

Report of the

Multistate Market Conduct Examination

As of December 31, 2007

For

Maine Bureau of Insurance

Massachusetts Division of Insurance

New York State Insurance Department

Tennessee Department of Commerce and Insurance

And

Other Participating Jurisdictions: Alabama, Alaska, American Samoa, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Vermont, Washington, West Virginia, Wisconsin and Wyoming

Of

Unum Life Insurance Company of America

NAIC Company #62235

2211 Congress Street

Portland, Maine 04102

The Paul Revere Life Insurance Company

NAIC Company #67598

18 Chestnut Street

Worcester, Massachusetts 01608

Provident Life and Accident Insurance Company

Provident Life and Casualty Insurance Company

NAIC Company #68195 and #68209

1 Fountain Square

Chattanooga, Tennessee 37402

First Unum Life Insurance Company

NAIC Company #64297

99 Park Avenue, 6th Floor

New York, New York 10016

NAIC Group # 0565

April 14, 2008

EXHIBIT

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RACKEMANN SAWYER & BREWSTER

PROFESSIONAL CORPORATION
COUNSELLORS AT LAW

Established 1886

April 14, 2008

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State of Maine
Bureau of Insurance
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Commonwealth of Massachusetts
Division of Insurance
One South Station
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Leslie Newman, Commissioner
State of Tennessee
Department of Commerce and Insurance
500 James Robertson Parkway - 5th Floor
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Nashville, TN 37243-1162

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State of New York
25 Beaver Street
New York, New York 10004-2319

James M. Benages, Regional Director
Employee Benefits Security Administration
U.S. Department of Labor
JFK Federal Building, Room 575
Boston, Massachusetts 02203

Dear Superintendent Kofman, Commissioner Burnes, Commissioner Newman,
Superintendent Dinallo, Regional Director Benages and the Chief Insurance Regulators
of the Participating States:

Pursuant to the authority granted by Title 24-A *Maine Revised Statutes Annotated* § 221, Chapter 175 *Massachusetts General Laws* § 4, *Tenn. Code Ann.* § 56-1-408, and *New York Insurance Law* § 309 and in accordance with the *NAIC Market Regulation Handbook* (“*Handbook*”) and the Regulatory Settlement Agreements (“*RSA*”) entered November 18, 2004, examinations have been conducted of disability income insurance claim handling practices of:

Unum Life Insurance Company of America (“Unum”)
The Paul Revere Life Insurance Company (“Revere”)
Provident Life and Accident Insurance Company (“Provident”)
Provident Life and Casualty Insurance Company (“Provident L&C”)
First Unum Life Insurance Company (“First Unum”)
(collectively, the “Companies”)

Further, pursuant to the provisions of the *RSA*, the examinations also included the Companies’ compliance with the terms of the *RSA*.

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Foreword

This report on the multistate market conduct examination of the Companies is provided pursuant to the *Handbook* and is made by exception. Additional practices, procedures, and files subject to review during the examination were omitted from the report if no improprieties were noted.

Profile of the Companies

Unum, Revere, Provident, Provident L&C and First Unum are direct or indirect subsidiaries of Unum Group, formerly UnumProvident Corporation (“the Parent Company”), a Delaware corporation. The Parent Company is the result of a merger between Unum Corporation and Provident Companies, Inc. on June 30, 1999. Previously, on March 27, 1997, Provident Companies, Inc. had acquired The Paul Revere Corporation. The four primary operations centers for the Companies are located in Chattanooga, Tennessee, Portland, Maine, Worcester, Massachusetts and Glendale, California.

Unum, a Maine corporation, primarily markets group short term and long term disability insurance as well as long term care insurance and group life insurance. It is licensed to transact business in the District of Columbia and all states, except New York. Revere, a Massachusetts corporation, primarily markets individual long term disability insurance. Revere is licensed to transact business in all fifty states and the District of Columbia. Provident, a Tennessee corporation, primarily markets individual long term disability insurance as well as life insurance through an employee-paid voluntary benefits program. It is licensed to transact business in the District of Columbia and all states,

except New York. First Unum is a licensed insurance company domiciled in the State of New York.

The Parent Company uses common management and processes in the administration of claims for Unum, Revere, Provident, Provident L&C and First Unum. Claims for each member insurer are adjusted from common locations using common procedures. The findings of this examination are therefore assumed to apply to each of the Companies.

Background

The 2003 Multistate Examination

On January 7, 2003, the Massachusetts Division of Insurance initiated a targeted market conduct examination of the individual disability insurance (“IDI”) claims handling practices of Revere. The Tennessee Department of Commerce and Insurance had initiated a market conduct examination of Provident’s disability insurance business as part of its financial examination as of December 31, 2000. The Tennessee examination focused on litigated disability insurance claims. On September 2, 2003, a multistate targeted market conduct examination (“the 2003 Multistate Examination”) was commenced by the Maine Bureau of Insurance, the Massachusetts Division of Insurance and the Tennessee Department of Commerce and Insurance concerning, respectively, Unum, Revere and Provident. Each domiciliary state acted as the Lead State (as defined in the then *Market Conduct Examiners Handbook* adopted by the NAIC) for its respective domiciled company, and the other two Lead State chief regulators were Active Participants. All fifty states, the District of Columbia and American Samoa chose to act

as Participating States in the 2003 Multistate Examination. The 2003 Multistate Examination addressed claims handling practices for both IDI and group long term disability (“LTD”) policies.

The purpose of the 2003 Multistate Examination was to determine if the disability insurance claims handling practices of the Companies reflected systemic “unfair claim settlement practices” as defined in the *NAIC Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance Model Act* (1972) or the *NAIC Claims Settlement Practices Model Act* (1990) (collectively, the “Model Act”), and particularly, as defined in Title 24-A *Maine Revised Statutes Annotated* § 2164-D(3), (4) and (5); Chapter 176D *Massachusetts General Laws* § 3; and *Tenn. Code Ann.* § 56-8-104(8). The results of the 2003 Multistate Examination were summarized in the November 18, 2004 Examination Report. It identified four general areas of concern, and led to a Plan of Corrective Action (“the Plan”) which was subsequently implemented through the RSA entered into by each of the Companies with its Lead State Regulator (“Lead Regulator”) and the United States Department of Labor (“DOL”), and subscribed to by forty-eight states and the District of Columbia. The Plan, as implemented through the RSA, is summarized below.

