Filing

an Extended Illness Benefit/Short Term Disability and/or Leave Request by Telephone

Hospital Sisters Health System

STD Policy #: 92707

Phone: 866-295-3007
Fax: 800-447-2498

Monday-Friday
7 a.m.
to
7 p.m.
Central

WHEN TO INITIATE AN EXTENDED ILLNESS BENEFIT/SHORT TERM DISABILITY AND/OR LEAVE REQUEST

- **Ten 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.
- You are required to report the leave to Unum within **seven calendar days** of your first day missed.
- 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 (child, spouse, parent) 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 active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.
- When you need to care for your spouse, son, daughter, parent or next of kin who has incurred a serious illness or injury in the line of duty on active duty in the Armed Forces, including the National Guard or Reserves.
- When you need any other type of leave that may be covered by applicable state leave laws.

HOW TO INITIATE AN EXTENDED ILLNESS BENEFIT/SHORT TERM DISABILITY CLAIM AND/OR LEAVE REQUEST

- 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 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-3859 (10/11)
Hospital Sisters Health System

INFORMATION NEEDED TO SUBMIT AN EXTENDED ILLNESS BENEFIT/ SHORT TERM DISABILITY AND/OR REQUEST FOR LEAVE

Please be prepared to provide the following information when you make your 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 (EIB & STD claims only)
- Your name and Social Security 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 (EIB & STD claims only)
- The dates of your first visit, your most recent visit, and your next scheduled visit with your physician for this condition (EIB & STD 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 (EIB & STD 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.

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

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 will not be able to obtain your related health information and may not be able to evaluate or administer your claim(s) and this may be the basis for denying your claim(s). Please sign and return this authorization to The Benefits Center noted above and provide a signed copy to your health care provider.

Short Term Disability Income Protection Program Authorization

I authorize health care professionals, hospitals, clinics, laboratories, pharmacies, or other medically related providers or facilities, rehabilitation professionals, health plans, insurance companies, third party administrators and employers;

To disclose information, whether originated before, during or after the date of this authorization, about my health, including Information about my health that may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; prescription drug history; mental and physical history, condition, advice or treatment, but does not include psychotherapy notes; and insurance claims and benefits;

To the following persons: Unum Group and its subsidiary Unum Life Insurance Company of America ("Unum"), the third party administrator for Hospital Sisters Health System's Short Term Disability Income Protection Program, and Unum's duly authorized employees and representatives.

I understand that any information Unum obtains pursuant to this authorization will be used to evaluate and administer my claim for short term disability or extended illness benefits, including Family Medical Leave and any assistance in my return to work.

This authorization is valid for one year 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. The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but certain other privacy laws may apply. Information disclosed under this authorization may be redisclosed only as permitted by law.

I may revoke this authorization by sending written notice to the address listed above at any time except to the extent that Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the Short Term Disability Income Protection Program.

_____ _____
(Claimant Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I sign 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.

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