Filing

a Leave Request and /or Short Term Disability Claim by Telephone

Cummins Inc.

Short Term Disability
Policy #: 122530
121665

Telephone: 866-229-4885
Fax: 800-447-2498

Monday-Friday

7 a.m.
to
7 p.m.

Central Standard Time

WHEN TO CALL UNUM

- When your health care provider 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 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 leave because your spouse, son, daughter or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- When you need to care for your spouse, child, parent or next of kin undergoing medical treatment, recuperation, or therapy, is in outpatient status, or is on the temporary disability retired list for a serious illness or injury incurred or aggravated in the line of duty on active duty in the Armed Forces (includes the National Guard or Reserves). This includes a veteran who was discharged from the Armed Forces for reasons other than dishonorable within the 5 year period before the employee's first day of leave.
- When you need any other type of leave that may be covered by applicable state leave laws.
- Thirty days before a planned leave based on prescheduled medical treatment related to a serious health condition for you or your family member, or the expected birth, adoption or foster care placement of a child.
- Thirty days before a disability based on the expected delivery date of a child or prescheduled medical treatment.

WHAT TO DO NEXT

- Notify your supervisor of your absence from work.
- Call 866-229-4885 to submit your claim and/or leave request. Please be prepared with the information requested on page 2 of this brochure.
- If you are eligible for leave, a certification of health care provider form may be required. If so, it will be mailed in your initial leave packet within 2 business days of filing your leave. You will be provided a minimum of 15 days from the date the leave is requested to complete and return this form.

FOR SHORT TERM DISABILITY CLAIMS

- Provide your health care provider with a signed and dated copy of the authorization form (last page of brochure). This form authorizes the release of medical information needed to evaluate your disability claim.
- Once you have filed your Short Term Disability claim via 866-229-4885, please fax a copy of the signed and dated disability authorization to the Unum Benefits Center at the following toll-free number, 800-447-2498. If you prefer, you may sign and submit your authorization electronically at www.unum.com/claims. Please sign up under the Individuals, employees and their families tab.

OUR COMMITMENT TO YOU

We understand 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.

INFORMATION NEEDED TO SUBMIT A SHORT TERM DISABILITY CLAIM AND/OR REQUEST FOR LEAVE

Please be prepared to provide the following information when you call to submit your claim/leave. 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)
- Your name and Social Security number or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Supervisor's name and telephone number
- 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

Please note: Leave is job protection under federal and state laws whereas a disability is income replacement. In many situations the two coverages overlap when you are missing work due to your own illness or injury.

In addition, the following information will be needed when submitting a disability claim.

- Healthcare provider's name, address, fax and telephone 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
- The dates of your first visit, your most recent visit, and your next scheduled visit with your healthcare provider for this condition
- Work restrictions or limitations stated by your healthcare provider, if any.

Prompt and complete information from you and your healthcare provider will help assure a timely decision and payment if you are eligible.

Unum may require additional medical information to better understand your disability claim. The timing of the decision depends on how quickly the information is received.

Unum will partner with you to gather all required information for the duration of your disability claim.

INFORMATION THAT MAY BE IMPORTANT TO YOU

Check your claim status, correspondence, and updates online – anytime.

Unum has developed a secure and easy way for you to manage your disability claim online. Our secure web services allow you to access and make changes to your open claims, as well as view updates and correspondence when they become available.

Our secure site helps eliminate delays and is simple to use. Here are a few main features:

- Sign and submit your electronic disability authorization form.
- Upload documents for disability claims from your personal computer.
- Register for direct deposit of your claim payment, when applicable.
- Check claim status, correspondence, and most recent payment information.
- Verify and change personal information and monitor you claim progress.

Unum Group, 1 Fountain Square, Chattanooga, TN 37402

unum.com

Claim Fraud Statements

Fraud Warning

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, New Mexico, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, Washington, and West Virginia require the following statement to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly 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 Alabama Residents

For your protection, Alabama law requires the following to appear on this claim form:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Fraud Warning for California Residents

For your protection, California law requires the following to appear on this claim form:
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

For your protection, Colorado law requires the following to appear on this claim form:
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

For your protection, the District of Columbia requires the following to appear on this claim form:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Fraud Warning for Florida Residents

For your protection, Florida law requires the following to appear on this claim form:
Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Warning for Kentucky Residents

For your protection, Kentucky law requires the following to appear on this claim form:
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Fraud Warning for Minnesota Residents

For your protection, Minnesota law requires the following to appear on this claim form:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Fraud Warning for New Hampshire Residents

For your protection, New Hampshire law requires the following to appear on this claim form:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Fraud Warning for New Jersey Residents

For your protection, New Jersey law requires the following to appear on this claim form:
Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and civil penalties.

Fraud Warning for New York Residents

For your protection, New York law requires the following to appear on this claim form:
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 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.

Fraud Warning for Pennsylvania Residents

For your protection, Pennsylvania law requires the following to appear on this claim form:
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 Warning for Puerto Rico Residents

For your protection, Puerto Rico law requires the following to appear on this claim form:
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 dollars ($5,000) and not more than ten thousand dollars ($10,000), 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.

Note: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to the address at the end of this form.

PERMISSION TO CONTACT HEALTH CARE PROVIDER
AND
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

For purposes of determining my eligibility for disability benefits and/or excusing my absence from work, I permit the following disclosures of medical information about me:

1. I permit any physician or other medical practitioner, hospital, or other medical facility or service, collectively referred to as "Medical Professionals," to disclose to Cummins' Disability Plan administrators, which includes on-site disability staff, disability staff at Cummins Business Services ("CBS") in Nashville, Tennessee and its contractor, Unum Life Insurance Company of America ("Unum"), any and all information about my health and medical care that supports this claim for disability benefits.

2. I permit on-site disability staff, CBS disability staff, and Unum to disclose this form to my management as necessary to support this claim for disability benefits or to manage my attendance or resolve any other matter related to my employment at Cummins Inc.

This Authorization to Disclose Medical Information About Me specifically includes my permission to disclose medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; HIV and AIDS; and alcohol or drug abuse including any data protected by Fed. Reg. 42 CFR Part 2 or other applicable laws. Information that may have been subject to privacy rules of the US Dept. of Health and Human Services, once disclosed, may be subject to re-disclosure by the recipient and may no longer be covered by those rules.

I may revoke this authorization by sending written notice to the address listed below at any time except to the extent Unum has relied on the authorization prior to notice of revocation. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

I understand if I do not sign this authorization or if I alter its content in any way, Cummins' Disability Plan administrators, CBS, and/or Unum may not be able to evaluate or administer my claim(s) for disability benefits and this may be the basis for denying my claim(s).

I also understand that disability leave will be counted towards my Family and Medical Leave (FMLA) entitlement to the extent my condition would otherwise qualify me for FMLA leave.

_____ _____
(Employee's Signature) (Date)

_____ _____
(Print Name) (Social Security Number)

I, _____, signed on behalf of the Employee as the Employee's personal representative. Please describe your authority to act as the Employee's personal representative (e.g., Power of Attorney Designee, Guardian, Conservator): _____. If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Fax or mail a completed copy of this authorization to:
Unum Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
Fax: 1-800-447-2498

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