The Regulatory Settlement Agreements

The RSA had several key objectives: to make significant changes in the Companies’ corporate governance; to implement a meaningful claim reassessment process; to make changes in the Companies’ claim organization; to implement significant

revisions to the Companies' claim procedures, and to monitor and measure the results of these changes. Specifically, the RSA provided for the following actions:

1. Changes in corporate governance: The RSA required the addition of three new directors, approved by the Lead Regulators, to the Board of Directors of the Parent Company. In addition, the RSA required that the Audit Committee of the Board of Directors be expanded by one new member, chosen from among the three new directors. The RSA also required the creation of a new standing committee of the Board of Directors, comprised of two of the new directors, and three other independent directors ("the Regulatory Compliance Committee"). The Regulatory Compliance Committee has met with the Lead Regulators and the DOL on a quarterly basis since its organizational meeting on February 18, 2005. The RSA also required the formation of a Regulatory Compliance Unit composed of officers and employees of the Companies, to report directly to the Regulatory Compliance Committee. The Regulatory Compliance Unit, in conjunction with the Companies' internal claim audit staff, has performed several compliance-related functions including monitoring the Companies' compliance with the terms of the RSA. Reports of the findings of the internal claim audit staff have been presented to the Lead Regulators and the DOL no less frequently than at each quarterly meeting of the Regulatory Compliance Committee.

2. Claim Reassessment Process: The RSA, as amended October 3, 2005, required that the Companies offer an opportunity to LTD and IDI claimants, whose claims were denied or benefits terminated during specified time periods (generally January 1997 – January 2005), to elect to have those claims reassessed pursuant to

guidelines set forth in the RSA. The reassessments were performed by a newly formed claim unit (the Claim Reassessment Unit, "CRU"), which was staffed with experienced claim representatives. In accordance with the RSA, the Companies mailed 290,903 notices to eligible claimants. A member of the examination team reviewed the Companies' methodology used for such mailings; the Companies also provided certification that such mailings had been made pursuant to the requirements of the RSA. A total of 78,422 claimants who received such notices elected to "opt-in" to the Claim Reassessment Process (29% of eligible LTD claimants who received notice opted-in; 21.7% of eligible IDI claimants who received notice opted-in); an additional 974 claimants requested reassessment pursuant to requirements set forth in the RSA. Of these 79,396 claimants who requested to participate in the reassessment process, 23,190 completed the requisite Reassessment Information Forms set forth in the RSA (29.2%), and accordingly had their claims reassessed (31.5% of LTD claimants who had previously opted-in and 20.7% of IDI claimants who had previously opted-in). The Claim Reassessment Process was completed in December, 2007, with results as follows:

- 41.7% of the total claims reassessed (involving 9,672 claims) were reversed in whole or in part, resulting in a cumulative total of approximately \$676.2 million of additional benefits either paid immediately or reserved for future payments;
- 45.1% of LTD claims reassessed (involving 8,911 claimants) were reversed in whole or in part, resulting in a cumulative total of approximately \$558.6 million of additional benefits either paid immediately or reserved for future payments;

- 22.1% of IDI claims reassessed (involving 761 claimants) were reversed in whole or in part, resulting in a cumulative total of approximately \$117.6 million of additional benefits either paid immediately or reserved for future payments.

3. Changes in claim organization and procedures: The RSA set forth a series of revisions to the Companies' claim procedures and the structure of its claim operations, with the objectives of:

- The engagement of experienced claim personnel at the earliest possible stage of claim reviews;
- Increased emphasis upon claim staff accountability for compliance with the terms of insurance policies and applicable law;
- Increased involvement of higher levels of claim management staff in each claim denial or claim termination decision;
- Creation of a separate compliance/accountability function at the claim denial and claim termination level;
- Assurance that co-morbid conditions are properly evaluated at every level of claim review;
- Increased utilization of Independent Medical Examinations;
- Additional compliance training for all claim staff, with emphasis upon the results of the 2003 Multistate Examination, the Plan, and the NAIC Unfair Claim Settlement Practices Act; and
- Additional training for group policyholder human resources personnel so as to better facilitate the process for LTD claims.

4. Regulatory monitoring and examination: The RSA provided for the Lead Regulators and representatives of the DOL to meet with the Regulatory Compliance Committee and with the Companies' senior management on a quarterly basis, to evaluate compliance with the Plan and the RSA generally. The Companies provided reports at

those meetings on the progress of the Claim Reassessment Process, the results of their internal claim audits, and the rates of complaints and newly filed litigation arising from disability claims. In order to provide feedback on the results of the changes in claim organization and claim procedures, and the Claim Reassessment Process, members of the examination team performed periodic reviews of randomly selected claim files (both claims reassessed by the CRU, and newly decided disability claims) in a series of five initial claim samples (each of which consisted of 15 CRU claims and 40 non-CRU claims). These preliminary reviews were performed from February 2006 through January 2007. The results of these preliminary reviews were presented at meetings of the Regulatory Compliance Committee and the Companies took corrective action as applicable.

Scope of Examination

The RSA (§ C.2 (p.20)) provides for a “full re-examination of the issues addressed by the [2003] Multistate Examination”. Sections D.6 (p. 21) and D.7 (p. 22) further specify that the re-examination shall establish separate error rates for each of the following types of claims:

- All IDI claims reassessed by the CRU;
- All LTD claims reassessed by the CRU;
- IDI claims in which benefits were denied or terminated after the RSA Implementation Date (January 18, 2005) through December 31, 2007 (“Operations IDI claims”); and

- LTD claims in which benefits were denied or terminated after the Implementation Date through December 31, 2007 (“Operations LTD claims”).

Claim Selection Methodology

The examination team requested the Companies to provide four separate comprehensive databases including all such claims. The first such request encompassed claims decided from the RSA Implementation Date through April 30, 2007; the second request encompassed claims decided through December 31, 2007. Based upon the resulting population sizes, random selections of claims were then made as follows: 50 CRU IDI claims; 100 CRU LTD claims; 50 Operations IDI claims; and 100 Operations LTD claims. Each such randomly selected claim file was reviewed by a member of the examination team.

Compliance with RSA-Mandated Actions

The RSA provided for the Companies to implement changes in corporate governance (§ B.1 (p. 6)), establish a claim reassessment process and provide notice of that process to eligible claimants (§ B.2 (p. 9)) and make changes in the claim organization and claim procedures (§ B.3 (p. 15)) by enumerated dates.

Examination Results

Examination of Claim Files

The RSA established a “maximum tolerance standard” (error rate) of 7% for each of the four examinations. (This is the same “error rate” specified in the *Handbook* for examinations.) Based upon the examiners’ review of the selected claims, the following error rates were determined:

- CRU IDI: 4%
- CRU LTD: 4%
- Operations IDI: 0%
- Operations LTD: 3%

Unum, Revere, Provident, Provident L&C and First Unum CRU Claim Files Reviewed

| Line of Business | Claims Reviewed | Number of Errors | Error Rate |
|------------------|-----------------|------------------|------------|
| LTD Claims | 100 | 4 | 4% |
| IDI Claims | 50 | 2 | 4% |

Unum, Revere, Provident, Provident L&C and First Unum Operations-LTD and Operations-IDI Claim Files Reviewed

| Line of Business | Claims Reviewed | Number of Errors | Error Rate |
|------------------|-----------------|------------------|------------|
| LTD Claims | 100 | 3 | 3% |
| IDI Claims | 50 | 0 | 0% |

In summary, the error rates in each case were below the 7% “maximum tolerance standard” set forth in the RSA and the *Handbook*.

