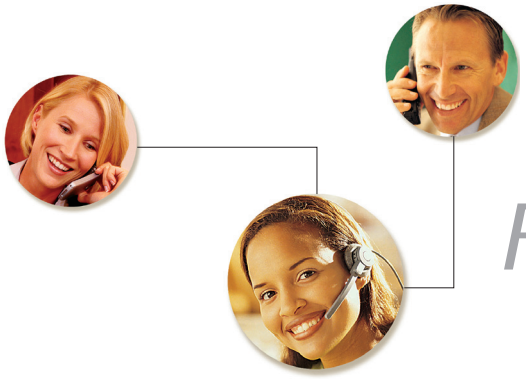

Filing

a Short Term Disability Claim and/or Leave Request by Telephone

MIAMIBEACH

STD Policy # 69502

To File An FMLA or Short Term Disability Claim call:

Phone: 877-217-5495

Fax: 800-447-2498

Monday-Friday

8 a.m.

to

8 p.m.

Eastern

WHEN TO INITIATE A SHORT TERM DISABILITY CLAIM AND/OR LEAVE REQUEST

- When your physician has determined you are unable to work due to illness, injury or pregnancy.
- When you need to be absent from work to care for a family member who has a serious health condition.
- When you need to care for a child due to birth, adoption or foster care placement.
- When you need to be absent from work for a qualifying exigency arising out of the fact that your spouse, son, daughter or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- When you need to care for your spouse, son, daughter, parent or next of kin who incurred or aggravated a serious illness or injury in the line of duty on active duty in the Armed Forces, including the National Guard or Reserves. This includes a veteran who was a member of the Armed Forces anytime within 5 years prior to the date of medical treatment, recuperation or therapy for such illness or injury.
- 30 days in advance of a planned leave based on prescheduled medical treatment for you or your family member related to a serious health condition, or the expected birth, adoption or foster care placement of a child.

HOW TO INITIATE A SHORT TERM DISABILITY CLAIM AND/OR LEAVE REQUEST

- You must notify your manager or supervisor of your absence from work.
- Call the toll-free number listed to the left to initiate your claim and/or leave request. Refer to "Information Needed to Submit a Claim and/or Leave Request" on page 2 of this brochure for a list of the information that is required to initiate a claim and/or leave request.
- See your physician and provide him/her with a signed and dated copy of the authorization form (attached). This form authorizes the release of medical information needed to evaluate your disability claim and/or leave request.
- Fax or mail a copy of the signed and dated authorization to the Unum Benefits Center.

OUR COMMITMENT TO YOU

Unum understands that a disabling illness or injury creates emotional, physical and financial challenges and we want to do whatever we can to help you. You have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during the claim process.

CU-4680 (01/10)
City of Miami Beach

INFORMATION NEEDED TO SUBMIT A SHORT TERM DISABILITY CLAIM AND/OR REQUEST FOR LEAVE

Please be prepared to provide the following information when you make your claim request. If someone else makes the call on your behalf, he/she may need to provide this information.

- Name of the company where you work
- Policy number (printed on the front of this brochure)
- Physician's name, address, fax and phone number (disability claims only)
- Your name and Social Security or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Supervisor's name and phone number
- A brief description of your medical condition including cause of condition (illness or injury), date of injury or beginning of illness, and whether it's work-related (disability claims only)
- The dates of your first visit, your most recent visit, and your next scheduled visit with your physician for this condition (disability claims only)
- Your last day worked and your first day absent from work due to your claim and/or leave request
- The date you expect to return to work (if you know), or the actual date if you have already returned to work at the time you call
- Work restrictions or limitations advised by your physician, if any (disability claims only)
- Please initiate your leave request first before detaching page 3 and giving it to your physician.

Prompt and complete information from you and your physician will help assure a timely decision and payment if you are eligible.

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, 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.

For California Residents

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.

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 Residents

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Florida Residents

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

For Maine, Tennessee and Virginia Residents

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

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.

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.

For Puerto Rico Residents

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Unum Group
1 Fountain Square
Chattanooga, TN 37402

unum.com

Fax or mail a completed copy of this authorization to:
Unum Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
Fax: 800-447-2498

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 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; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; professional licensing body; and employer that has information about my health, financial or credit history, professional license, 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 Group, its insurance subsidiaries* and duly authorized representatives ("Unum"), and, where applicable, to persons or entities that may assist me with or provide services related to my claim(s) for Social Security or other government-sponsored benefits. 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).

Please detach this page here ✂ Submit to your health care provider.

_____ _____
(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 Group insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company and The Paul Revere Life Insurance Company.