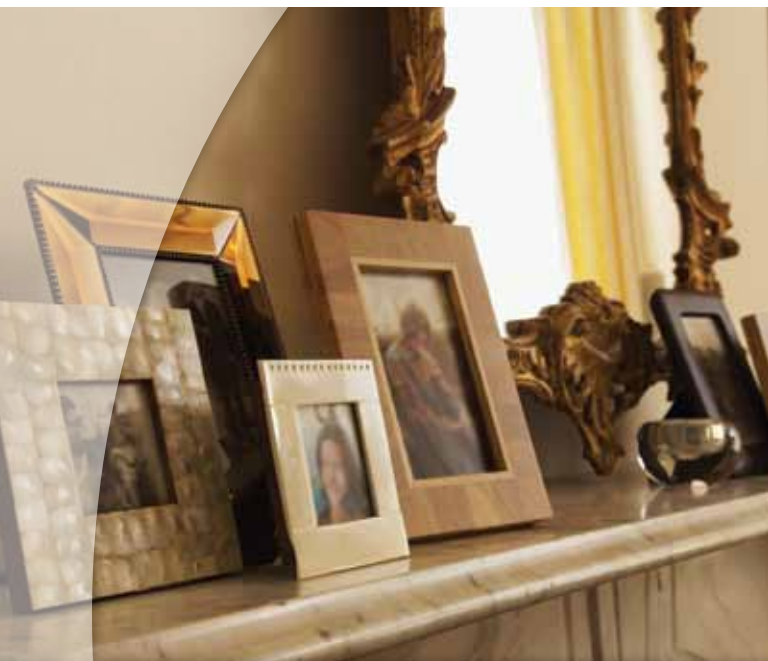




Better benefits at work.

Long term care insurance is underwritten by the following subsidiaries of Unum Group: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company.



Long term care insurance

Facts about your long term care benefits

Unum Life Insurance Company of America, Portland, Maine

First Unum Life Insurance Company, New York, New York

Provident Life and Accident Insurance Company, Chattanooga, Tennessee

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Our commitment to helping you

We know the important role long term care (LTC) insurance benefits play in helping an individual who is unable to live independently. That's why our knowledgeable and experienced benefit professionals are committed to providing our long term care claimants with thorough, fair, objective and timely claim decisions. This brochure describes in detail our customer centered approach to the claims process, and provides answers to commonly asked questions about filing a long term care insurance claim.

Eligibility

When am I eligible for long term care benefits?

You are eligible for long term care benefits when you become chronically ill or disabled. Being chronically ill or disabled means that you are unable to perform at least two Activities of Daily Living (ADLs) such as eating, bathing, continence, dressing, toileting, and transferring without *substantial** assistance from another person. It may also mean that you suffer from a *severe** cognitive impairment that requires substantial supervision by another person to protect you from threats to your health and safety. *The ADL loss must be expected to last for at least 90 days, as certified by a Licensed Health Care Practitioner.** The ADL loss must be recertified every 12 months. Additionally, services must be provided according to a written plan of care developed by your Licensed Health Care Practitioner.

*Italicized language is required by federal law for plans which are intended to be tax-qualified.



Satisfying the Elimination Period

What is an Elimination Period?

An Elimination Period is a specified number of days that you must receive long term care services before you begin receiving benefits from your policy.

Must I satisfy an Elimination Period before I file an LTC claim?

You are not required to satisfy an Elimination Period before filing a claim. Once your ability to perform two or more ADLs is lost or you suffer a *severe** cognitive impairment, and you are receiving care covered under your policy, you or your representative should file a claim. Once we receive your claim form, we can begin gathering the medical information needed to make a benefit determination.

Obtaining a claim form, filing a claim


How do I obtain a claim form?

You or your designated representative should call our LTC Benefit Center at 1-800-693-4988 and we will fax or mail a claim form to you within two business days. You can also access a claim form via our web site at unum.com.

What is the process for filing a claim?

You or your designated representative should fully complete the claim form, attaching additional pages if more space is needed to fully describe your condition and care needs. The claim form must be signed by you, or by a legally designated representative (such as someone to whom you have granted Power of Attorney) who must provide a copy of the appropriate legal papers. Your physician's signature is not required. This authorization is used to request medical information and other pertinent documentation.

Once we receive your claim, we will send you or your representative a written acknowledgment within three business days. At that time, a Benefits Specialist will be assigned to your claim. If, after reviewing your claim form, the Benefits Specialist determines that additional information or clarification is needed, he or she may call you or your representative.



What is the role of the Benefits Specialist?

The Benefits Specialist assigned to your claim is a trained professional, and will be responsible for coordinating all aspects of your claim. Benefits Specialists have in-depth knowledge of long term care issues and have access to the resources needed to manage your claim in the most effective way possible.

Your Benefits Specialist may request copies of medical records or other documentation that we need to make a decision about your benefit. Throughout the claims process, your Benefits Specialist will stay in contact with you and your family to provide support and monitor your progress. The Benefits Specialist also stays in touch through status letters sent to you or your designated representative every 21 days until a decision is reached.