Compliance with RSA-Mandated Actions

As described above, the RSA mandated that the Companies take certain actions by particular dates. The Companies timely complied with each of the RSA-mandated actions.

Changes in Corporate Governance

The Companies timely complied with each of the requirements specified in the RSA concerning “Changes in Corporate Governance”. RSA § B.1 (p. 6).

Implementation of the Claim Reassessment Process and Notice to Claimants

The Companies timely complied with each of the requirements specified in the RSA concerning the Claim Reassessment Process. RSA § B.2 (p. 9).

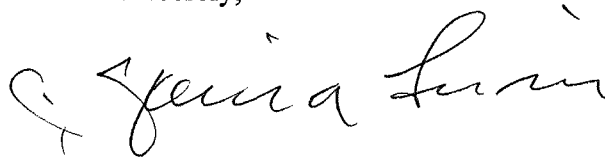
Changes in Claim Organization and Procedures

The Companies implemented the changes in claim organization and procedures mandated by the RSA and provided a certificate of compliance to the Lead Regulators. RSA § B.3 (p. 15).

Report Submission

This report of examination is hereby respectfully submitted.

Sincerely,

A handwritten signature in black ink, appearing to read "J. David Leslie". The signature is written in a cursive style with a large initial "J" and "L".

J. David Leslie
Rackemann, Sawyer & Brewster, P.C.
Examiner-In-Charge

Examiners:
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Kevin J. McAdoo, Special Deputy Receiver
John S. Coulton, Esq.

Report of the
Targeted Multistate Market Conduct Examination
As of December 31, 2002 ("Initial Review") and
February 29, 2004 ("Follow-Up Review")

Of

Unum Life Insurance Company of America
NAIC Company #62235
Portland, Maine

The Paul Revere Life Insurance Company
NAIC Company #67598
Worcester, Massachusetts

Provident Life and Accident Insurance Company
NAIC Company #68195
Chattanooga, Tennessee

NAIC Group # 0565

November 18, 2004

Exhibit F

Provident Settlement Agreement

IN THE MATTER OF
PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
PROVIDENT LIFE AND CASUALTY INSURANCE COMPANY
Chattanooga, Tennessee

REGULATORY SETTLEMENT AGREEMENT

**TARGETED MULTISTATE DISABILITY
INCOME MARKET CONDUCT EXAMINATION**

This Regulatory Settlement Agreement (“Agreement”) is entered into as of this ___ day of November, 2004, by and between Provident Life and Accident Insurance Company and Provident Life and Casualty Insurance Company (collectively, the “Company”), the Commissioner of the Tennessee Department of Commerce (the “Lead Regulator”), the Superintendent of the State of Maine Bureau of Insurance and the Commissioner of the Massachusetts Division of Insurance (collectively with the Lead Regulator, the “Lead Regulators”), the insurance regulators of each of the remaining States, the District of Columbia and American Samoa that adopt, agree to and approve this Agreement (the “Participating Regulators”) and the United States Department of Labor (the “DOL”).

A. Recitals

1. The Company maintains its home office at Chattanooga, Tennessee. At all relevant times, the Company has been a licensed insurance company domiciled in the State of Tennessee. The Company and its affiliates Unum Life Insurance Company of America (“Unum”) and The Paul Revere Life Insurance Company (“Revere”) are subsidiaries of UnumProvident Corporation, a Delaware corporation, with its principal place of business in Chattanooga, Tennessee (the “Parent Company”). At all relevant times, Unum is and has been a licensed insurance company domiciled in the State of Maine, and Revere is and has been a

licensed insurance company domiciled in the Commonwealth of Massachusetts. The Company, Unum, and Revere, are collectively referred to as the "Companies."

2. On September 2, 2003, the Lead Regulators of the domiciliary states of the Companies, Maine, Massachusetts, and Tennessee called a multistate targeted market conduct examination of Provident Life and Accident Insurance Company, Unum and Revere (the "Multistate Examination") to determine if the individual and group long term disability income claim handling practices of the Companies reflected systemic "unfair claim settlement practices" as defined in the National Association of Insurance Commissioners ("NAIC") *Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance Model Act (1972)* or *NAIC Claims Settlement Practices Model Act (1990)* (collectively, the "Model Act") pursuant to the procedures established by the *NAIC Market Conduct Examiner's Handbook* (the "Handbook").

3. The other forty-seven states, the District of Columbia and American Samoa chose to be "Participating States" in the Multistate Examination. Contemporaneously with the Multistate Examination, the DOL was conducting an investigation of the Companies (the "DOL Investigation") pursuant to Section 504 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. Section 1134.

4. As a result of the Multistate Examination, the Lead Regulators engaged in discussions with the Companies with respect to regulatory concerns raised by the Multistate Examination, a plan of corrective action by the Companies to address those concerns for the benefit of the Companies' current and former policyholders and insureds, and a means of providing for the enforcement of such a plan. After extensive discussion, the Companies agreed to a plan of corrective action to be set forth in this Agreement and substantially identical

regulatory settlement agreements between Unum and Revere and their respective domiciliary regulators and to the payment of a \$15,000,000 fine. In addition, the insurance subsidiary of the Parent Company that is domiciled in New York, First Unum Life Insurance Company (the "New York subsidiary"), will enter into a substantially identical regulatory settlement agreement with the New York Superintendent of Insurance and the Lead Regulators. As the result of the ongoing Multistate Examination and the DOL Investigation, the Companies, the DOL and the Lead Regulators decided to enter into a global settlement resolving common matters pertaining to the Multistate Examination and the DOL Investigation. An Examination Report concerning the Multistate Examination is being released concurrently with this Agreement that contemplates the execution of this Agreement and/or the entry of consent orders where necessary under the law or practice of a particular Participating Regulator's state.

