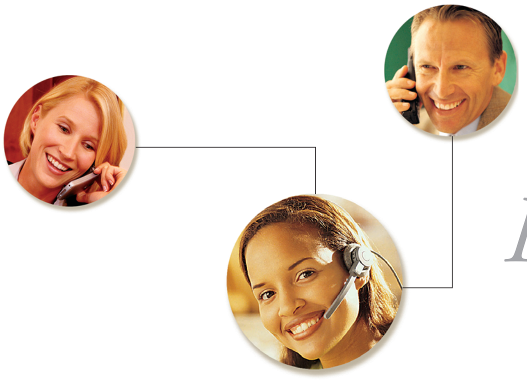

# *Filing*

## A Disability Claim and/or Family Medical Leave Request by Telephone

**STD Policy #:** 532025

Phone: 866-762-8702
Fax: 800-447-2498

Monday-Friday

8 a.m.
to
8 p.m.

Eastern

For eligible employees of Pearson Inc. and the affiliated operating companies of Pearson Inc. that participate in these Pearson-sponsored benefit plans.

CU-2526 (10-07)
Pearson Inc.

You can call one toll-free number to initiate a short-term disability claim and family medical leave of absence. Whether requesting a medical leave for yourself or a family leave to care for an eligible family member, you must call the following toll-free number: 866-762-8702.

### WHEN TO INITIATE A DISABILITY CLAIM AND/OR FAMILY MEDICAL LEAVE REQUEST

For Yourself:

- Thirty days in advance of a planned medical absence, such as prescheduled surgery or an expected maternity leave.
- If your physician has determined you are unable to work due to illness, injury or for maternity reasons.

For a Family Member:

- If you need to be absent from work to deal with a serious health condition affecting a member of your family.
- If you will be absent from work to care for a child due to birth, adoption or foster care placement.

### HOW TO INITIATE A DISABILITY CLAIM AND/OR FAMILY MEDICAL LEAVE REQUEST

- Notify your Supervisor of your absence from work under the procedures that apply to your company or department.
- If your leave request involves your own health condition:
  - You should first see your physician and provide him or her with a signed and dated copy of the authorization form (attached). This form authorizes the release of medical information you need in order to process any benefit for which you may be eligible.
  - Next, call to initiate your claim. Refer to the checklist on the back of this brochure and call Unum's toll-free number (listed above) to initiate your claim request.
  - Then, fax or mail a **signed** copy of the completed authorization to the Unum Benefits Center.

  In addition to your inital call, you must call Unum again the day before your leave actually begins.
- If your leave request involves the care of a family member:
  - Call Unum's toll-free number (listed above) to initiate your leave request.
  - Within two days of your call, Unum will forward you the forms you and your family member's health care provider will need to complete and return directly to Unum.

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

**The following information may be required when you make your claim and/or leave request. Please be prepared. If someone else makes the call on your behalf, he or she will 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
- 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
- The dates of your first visit, your most recent visit, and your next scheduled visit with your physician for this condition
- Your last day worked and your first day absent from work due to this condition
- 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

*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 any 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

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.

### 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.

### 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 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 purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

### For New Jersey Residents

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

### For 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 each such violation.

**Unum Group**
1 Fountain Square
Chattanooga, TN 37402

www.unum.com

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Insurance products are underwritten and sold and services provided by the subsidiaries of Unum Group. Not all companies do business in all jurisdictions.

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

unum

**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

# Authorization Form

**Note:** The Health Insurance Portability and Accountability Act (HIPAA) 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 address above.

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 or requests for leave for 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 any information Unum obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for disability benefits, which may include assisting me in returning to work. I understand this information may also be used by Unum, acting on behalf of my employer, to (1) clarify and authenticate information presented on the Certification of Health Care Provider or other medical certification I submit, or any certification of fitness for duty, and (2) determine whether my request for leave is covered by the federal Family and Medical Leave Act, or other applicable state law. I agree to allow a health care provider representing Unum to contact my health care provider in relation to my request for leave for clarification or authentication. I further understand the information Unum obtains pursuant to this authorization is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below, or the duration of my claim or leave, 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 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) or request for leave and this may be the basis for denying my claim(s) or request for leave. 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) or request for leave and this may be the basis for denying my claim(s) or request for leave.

| | |
|---|---|
| ______________________________ | ______________________________ |
| **(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.

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[*] This authorization is valid for the following Unum Group insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company. Unum is the marketing brand of Unum Group's insuring subsidiaries.