In addition to our Benefits Specialists, the LTC Benefit Center has a dedicated Service Unit. This group provides telephone support to our customers during the claims process. These representatives have extensive LTC knowledge and claims experience, and are ready to answer your questions when you call. You can feel confident that you will receive the highest quality service.

What is the next step in the benefit management process?

Once your claim and all additional information is received, a final claim determination is made regarding your benefits. The average time frame from receipt of a completed and properly signed claim form to final claim determination is approximately four to six weeks. Of course, each claim is unique and you may experience time frames that are different from this.

Once a claim decision is made, the Benefits Specialist will call you or your representative within one business day, and will follow up with a clearly written explanation of the decision and the basis for the determination.

Determining eligibility

How is my benefit eligibility determined?

Once we receive a signed claim form, we will request supporting documentation to make an accurate determination of your eligibility for benefits. Supporting information may include:

- physician and hospital records;
- home health care agency or facility notes;
- caregiver records or interview by telephone; or
- a functional assessment.

A Benefits Specialist thoroughly reviews all the information relevant to your claim. Our in-house medical staff may also have input into the final claims decision. If we have difficulty obtaining medical records, we may request assistance from you or your representative to help speed up the process.

What role does the medical staff play in my claims decision?

Our medical staff consists of on-site physicians and nurses who interpret and clarify medical conditions, reports and tests. This input enables the Benefits Specialist to make informed decisions about medically complex claims.

If I have questions, how can I reach a Benefits Specialist?

If you have questions regarding your claim, you can call us at any time. It's important to you — and to us — that you receive a timely response. Our commitment is to respond to your calls within the following time frames:

- If we receive your inquiry before 3 p.m., Eastern Standard Time (EST), we will respond to you the same day.
- If you contact us after 3 p.m. (EST), we will contact you the next business morning before 10 a.m. in your time zone.

Additional requirements

Some policies require that additional documentation be submitted to us. If you have a tax-qualified plan, the federal government stipulates that your Licensed Health Care Practitioner must certify that your disability is expected to last a minimum of 90 days. You will also be required to submit a Plan of Care developed by your Licensed Health Care Practitioner. Please see your contract (under “Claim Information” section) for specific requirements.

A functional assessment

What is a functional assessment?

A functional assessment is a face-to-face meeting with you and a medical professional and is used to obtain additional details about your ability to perform Activities of Daily Living, or to clarify the extent or existence of cognitive impairment.

Our company works with an independent agency that contracts with assessment professionals throughout the country, who can assess your needs regardless of where you live. Assessments are not necessary on every claim. Your Benefits Specialist will notify you or your representative if an assessment is needed in order to make a final eligibility determination on your claim.

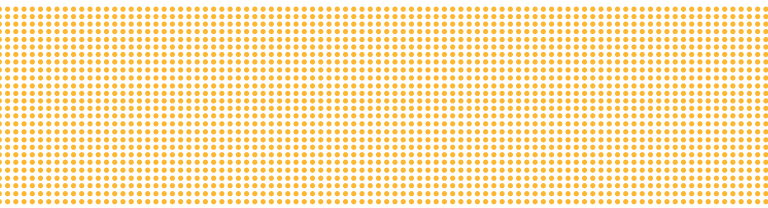


Experience you can rely on

Unum has been in the employee benefits business for more than 160 years. We provide benefits to 12 million individuals in the U.S.,¹ helping them protect their families and preserve their assets.

We are committed to providing you with a high level of service. You can rely on us for a smooth, efficient claims process and for personal support when you need us most.

This is not intended to be a complete description of the individual and group long term care policies underwritten by Provident Life and Accident Insurance Company, Unum Life Insurance Company of America, and First Unum Life Insurance Company. Some coverage options may not be available in all states. These policies have exclusions and limitations that may affect benefits payable. For costs and complete details of coverage, refer to Policy Series LTC03, RLTC03, GLTC04, RGLTC04; in New York refer to Policy Series LTC03, LTC03F, LTCP03, LTCP03F, LTCT03, LTCT03F, RLTC03, RLTC03F, RLTCP03, RLTCP03F, GLTC04, RGLTC04 or call your Unum or First Unum representative. In Florida, Idaho, Oklahoma and Virginia, refer to LTC03, LTCP03, LTCT03, RLTC03 or RLCTP03 (underwritten by Provident Life and Accident Insurance Company). In Texas, refer to LTC03, LTCP03, LTCT03, LTC03A5, LTCP03A5, LTCT03A5, LTC03A10, LTCP03A10, LTCT03A10, RLTC03, RLTC03A5, RLTCP03A10 (underwritten by Provident Life and Accident Insurance Company), TQGLTC952, GLTC04, or RGLTC04 (underwritten by Unum Life Insurance Company of America).



¹ Unum internal data, 2008. This statistic does not include Colonial or Unum UK.

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