



**CLAIM FOR LIFE / ACCIDENTAL DEATH  
AND DISMEMBERMENT BENEFITS**  
Unum, Group Life Benefits

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

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

Our centralized mail processing center located in Columbia, SC  
services our Benefits Center in Portland, ME

**Please fax this form to:**

**Unum  
Group Life Benefits  
Fax 800-447-2498 or 877-851-7624**

Or mail to:

Unum  
Group Life Benefits  
P.O. Box 100158  
Columbia, SC 29202-3158  
Telephone 1-800-445-0402

This form must be completed and returned promptly by the Employer for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please be sure to keep a copy of this form and any attachments for your records.

Please submit the following documentation for this claim:

- A completed Notice of Claim
- A copy of the death certificate (a photocopy or fax is acceptable)
- The original enrollment form and any enrollment forms for a change in coverage
- All beneficiary designation forms
  - if named beneficiary has predeceased the Insured, a copy of the deceased beneficiary's death certificate
  - if the beneficiary is the Estate of the Insured, a copy of the court appointment naming the Executor, Administrator, or Personal Representative

If this is an Accidental Death Claim, also complete section A-1, and submit police and EMS reports

If this is a Dismemberment Claim, also complete sections A-2 and A-3, and submit police, EMS, and medical reports

If this is an Accelerated Death Claim, also complete sections B-1 and B-2

In order to accurately determine the Life Benefit payable; please provide the following salary verification/documentation:

**If Definition of Annual Earnings is: Required Documentation:**

- |   |   |
|---|---|
| 1) W-2                                  | Include copy of Previous Year's W-2<br>(year prior to month/year of date last worked)   |
| 2) Salary with Commissions and/or Bonus | One month's payroll records (for month preceding date last worked) plus documentation of commissions and/or bonus paid over the last 12 months (as defined in your contract). |



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### **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 and 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.

#### **Fraud Warning 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.

#### **Fraud Warning 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.

#### **Fraud Warning for Maine, Tennessee, Virginia, and Washington Residents**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

#### **Fraud Warning for Florida Residents**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

#### **Fraud Statement 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.

#### **Fraud Statement for New York Residents**

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing 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.

#### **Fraud Statement 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.

## SECTION 1: INSURANCE INFORMATION

Indicate the type of claim being filed:

- ☐ Life – Policy Number \_\_\_\_\_ Division \_\_\_\_\_  
☐ Dependent? ☐ Voluntary  
☐ Accelerated? % Requested \_\_\_\_\_ ☐ Individual
- ☐ AD&D – Policy Number \_\_\_\_\_ Division \_\_\_\_\_  
☐ Dependent?
- ☐ Special Risk – policy number \_\_\_\_\_ GTA \_\_\_\_\_  
☐ Dependent?

## SECTION 2: EMPLOYER INFORMATION

Company Name \_\_\_\_\_ Subsidiary/Affiliate/Branch \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Name and Title of Authorized Representative \_\_\_\_\_  
 Telephone number \_\_\_\_\_ Fax Number \_\_\_\_\_  
 Signature of Authorized Representative \_\_\_\_\_

## SECTION 3: EMPLOYEE INFORMATION

Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Please provide any other names (i.e., maiden name, alias, hyphenated name, etc.) that this person is or has been known by.  
 \_\_\_\_\_

Address of Employee \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employment Status: ☐ Full Time ☐ Part Time Hours/week \_\_\_\_\_  
 Hourly or Salary Employee? \_\_\_\_\_

Job Title/Class \_\_\_\_\_ Salary/Rate of Pay \_\_\_\_\_

Date of Hire \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

Date Last Physically at Work \_\_\_\_\_ Reason for Ceasing Work \_\_\_\_\_

Is the employee receiving any company sponsored retirement benefits? ☐ Yes ☐ No

If yes, please explain type \_\_\_\_\_

Date of Death \_\_\_\_\_ Accidental Claim being submitted? ☐ Yes ☐ No

Amount of Unum Group Life Insurance:

Basic Life	\$ _____	Supplemental Life	\$ _____	Special Risk Basic	\$ _____
Basic AD&D	\$ _____	Supplemental AD&D	\$ _____	Special Risk Supp	\$ _____
		Travel Accident	\$ _____		

Date of Last Change in Amount of Insurance _____	Amount of Last Change	Basic Life	\$ _____	Increased	Decreased
		Supplemental Life	\$ _____	Increased	Decreased
		Basic AD&D	\$ _____	Increased	Decreased
		Supplemental	\$ _____	Increased	Decreased
		Travel Accident	\$ _____	Increased	Decreased
		Special Risk Basic	\$ _____	Increased	Decreased
		Special Risk Supp	\$ _____	Increased	Decreased

Date of Last Premium Payment \_\_\_\_\_

If accidental claim being submitted, does the deceased have any unmarried dependent children currently at the 12th grade level or who are enrolled in an institution of higher learning beyond the 12th grade? ☐ Yes ☐ No