5. The plan of corrective action addresses a number of regulatory and statutory concerns raised by the Lead Regulators and the DOL. It seeks to accomplish the following:
 - a. provide an effective Claim Reassessment Process for an identified class of claimants who seek review of the earlier decision using an experienced claim unit formed by the Companies solely for this purpose to (i) perform a de novo review of the claims using past and current information that is relevant to the claim decision and (ii) apply the improved claim handling procedures contemplated by this Agreement in order that this Claim Reassessment Process constitute a fair way in which to remedy deficiencies that may have affected the earlier claim decisions covered by this Agreement;
 - b. provide changes to claim procedures that will improve the claim handling process and benefit current and future policyholders and insureds by (i) reflecting regulatory standards in the area of market conduct for handling disability claims, (ii) addressing the

Companies' commitment to claim handling procedures that promote the fair, objective and thorough treatment of claims and be indicative of best practices in the handling of individual and group long term disability claims, and (iii) complying with applicable state and federal laws and regulations; and

c. provide for oversight in order to ensure compliance or effect enforcement, which oversight and ongoing monitoring includes (i) additions to the governance structure of the Parent Company and (ii) review by the Lead Regulators and the DOL so that activities of the Companies hereunder and reviews by staff or examiners of the Lead Regulators and the DOL will result in quarterly reporting on the results of the Claim Reassessment Process and generally on the handling of individual and group long term disability claims and appropriate follow-up to resolve questions or correct any potential non-compliance with policies or procedures.

6. This Agreement sets forth (i) the plan of corrective action, (ii) provisions concerning the enforcement of the Company's compliance with the plan of corrective action, and (iii) other miscellaneous provisions of this Agreement.

7. Location of Definitions. Listed definitions are contained in this Agreement unless there is specific reference to the definition being in an Exhibit or Attachment to an Exhibit to this Agreement.

- a. "Agreement" is defined in the preamble paragraph.
- b. "AP" is defined in paragraph B.3.c.(i)
- c. "Applicable Consent Order" is defined in paragraph C.5.c.
- d. "Board of Directors" is defined in paragraph B.1.a.
- e. "Claim Reassessment Process" is set forth in paragraph B.2.
- f. "Claim Reassessment Unit" is defined in paragraph B.2.a.

- g. "Company" is defined in the preamble paragraph.
- h. "Companies" is defined in paragraph A.1.
- i. "DOL" is defined in the preamble paragraph.
- j. "DOL Investigation" is defined in paragraph A.3.
- k. "ERISA" is defined in paragraph A.3.
- l. "FCE" is defined in paragraph B.3.c.(i)
- m. "Governance Implementation Date" is defined in paragraph B.1.a.
- n. "Group" is defined in paragraph B.3.j.
- o. "Handbook" is defined in paragraph A.2.
- p. "IME" is defined in paragraph B.3.c.(i)
- q. "Implementation Date" is defined in paragraph B.2.a.
- r. "Lead Regulator(s)" is defined in the preamble paragraph.
- s. "Model Act" is defined in paragraph A.2.
- t. "Multistate Examination" is defined in paragraph A.2.
- u. "New York subsidiary" is defined in paragraph A.4.
- v. "NAIC" is defined in paragraph A.2.
- w. "Parent Company" is defined in paragraph A.1.
- x. "Participating Regulators" is defined in the preamble paragraph.
- y. "Plan" is defined in the heading to paragraph B.
- z. "Regulatory Compliance Committee" is defined in paragraph B.1.c.
- aa. "Requesting Claimant" is defined in paragraph B.2.b.
- bb. "Specified Claimant" is defined in paragraph B.2.b.

B. Plan of Corrective Action (the "Plan")

1. Changes in Corporate Governance

a. Expansion of Board of Directors. The Lead Regulators, and the Board of Directors of the Parent Company (the "Board of Directors") have agreed that additional members with specific experience and qualifications shall be added to the Board of Directors. (Prior to entering this Agreement the Board of Directors directed a search using an outside search firm to identify candidates with senior management experience in the insurance or financial services industries and on August 12, 2004 elected three new independent directors with such qualifications.) The Board of Directors shall be expanded by the addition of three other directors who shall be "independent" directors under current rules of the New York Stock Exchange. In the first instance, two directors will be added, each of whom will have significant insurance industry or insurance regulatory experience, and they will be approved by the Lead Regulators. The Company shall provide the names of the two prospective new members of the Board of Directors to the Lead Regulators by November 19, 2004. If the two proposed new members are approved by the Lead Regulators prior to December 15, 2004, they will be elected by the Board of Directors no later than December 16, 2004. However, if either or both of the two proposed new members is disapproved, the Board of Directors will continue in good faith to search to identify to the Lead Regulators as promptly as reasonably practicable (but no later than 60 days from the date of such disapproval) one or two additional qualified candidates, as appropriate, to propose as members of the Board of Directors. Following their approval by the Lead Regulators, such person or persons shall be elected by the Board of Directors at its next regularly scheduled meeting. The date of the election of the second of the two new members to the Board of Directors will be the "Governance Implementation Date", unless the two new members

approved by the Lead Regulators are elected to the Board of Directors prior to November 19, 2004, in which case the Governance Implementation Date will be December 16, 2004. In addition to the two directors described above, the Board of Directors undertakes that the next following person to be added to the Board of Directors as a result of the retirement, resignation, death or failure to stand for reelection of an existing director or to fill an existing or newly-created vacancy will be a person with significant insurance regulatory experience. In any event, a person with such qualifications will be proposed by the Board of Directors for board membership and such person's name shall be provided to the Lead Regulators no later than June 30, 2005. If the Lead Regulators approve the proposed new member, the person will be elected to the Board of Directors at the next regular meeting of the Board of Directors following approval. If the Lead Regulators disapprove the proposed new member, the Board of Directors will continue in good faith to search to identify as promptly as reasonably practicable (but no later than 60 days from the date of such disapproval) a person with such qualifications to propose as a member of the Board of Directors. Following the candidate's approval by the Lead Regulators, the person will be elected to the Board of Directors at its next regularly scheduled meeting. If any of the new directors ceases to serve as a director prior to the end of the term of this Agreement, the process described in this paragraph shall be applied to the selection of any replacement.

b. Audit Committee. No later than the Governance Implementation Date, at least one of the new directors referenced in paragraph B.1.a. will be appointed to the Audit Committee.

c. Creation of Regulatory Compliance Committee. No later than the Governance Implementation Date, the Board of Directors shall establish a new standing committee that shall consist of the two new directors and three existing independent directors, the "Regulatory Compliance Committee". The responsibilities of the Regulatory Compliance Committee shall include monitoring and reporting to the Board of Directors regarding the Parent Company and its subsidiaries' compliance with applicable laws concerning market conduct, Title I of ERISA, and the Companies' compliance with the Plan, along with such other matters as may be authorized or delegated by the Board of Directors to assist the Board in the discharge of its fiduciary duties and responsibilities.

