✔ SECTION B - ATTENDING PHYSICIAN'S STATEMENT
✔ COPY OF PHYSICIAN'S OR HOSPITAL BILL (Must have diagnosis, date of treatment, and charges).

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 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.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine 04122

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. 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 address noted on page one.

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; GENEX Services, Inc., 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, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum, 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 Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return 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 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 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, 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.

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