

# MEDICAL TREATMENT BENEFIT CLAIM FORM

## THE EDUCATOR SALARY PROTECTION PLAN

Normal turn around time on completed claim forms received should be 2 weeks for claim to be processed and a response in the mail 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 process 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:**

**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 since the last date of treatment. No more than one benefit will be paid for all treatment during any 24 hour period. No Medical Treatment Benefit will be paid for any Dental Work or Routine Medical Examinations (OB/GYN, Mammograms, yearly eye exams and yearly physicals, etc).**

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 <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.		Employed By (School District, Parish, BOE, County, etc...)	
Home Address		Telephone	Social Security Number
City	State	ZIP	Date of Birth
Nature of Sickness or Injury			
Date(s) of Treatment			
Date <u>Accident</u> or <u>Sickness</u> Began		How and Where Did Accident Happen? <input type="checkbox"/> A.M. <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 or 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

**Mail Completed Claim Form to:**

**Mass Group Marketing, Inc.**  
**2121 N. Glenville Drive**  
**Richardson, Texas 75082**  
**Phone: (800) 527-4572 Fax: (972) 881-2251**

**SECTION B: ATTENDING PHYSICIAN'S STATEMENT**  
**If A Diagnosis is Not Shown On The Physician's or Hospital Bill,**  
**This Portion Must Be Completed Before Claim Can Be Processed**

Patient's Name	Date(s) of Hospital Confinement (If Applicable) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		
Nature of Sickness or Injury	Was the Claimant unable to work due to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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.)

Underwritten by:



Unum Life Insurance Company of America  
 Portland, Maine