Name of dependent child \_\_\_\_\_ Age \_\_\_\_\_

Name of dependent child \_\_\_\_\_ Age \_\_\_\_\_

#### SECTION 4. DEPENDENT INFORMATION (for Dependent claim)

Full Name of Dependent \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Effective Date of Insurance \_\_\_\_\_ Date of Death \_\_\_\_\_ Amount of Life Coverage \_\_\_\_\_  
 Dependent Social Security # \_\_\_\_\_ Amount of AD&D Coverage \_\_\_\_\_  
 Was employee actively working at time of death of dependent? ☐ Yes ☐ No

#### SECTION 5 BENEFICIARY INFORMATION (Please attach additional sheet if necessary)

1. Name of Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address of Beneficiary \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Social Security # \_\_\_\_\_

2. Name of Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address of Beneficiary \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Social Security # \_\_\_\_\_

3. Name of Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address of Beneficiary \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Social Security # \_\_\_\_\_

4. Name of Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address of Beneficiary \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Social Security # \_\_\_\_\_

5. Name of Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address of Beneficiary \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Social Security # \_\_\_\_\_

#### SECTION 6. MINOR BENEFICIARY INFORMATION

If any of the above beneficiaries are minors, please complete the following information:

Full Name of Beneficiary \_\_\_\_\_  
 Full Name of Guardian/Custodian \_\_\_\_\_  
 (include Guardian/Custodian papers if applicable)  
 Mailing Address of Guardian/Custodian \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

#### SECTION 7. SURVIVOR INFORMATION (Complete for claims eligible for Life Planning Resources)

Name of Survivor \_\_\_\_\_ Telephone Number \_\_\_\_\_  
 Address \_\_\_\_\_

**TO BE COMPLETED BY BENEFICIARY OR AUTHORIZED REPRESENTATIVE: Please Answer All Questions**

Full Name of Deceased \_\_\_\_\_ Social Security Number \_\_\_\_\_

When did accident happen? \_\_\_\_\_ Time? \_\_\_\_\_

Where did accident happen? \_\_\_\_\_

How did accident happen? \_\_\_\_\_

What was the deceased doing at the time of the accident? \_\_\_\_\_

**List all Physicians and Surgeons who attended deceased for these injuries**

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Advise if Autopsy or Inquest was held \_\_\_\_\_

(Note: attach summary of autopsy report or copy of inquest proceedings)

**List all witnesses to the accident**

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

**List all investigating authorities**

Investigating Officer Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Other – Name/Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

**List all physicians who have attended deceased during the last five years (State ailments involved)**

Name and Address \_\_\_\_\_

Ailment \_\_\_\_\_

Name and Address \_\_\_\_\_

Ailment \_\_\_\_\_

Name and Address \_\_\_\_\_

Ailment \_\_\_\_\_

Name and Address \_\_\_\_\_

Ailment \_\_\_\_\_

Name and Address \_\_\_\_\_

Ailment \_\_\_\_\_

In what capacity are you acting to complete this form?

☐ Named Beneficiary    ☐ Representative of Named Beneficiary    ☐ Administrator of Estate

☐ Other (please specify) \_\_\_\_\_

Telephone Number \_\_\_\_\_

Named Beneficiary Social Security Number or Taxpayer I.D. Number \_\_\_\_\_

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN FOR ACCIDENTAL DISMEMBERMENT**

Patient's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Accident Causing Loss \_\_\_\_\_ Date First Consulted \_\_\_\_\_

Has the patient ever had the same or similar symptoms? ☐ Yes ☐ No If Yes, Date \_\_\_\_\_

Diagnosis or Nature of Injury \_\_\_\_\_

Describe Accident \_\_\_\_\_

When did symptoms first appear or accident happen? \_\_\_\_\_

Is condition arising out of employment? ☐ Yes ☐ No

If loss is extremity, where is amputation? \_\_\_\_\_

Please indicate where the amputation occurred using the illustration below: Remarks: \_\_\_\_\_



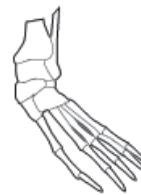
RIGHT



LEFT



RIGHT



LEFT

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No (Attach records)If loss is hearing, is loss in both ears? ☐ Yes ☐ NoIs loss total and irrecoverable? ☐ Yes ☐ No (Please attach audiograms and office notes)

If loss is vision please provide the following:

Date of first eye examination \_\_\_\_\_

Date of last eye examination \_\_\_\_\_ and visual acuity (Using Snellen Notation – See Below)

**Uncorrected**

O.D. \_\_\_\_\_

O.S. \_\_\_\_\_

**Corrected**

O.D. \_\_\_\_\_

O.S. \_\_\_\_\_

If the injury necessitated removal of either or both eyes, give date of removal \_\_\_\_\_

Vision can be restored in whole or in part by: ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorableIf by operation, do you recommend it? ☐ Yes ☐ No

Date corrected vision was irrecoverably reduced to 20/200 or less \_\_\_\_\_

In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ NoIn your opinion, was the loss caused in any way by illness or disease? ☐ Yes ☐ No

List dates you provided treatment for this illness or injury: \_\_\_\_\_

List names of other physicians who treated insured for this or a contributory condition:

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

PLEASE ATTACH COPIES OF OFFICE NOTES RELATED TO THIS INJURY

Name (Attending Physician – Please print) \_\_\_\_\_

Degree/Professional Designation \_\_\_\_\_ Telephone Number \_\_\_\_\_

Physician's Address (Number and Street, City/Town, State, Zip Code) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY THE CLAIMANT**

Date of injury or date you first noticed symptoms of your illness \_\_\_\_\_

Describe how and where injury occurred or describe the first symptoms of your illness and nature of illness. \_\_\_\_\_

Is your injury or illness related to your occupation? ☐ Yes ☐ No If yes, explain \_\_\_\_\_

Date you were first treated for your illness or injury \_\_\_\_\_

List all those that treated you for your illness or injury

Physician Name \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Telephone Number \_\_\_\_\_

Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

Hospital Telephone Number \_\_\_\_\_

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No

(If yes, please attach Physician/Hospital information)

**Special Notice to Minnesota Claimants:**

Your authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, fire-fighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care and or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who qualify under the good Samaritan law.



**Attachment B-2 – Accelerated Benefit – Attending Physician’s Statement (1-800-445-0402)**

Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

When did symptoms first appear or injury happen? \_\_\_\_\_

Has patient ever had same or similar condition? ☐ Yes ☐ No

If “Yes” state when and describe \_\_\_\_\_

Names and addresses of other treating physicians:

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_

Diagnosis \_\_\_\_\_

(Including any complications)

If Cancer, indicate Stage \_\_\_\_\_

Date of Distant Metastases \_\_\_\_\_ Location of Metastasis \_\_\_\_\_

Hospice Referral? ☐ Yes ☐ No If yes, Date \_\_\_\_\_

Date of First Visit \_\_\_\_\_ Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other  
If “Other” please specify \_\_\_\_\_

Date of Last Examination \_\_\_\_\_

During last 6 months, has patient: ☐ Recovered ☐ Improved ☐ Retrogressed ☐ Unchanged

Is patient: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

Has Patient been Hospital Confined? ☐ Yes ☐ No Dates: \_\_\_\_\_

If “Yes” give name and address of hospital \_\_\_\_\_

Functional Capacity (American Heart Association)

☐ Class 1 (no limitation)

☐ Class 3 (marked limitation)

☐ Class 2 (slight limitation)

☐ Class 4 (complete limitation)

Therapeutic Class (Activity)

☐ A. (No restrictions)

☐ C. (moderate restrictions)

☐ B. (slight restrictions)

☐ D. (marked restrictions)

☐ E. (complete restrictions)

**What is the estimated life expectancy?**

☐ Less than 6 months

☐ 6 – 12 months

☐ 12 – 24 months

☐ Greater than 24 months

Name of Attending Physician – Please Print \_\_\_\_\_

Degree \_\_\_\_\_ Medical Specialty \_\_\_\_\_

Telephone Number \_\_\_\_\_

Street Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_



Unum, Group Life Benefits Services  
P.O. Box 100158, Columbia, SC 29202-3158  
Telephone: 1-800-445-0402

**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, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to the address above.

**AUTHORIZATION  
For Life or Accidental Death Claim**

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy, emergency medical service agency, or other medically related facility or service; medical examiner's office; coroner's office; health plan; rehabilitation professional; vocational evaluator; insurer; reinsurer; insurance service provider; third party administrator; producer; government organization; law enforcement agency; consumer reporting agency; and employer that has (1) information about the health, death, financial or credit history, earnings, employment history, or other insurance claims and benefits, or (2) blood, urine or other specimens of \_\_\_\_\_ (print name of deceased) to disclose any and all of this information and specimens to persons who administer claims for Unum, its insurance subsidiaries\* and duly authorized representatives ("Unum"). Information about the deceased may include, but is not limited to, autopsy reports, photographs and findings, medical examiner reports and photographs, laboratory test results and findings, toxicology results, police reports and photographs, accident reports, or incident reports of any kind. Health information about the deceased 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 that any information Unum obtains pursuant to this authorization will be used for evaluating and administering the claim(s). I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of the claim, 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, alter, or do not sign this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

\_\_\_\_\_  
Signature of Claimant (or Other Person Authorized  
to Act on Behalf of Deceased)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Social Security Number)

I, \_\_\_\_\_, signed on behalf of the claimant as the claimant's personal representative. If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

\* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, and The Paul Revere Life Insurance Company.



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**AUTHORIZATION**  
**For Accidental Dismemberment or Accelerated Benefit Claim**

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy, emergency medical service agency, or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurer; reinsurer; insurance service provider; third party administrator; producer; government organization; law enforcement agency; consumer reporting agency; and employer that has (1) information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits, or (2) my blood, urine or other specimens to disclose any and all of this information and specimens to persons who administer claims for Unum, its insurance subsidiaries\* and duly authorized representatives ("Unum"). Information may include, but is not limited to, laboratory test results and findings, toxicology results, police reports and photographs, accident reports, or incident reports of any kind. Health information 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 that any information Unum obtains pursuant to this authorization will be used for evaluating and administering the claim(s). I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

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\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Social Security Number)

I, \_\_\_\_\_, signed on behalf of the claimant as the claimant's personal representative. If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

\*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.