d. Creation of Regulatory Compliance Unit. No later than the Implementation Date, the Parent Company shall form a new Regulatory Compliance Unit of officers or employees of the Parent Company or its subsidiaries who shall not be members of the Claim Reassessment Unit discussed below. The Regulatory Compliance Unit shall report directly to the Regulatory Compliance Committee (or to the Board of Directors until such Committee is appointed) with respect to all market-conduct matters and ERISA requirements. The responsibilities of the Regulatory Compliance Unit shall include (i) monitoring compliance with applicable laws concerning market conduct and ERISA requirements, (ii) monitoring compliance with the Plan (including the functions of the Claim Reassessment Unit) through the performance of periodic audits, (iii) providing assistance to claimants upon request that will ease and facilitate the claim submission process, and (iv) gathering data to facilitate the Lead Regulators' and the DOL's ongoing monitoring of the Companies' compliance with the Plan. The Regulatory Compliance Unit shall be managed by an officer who is an experienced insurance professional, whose experience includes compliance related matters. Employees of the

Parent Company and all of its subsidiaries shall be provided with a toll free hotline number to confidentially report concerns respecting claim handling, such reports to be provided to the manager of the Regulatory Compliance Unit. Claimants shall be provided with a toll free hotline number for assistance throughout the claim handling process, the performance of which will be monitored by the Regulatory Compliance Unit. A log of all telephone calls to both hotline numbers shall be maintained, and quarterly reports concerning such logs shall be provided to the Regulatory Compliance Committee.

e. Quarterly Board Committee and Management Meetings with Lead Regulators and the DOL. During each calendar quarter beginning with the regular quarterly meeting of the Board of Directors following the Governance Implementation Date, the Regulatory Compliance Committee and the management of the Company shall each meet separately with the Lead Regulators to evaluate compliance with the Plan. The DOL shall receive notice of these quarterly meetings and may attend as it deems appropriate. The Lead Regulators shall update Participating Regulators concerning these meetings through the NAIC on a quarterly basis.

2. Claim Reassessment Process

a. Formation of Claim Reassessment Unit. Thirty (30) days after approval of this Agreement by the Company, the Lead Regulators, the DOL and no less than two-thirds of the Participating States in the Multistate Examination, unless a lesser number is agreed to by the Companies (and assuming approval of substantially identical regulatory settlement agreements between Unum and Revere and their respective domiciliary regulators, and the execution of a substantially identical regulatory settlement agreement between the New York subsidiary, the New York Superintendent of Insurance and the Lead Regulators) (the "Implementation Date"),

the Company shall form a claim reassessment unit staffed with experienced claim representatives to handle further review of previously denied or terminated individual and group long term disability claims that are resubmitted under this paragraph (the "Claim Reassessment Unit"). The Claim Reassessment Unit shall be managed by an experienced claim manager and shall report to the most senior executive in charge of claim operations. The Claim Reassessment Process, unit structure and operating procedures of the Claim Reassessment Unit, developed in consultation with and approved by the Lead Regulators and the DOL, are described in Exhibit 1 attached hereto. Staffing of the Claim Reassessment Unit shall be adjusted appropriately from time to time so that claim decisions are made in a timely manner in accordance with the operating procedures set forth in Exhibit 1.

b. Implementation of Claim Reassessment Process. Beginning earlier and ending no later than the fifteenth business day following the Implementation Date, the Companies shall mail a notice (in the form of Attachment A-1 to Exhibit 1) to all of the Specified Claimants advising that they may resubmit their claim for further review by the Claim Reassessment Unit established for that purpose. "Specified Claimant" means any claimant of one of the Companies or any claimant of the New York subsidiary, who presented a claim for group or individual long term disability benefits, and whose claim was denied or whose benefits were terminated on or after January 1, 2000 and prior to the Implementation Date for reasons other than the following: (i) death of the claimant, (ii) claim was withdrawn, (iii) claimant did not satisfy the elimination period, or (iv) maximum benefits were paid, and also excludes (x) a claimant who had his or her claim resolved through litigation or settlement, or (y) a claimant who has pending litigation against the Company challenging the denial or termination of his or her claim, which lawsuit was filed after the date of receipt of notice of the Claim Reassessment

Process or a claimant whose lawsuit was filed prior to the date of receipt of notice of the Claim Reassessment Process in which lawsuit there has been a verdict or judgement on the merits prior to completion of the reassessment on the claim. Specified Claimants whose claims were denied or benefits terminated due to a return to work shall receive a special notice in the form of Exhibit 1, Attachment A-2 . The Claim Reassessment Process will be available to:

1. Any of the Specified Claimants who elect to participate within the time period set forth in Exhibit 1; and

2. Any other group or individual long term disability claimant of one of the Companies (or of the New York subsidiary) whose claim was denied or whose benefits were terminated prior to January 1, 2000 and who requests participation in the Claim Reassessment Process, provided that any such denial or termination of benefits took place no earlier than January 1, 1997 and the claimant would otherwise be included with the definition of "Specified Claimant" except for the application of the January 1, 2000 date; and

3. Any other group or individual long term disability claimant of one of the Companies (or of the New York subsidiary) whose claim was denied or whose benefits were terminated on or after January 1, 1997 and prior to the Implementation Date, who disputes the Companies' characterization on any rational basis that such denial or termination falls into any of the reasons outlined in (i) – (iv) of the definition of "Specified Claimant" and who requests to participate in the Claim Reassessment Process.

Any claimant who requests to participate pursuant to subparagraphs 2. or 3. above shall be referred to herein as a "Requesting Claimant". The initial notice will inform each Specified Claimant (i) how to communicate to the Company his or her election to participate and the time period in which to respond, (ii) that he or she will be sent an acknowledgement of their election

to participate, (iii) that the Claim Reassessment Process will review claims based on the original dates of their closure or denial with the oldest claims being reviewed first, (iv) that after electing to participate, a subsequent notice (Attachment B to Exhibit 1) will be sent at a time that is closer to the period when his or her claim will be reviewed indicating the approximate time period of that review and seeking information on a Reassessment Information Form (Attachment C to Exhibit 1) to support the Claim Reassessment, and (v) that receipt of a completed Reassessment Information Form will be acknowledged, and (vi) that by electing to have his or her claim reassessed, the claimant conditionally agrees to forego the pursuit of a legal action as specified in paragraph B.2.d. The phased approach to review and follow up notices are intended to provide Specified Claimants and Requesting Claimants who elect to have their claim reviewed a better indication of the timing of that review and when to expect a decision. In conducting all reviews, including but not limited to reviews conducted pursuant to the Claim Reassessment Process, the Companies must give significant weight to evidence of an award of Social Security disability benefits as supporting a finding of disability, unless the Companies have compelling evidence that the decision of the Social Security Administration was (i) founded on an error of law or an abuse of discretion, (ii) inconsistent with the applicable medical evidence, or (iii) inconsistent with the definition of disability contained in the applicable insurance policy. The Company shall maintain its records so that the filing and results of the Claim Reassessment Process may be tracked on a state-by-state basis as well as on a group basis.

