REQUEST FOR CONTINUATION OF GROUP LIFE INSURANCE FOR INCAPACITATED CHILDREN

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158

Toll-free: 1-800-445-0402 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

For use with policies issued by the following Unum Group ["Unum"] subsidiaries:

Unum Life Insurance Company of America Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

INSTRUCTIONS

This form should be completed when applying for continued Life Insurance coverage for a dependent child who is incapacitated and over the age of 26.

- **Employer Statement:** This section of the form should be completed by the employer. Also, please provide a copy of the dependent child's original and most current enrollment forms.
- **Employee Statement:** This section of the form should be completed by the employee.
- **Attending Physician Statement:** Part I should be completed by the employee. Part II should be completed by the physician who treats the dependent child for the incapacitating condition.

The completed form should be mailed to the address noted above or faxed to 1-800-447-2498.

EMPLOYER STATEMENT (PLEASE PRINT)

A. Information About the Employer

Company Name	Subsidiary/Affiliate Branch	
UNIVERSITY SYSTEM OF MARYLAND		
Street Address	Policy Number 115327	
City	State	Zip

B. Information About the Employee

Employee Name	Social Security Number
Street Address	Date of Hire
City, State, Zip	Telephone Number

C. Information About Prior Continued Coverage

Has the child's coverage been continued beyond age 19 by any previous insurer? ☐ Yes ☐ No
If yes, please provide a copy of the prior insurer's approval notice.

D. Signature of Benefit Administrator

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form (Please Print)

Title of Person Completing Form	Telephone Number	Fax Number

Signature	**Date Signed**
X	

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EMPLOYEE STATEMENT (PLEASE PRINT)

A. Information About the Employee

Employee Name	Social Security Number

B. Information About the Dependent Child

Dependent Child Name	Dependent Child Date of Birth

Dependent Child Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Is the child dependent on you for support? ☐ Yes ☐ No	If yes, what percentage of the child's support do you contribute?
Does the child received Social Security Disability Insurance or an equivalent? ☐ Yes ☐ No	If yes, what is the source of the income?

Has the child been a full-time student since reaching age 19? ☐ Yes ☐ No

If yes, please advise the school name, address, telephone number and dates attended.

Has the child been working since reaching age 19? ☐ Yes ☐ No

If yes, please provide the following information for each employer. If there have been more than two, please provide the following information for each employer on a separate sheet of paper and include it with this form.

Employer Name	Employer Address and Telephone Number	Dates of Employment

C. Information About Any Hospitals and/or Inpatient Treatment

Please list any hospitalizations/inpatient treatment the child has had in the last 12 months. If there have been more than four, please provide the following information for each hospitalization/inpatient treatment on a separate sheet of paper and include it with this form

Name of Institution(s)	Dates of Admission and Discharge	Nature of Care

D. Signature of the Employee

The above statements are true and complete to the best of my knowledge and belief.

Language Preference: ☐ English ☐ Spanish

Print Name	Telephone Number

Signature X	**Date Signed**

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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY THE EMPLOYEE

Employee Name	Social Security Number
Patient Name	Patient Date of Birth

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete, sign, and date this statement. The information provided on this report will help us to determine if your patient is eligible for this coverage.

A. Diagnosis Information

Diagnosis	ICD Code:
Date first diagnosed	Date last examined

B. Information About Patient Status

Is the child currently incapable of self-sustaining employment because of mental or physical handicap? ☐ Yes ☐ No

Did such an incapacity exist prior to the child turning age 19? ☐ Yes ☐ No Date of Onset

May the child be employable in the future? ☐ Yes ☐ No ☐ Questionable/Unknown
If yes, when do you anticipate s/he will be able to work? ☐ 6-12 months ☐ 12-24 months

Please provide details of the patient's condition that prevent him/her from self-support or working.

C. Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, First Name, MI, Suffix) Please Print

Medical Specialty	Telephone Number	Fax Number
Address		
City	State	Zip

Signature of Physician	**Date**
X	