4. The Company commits to use its best efforts to complete the Claim Reassessment Process by December 31, 2006, although, for good cause shown, the Lead Regulators and the DOL may agree to extend the time for completing that process.

c. Monitoring of Claim Reassessment Process. The Regulatory Compliance Unit shall conduct or cause to be conducted ongoing audits of the Claim Reassessment Process and report its findings to the Regulatory Compliance Committee, the Lead Regulators, the DOL and senior management at least quarterly. The Lead Regulators shall monitor the Claim Reassessment Process and shall conduct examinations of the Claim Reassessment Unit decisions in the manner and at such intervals as they deem appropriate. The DOL may monitor the Claim Reassessment Process and conduct examinations of the Claim Reassessment Unit as it deems appropriate. The results of the internal audits directed by the Regulatory Compliance Unit and the reviews of claim reassessment decisions directed by the Lead Regulators will be reviewed at the quarterly meetings contemplated by paragraph B.1.e. above in order to specifically evaluate the ongoing performance of the Claim Reassessment Process. Any cases reported by the Regulatory Compliance Unit or by the Lead Regulators at the quarterly meetings that have not resolved an identified potential error or claim handling practice that is non-compliant will be promptly addressed by further review of the Claim Reassessment Unit and reported on at the next quarterly meeting. The Lead Regulators shall meet quarterly with the Regulatory Compliance Committee and senior management of the Companies to review the status of the Claim Reassessment Process. The DOL shall receive notice of these meetings and may attend as it deems appropriate.

d. Effect on Litigation. This Agreement neither imposes any obligations upon, nor takes away any rights of, any claimant who chooses not to resubmit for reassessment his or her previously denied or terminated claim for benefits. Rather, the purpose of the Claim Reassessment Process provided for under this Agreement is to offer an entirely optional method for claimants who wish to have their claims reassessed under these procedures. If a claimant

does decide to resubmit his or her claim for reassessment, however, then the Company may require such claimant to agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, then such claimant shall not pursue any legal action to the extent (and only to the extent) such action is based on any aspect of the prior denial or termination that is reversed or changed. If the Company does so require, then any applicable statutes of limitations shall be tolled during the pendency of the Claim Reassessment Process. A copy of this Agreement shall be the only evidence required of such tolling. If a claimant has pending litigation against the Company, is eligible under this Agreement to participate in the Claim Reassessment Process and decides to resubmit his or her claim for reassessment, then the Company may require the claimant to (i) take such action as is necessary to stay such litigation pending the Claim Reassessment Process, if the court will agree to such a stay, and (ii) agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, then such claimant shall withdraw any litigated claim, including any extra-contractual claims, to the extent (and only to the extent) such claims are based on any aspect of the prior denial or termination that is reversed or changed. That is, to the extent that following the reassessment there remains a complete or partial denial of benefits, a claimant's right to initiate or continue litigation regarding that portion of the prior denial that has not been reversed or changed shall not be waived. As to any such claimant in whose litigation a final verdict or judgement is entered prior to completion of the claimant's reassessment, the Company's obligation to conduct and/or complete the Claim Reassessment Process pursuant to this Agreement shall cease.

3. Changes in Claim Organization and Procedures

a. Changes in Claim Organization. The Company's claim organization shall include the following ongoing objectives:

- (i) Engagement of experienced claim personnel at the earliest stage of reviewing a claim;
- (ii) Increased emphasis upon claim staff accountability for compliance with the terms of insurance policies and applicable law;
- (iii) Increased involvement of higher levels of management in claim denial and benefit termination decisions through approval requirements;
- (iv) Creation of a separate compliance-accountability function at the claim denial and benefit termination level focusing on compliance, documentation, accountability for compliance, whether the claimant has been treated fairly under the circumstances, and any action that may be construed as an instance of an improper claim practice.

No later than the Implementation Date, the Company shall implement changes to its claim organization consistent with the foregoing objectives and developed in consultation with the Lead Regulators and the DOL as described in Exhibits 2 and 3 hereof.

b. Communications with Appeals Personnel. Company personnel (including but not limited to claims handling personnel) shall not interfere with nor attempt in any way to influence other Company personnel involved with the separate appeal process following denial of benefits or termination of any claim.

c. Changes in Claim Procedures. The Company's claim procedures shall include the following ongoing objectives:

- (i) Increased focus on policies and procedures relating to medical and related evidence, including but not limited to the following:
 - Obtaining complete medical records needed for the decision;
 - Appropriate use and consideration of in-house medical resources;

- Contacting an Attending Physician (“AP”) where circumstances warrant and fairly interpreting or applying information from the claimant’s AP;
 - Obtaining a field visit where circumstances warrant;
 - Conducting an occupational review, as appropriate;
 - Obtaining an Independent Medical Evaluation (“IME”) or Functional Capacity Evaluation (“FCE”) in appropriate circumstances and fairly interpreting or applying the IME or FCE , without any attempt to influence the impairment determinations of professionals conducting the IME and/or FCE;
- (ii) Clear and express notice to claimants of the information to be provided by the claimants and the information to be collected by the Company. If a file is determined to lack specific information, Company personnel will work with claimant to obtain such information in accordance with appropriate procedures established for such purposes.

No later than the Implementation Date, the Company shall implement changed claim procedures consistent with the foregoing objectives developed in consultation with the Lead Regulators and the DOL as described in Exhibits 4, 5, 6, and 7 hereto.

d. Selection of Evaluation Personnel. The Company shall select individuals to conduct IMEs or FCEs solely on the basis of objective, professional criteria, and without regard to results of previous IMEs or FCEs conducted by such individuals.

e. Professional Certification. Each clinical, vocational and medical professional employed by the Company must execute the “Statement Regarding Professional Conduct” found at Exhibit 5, which includes a commitment to provide fair and reasonable evaluations considering all available medical, clinical, and/or vocational evidence, both objective and subjective, bearing on impairment. In addition, for each determination as to a claimant’s impairment(s), each clinical, vocational and medical professional who makes a determination as to claimant impairments must certify that he or she has reviewed all medical, clinical and vocational evidence provided to that professional by Company personnel bearing on the

impairment for which such professional is trained prior to making a determination as to such impairments.

f. Providing Medical, Clinical and/or Vocational Evidence. Claim personnel, in soliciting evaluations of claimant impairment by clinical, vocational and medical professionals (employed by the Company or otherwise), shall provide to such professionals all available medical, clinical and/or vocational evidence in the claim file, both objective and subjective, concerning impairment.

g. Claims involving co-morbid conditions. (i) When multiple conditions or co-morbid conditions are present, Company personnel will ensure that all diagnoses and impairments are considered and afforded appropriate weight in developing a coherent view of the claimant's medical condition, capacity and restrictions/limitations. (ii) No later than the Implementation Date, the Companies will implement improved procedures for evaluating claims which involve multiple or co-morbid conditions in accordance with Exhibit 4 hereto and subparagraph (i) above.

h. Training. No later than March 1, 2005, substantially all employees in the Company's claim operations shall be provided appropriate training designed to educate them on the responsibilities arising from the changes in claim procedures included in paragraph B.3 of this Agreement with emphasis on concerns raised in the Multistate Examination and the corrective measures set forth in the Plan. This training will include specific instruction on the following: (i) Company personnel should recognize the special function that medical professionals perform in assessing medical information concerning claimants and should not attempt to influence an in-house physician or an IME or FCE in connection with such professional's opinion concerning the medical evidence or medical condition relating to a

claimant, and (ii) Company personnel in claim handling positions will be evaluated and will be eligible for incentive compensation only on the basis of the quality of performance in the position each holds, and the outcome of any claim decision or any number of claim decisions is not permitted as a part of this evaluation or award of incentive compensation. The Company hereby confirms that it shall not measure the performance of claim personnel or otherwise incentivize their performance, or deny or close specific claims based on claim denial or closure targets. Not later than March 1, 2005, all group policyholder human resources staff shall be offered appropriate training alternatives designed to help them support employee-claimants in making claims.

i. Monitoring of Compliance with Revised Claim Procedures. The Lead Regulators shall monitor compliance with the changes in claim procedures set forth in paragraphs B.3.b. through B.3.g. above and may conduct examinations of claims in the manner and at such intervals as the Lead Regulators deem appropriate. The DOL may monitor compliance with changes in claim procedures set forth in paragraphs B.3.b. through B.3.g above and may conduct examinations of claims in the manner and at such intervals as the DOL deems appropriate. The examinations of claims will include but not be limited to review of claim files for the following problems, including failure to:

- Conduct a field visit where circumstances warrant;
- Obtain complete medical records;
- Fairly interpret or apply information from the claimant's AP;
- Use appropriate in-house medical resources;
- Fairly interpret or apply in-house medical opinions;
- Contact AP where circumstances warrant;
- Conduct appropriate occupational review;
- Obtain an IME or FCE where circumstances warrant;
- Select individuals to conduct IMEs and FCEs solely on the basis of objective, professional criteria, and without regard to results of previous IMEs or FCEs;
- Fairly interpret or apply IME or FCE results;

- Appropriately classify disabilities under the mental and nervous limitation provisions of its policies; or
- Follow Company claim procedures or other Company procedures.

Claim files will also be examined for evidence of:

- Reliance on lack of “objective” data or “objective” medical information as a basis for claim denial or termination of benefits;
- Faulty or overly restrictive interpretation or application of policy provisions, including the definition of “occupation” in “own occupation” policies;
- Actions suggesting a pre-disposition or bias against the claimant;
- Threats to seek repayment of past benefits;
- Forcing claimants to seek legal counsel to obtain benefits; or
- Evidence of any incentives provided to deny or terminate benefits.

j. Standard for Compliance. The Company shall be deemed in compliance with the Handbook’s maximum tolerance standard for claim procedures (presently 7%) unless the collective number of claim files with errors for the Company and its affiliated companies executing substantially similar agreements as of this date (the “Group”) results in an error rate that exceeds such maximum tolerance standard. Such error rate(s) shall be determined by the Lead Regulators’ review of separate statistically credible random samples of the total files for the Group’s long term *group* and *individual* disability income insurance claims denied or benefits terminated on or after the Implementation Date, in accordance with paragraph B.3.i above. Separate Group error rates shall be determined for the Group’s long term: (i) group disability income claims; and, (ii) individual disability income claims.

k. Opportunity for Review and Comment. The Companies shall be entitled to review and comment on any such examination results in accordance with the provisions of the Handbook.

l. Claim Files. A claim file shall include all documents relating to a claim history and/or decision, including but not limited to correspondence, medical records, vocational records, forms, internal memoranda and internal communications (including e-mail

communications), which shall be maintained in the claim file either in a paper file, or in electronic form in the case of the Companies' offices which operate in a "paperless" environment. The Lead Regulators and the DOL shall have access to all such paper or electronic files at all times. All claims reassessments pursuant to Paragraph B.2. and all new claim reviews pursuant to Paragraph B.3. shall be based upon a review of the entire claim file.

C. Other Provisions

1. This Agreement shall be governed by and interpreted according to laws of the State of Tennessee, excluding its conflict of laws provisions, and any applicable federal laws.

2. It is expected that the Lead Regulators, on behalf of and for the benefit of the Participating Regulators, will monitor the Company's compliance with this Agreement and any Consent Order to which it is attached. The DOL may also monitor the Company's compliance with this Agreement and any consent Order to which it is attached. It is further expected that the Lead Regulators, on behalf of and for the benefit of the Participating Regulators, will conduct a full re-examination of the issues addressed by the Multistate Examination within twenty-four months after the Implementation Date and make all reasonable efforts to complete such re-examination within six months of its commencement. The DOL also reserves the right to conduct further investigation as it deems appropriate.

3. The reasonable costs of the Lead Regulators in monitoring the Company's compliance with this Agreement, including the cost of conducting any reviews or examinations provided for by the Agreement, shall be paid by the Company.

4. This Agreement is being made in conjunction with the entry of related Consent Orders arising from the Multistate Examination, and it shall be implemented and administered harmoniously with those Consent Orders.

5. a. The Lead Regulator shall deliver this Agreement to each of the Participating States within five (5) days following its execution by the Company, the DOL and the Lead Regulator.

b. Each person signing on behalf of a Participating State gives his/her express assurance that under applicable state laws, regulations and judicial rulings, that the person has the authority to enter into this Agreement on behalf of the Participating State.

c. Each Participating Regulator shall execute and deliver this Agreement to the Lead Regulator within thirty (30) days following the receipt of this Agreement from the Lead Regulator. If a Participating Regulator finds that, under applicable state law, regulation or procedure, the preparation and execution of a consent order is necessary to carry out the terms of this Agreement, such a consent order (the "Applicable Consent Order") shall be prepared by such Participating Regulator within thirty (30) days following the receipt of this Agreement from the Lead Regulator. The Lead Regulators may waive the thirty (30) day period for Participating Regulators to execute this Agreement.

d. For purposes of this Agreement, an "Applicable Consent Order" shall be satisfactory to the Company if it: (i) incorporates by reference and attaches via exhibit a copy of this Agreement, (ii) expressly adopts and agrees to the provisions of this Agreement, and (iii) includes only those other terms that may be legally required in the state of the applicable Participating Regulator. However, nothing in this Agreement shall be construed to require any state to execute and deliver an Applicable Consent Order if such state elects instead to sign this Agreement.

6. Within ninety (90) days of the Implementation Date, the Company will send a letter to the Plan Administrator of each ERISA-covered plan as to which any of the Companies

provided group long term disability insurance coverage between January 1, 1997 and December 31, 1999, indicating that the Agreement is available on the Parent Company's website and making particular reference to Section B.2.b.

7. Time is of the essence in implementing the provisions of this Agreement, and the times specified may only be extended for good cause and with the advance written consent of the Lead Regulators, but such consent of the Lead Regulators shall not be unreasonably withheld.

8. A decision by the Lead Regulator in this Agreement means a decision that has been agreed to by all three of the Lead Regulators under this Agreement and substantially identical agreements referred to in the Recitals.

9. This Agreement shall remain in effect until the later of (i) January 1, 2007; (ii) the substantial completion of review by the Claim Reassessment Unit of claims for which review has been requested by Specified Claimants and Requesting Claimants and information needed for the review has been submitted on a timely basis; or (iii) the completion of the full re-examination referenced in paragraph C.2. Except as set forth in paragraph C.10 below, this Agreement and its provisions terminate for all purposes pursuant to this paragraph C.9.

10. Notwithstanding the termination of this Agreement to the extent provided in accordance with paragraph C.9 above:

(i) This Agreement shall survive as to the following provisions, which also individually survive: paragraphs -- B.2.b.3 (insofar as it relates to the consideration to be given Social Security disability awards); B.3.a (insofar as it establishes objectives for the Company's claim organization); B.3.b; B.3.c. (insofar as it establishes objectives for the Company's claim procedures); B.3.d; B.3.e; B.3.f; B.3.g. (insofar as it establishes objectives regarding evaluation of claims with co-morbid conditions); B.3.h (insofar as it confirms that claim personnel

performance shall not be measured based on claim denial or termination targets or that claims will be closed based on termination or denial targets); B.3.1 (insofar as it describes the content of a claim file).

(ii) The foregoing surviving obligations of the Company may only be amended by obtaining the consent of the Lead Regulators (acting in accordance with paragraph C.8), two-thirds of the Participating Regulators and the DOL, to any such amended provision: and,

(iii) Following termination of this Agreement for purposes of paragraph C.9 above, the Company will not materially change the claim procedures described in Exhibits 4, 5, 6 and 7 hereto unless (1) it first notifies the Lead Regulators and the DOL thirty days in advance of the proposed change and (2) the Lead Regulators and the DOL, within ten days of receipt of such notice, do not reasonably object.

11. Neither this Agreement nor any related negotiations, statements or court proceedings shall be offered by the Company, the Lead Regulator, the DOL or the Participating Regulators as evidence of or an admission, denial or concession of any liability or wrongdoing whatsoever on the part of any person or entity, including but not limited to the Company, the Companies or the Parent Company, or as a waiver by the Company, the Companies or the Parent Company of any applicable defense, including without limitation any applicable statute of limitations or statute of frauds, except as set forth in B.2.d. of this Agreement.

12. The Company does not admit, deny or concede any actual or potential fault, wrongdoing or liability in connection with any facts or claims that have been or could have been alleged against it, but considers it desirable for this matter to be resolved because this Agreement will provide substantial benefits to the Company's present and former policyholders and insureds.

13. Neither this Agreement nor any of the relief to be offered under this Agreement shall be interpreted to alter in any way the contractual terms of any policy, or to constitute a novation of any policy. Neither this Agreement nor any relief to be offered under this Agreement shall be interpreted to reduce or increase any rights of participants in ERISA-covered plans, including but not limited to rights to which they may be entitled pursuant to ERISA 29 U.S.C. 1133, and 29 C.F.R. 2560.503-1, including any appeal or review rights under the plan. Other than those rights afforded under this Agreement, no additional rights are provided to the extent that any Specified Claimants or Requesting Claimants have previously exercised their rights as mentioned in this paragraph 13 (or have failed to exercise their rights and therefore, as provided for under ERISA, have permitted those rights to lapse).

14. The effectiveness of this Agreement is conditioned upon the following:

(i) approval and execution of the Agreement by the Company, the Lead Regulators and the DOL, (ii) approval and execution of the Agreement by appropriate documentation of no less than two-thirds of the Participating States unless a lesser number is agreed by the Company, (iii) approval and execution of substantially identical regulatory settlement agreements between each of the other two insurance companies that come within the definition of Companies and their respective domiciliary regulators, and (iv) the approval and execution of a substantially identical regulatory settlement agreement between the New York subsidiary, the New York Superintendent of Insurance and the Lead Regulators.

15. During the pendency of this Agreement, each of the Participating Regulators agrees that such Participating Regulator and his or her insurance department (i) will not conduct a market conduct examination of the Companies relating to the Model Act, and (ii) will not impose a fine, injunction or any other remedy on any of the Companies for any of the matters

that are the subject matter of this Agreement and may only participate on terms set forth in this Agreement in any fine or remedy that may be imposed under this Agreement . Notwithstanding the foregoing, upon notice from any Participating Regulator to the Lead Regulators, the Participating Regulator and the Lead Regulators shall proceed to investigate an assertion of the Company's non-compliance herewith regarding residents of said Participating Regulator's state.

16. This Agreement (or its Exhibits and their Attachments) may be amended by the Lead Regulators, the DOL and the Company without the consent of any Participating Regulator, provided that any such amendment does not materially alter this Agreement. Any amendment to the terms of the Agreement (or to its Exhibits and their Attachments) which would affect the regulatory authority of any Participating Regulator(s) shall not become effective without the consent of such Participating Regulator(s). All such amendments to this Agreement shall be in writing.

17. The DOL may enter into arrangements or agreements with any of the Lead Regulators or Participating Regulators pursuant to Section 506 of ERISA, 29 U.S.C. Section 1136, for cooperation, mutual assistance, or use by the DOL of facilities or services in connection with monitoring compliance with the Agreement and Title 1 of ERISA (including 29 C.F.R. Section 2560.503-1) and receiving reports on activities undertaken in connection with this Agreement. To the extent the Secretary enters into such an arrangement or agreement with any of the Lead Regulators or Participating Regulators, the Company shall provide reimbursement for any expenses incurred pursuant to C.3 of this Agreement.

18. For the duration of this Agreement, if any Lead Regulator or Participating Regulator finds any information which it believes constitutes a violation of ERISA with respect

to any employee benefit plan, such regulator shall report that information to the DOL as soon as practicable.

D. Remedies

1. In the event that the Group fails to implement all of the changes in corporate governance provided for in paragraph B.1. of this Agreement within the times specified in that paragraph, the Group shall pay a fine of \$100,000 per day until the failure of compliance is cured; provided, however, the Group will not be deemed to be non-compliant with the time requirements of paragraph B.1. if the Lead Regulators have not approved both of the candidates proposed by the Board of Directors to become new directors.

2. In the event that the Group fails to implement the Claim Reassessment Process provided for in paragraph B.2. of this Agreement within the times specified in that paragraph, the Group shall pay a fine of \$100,000 per day until the failure of compliance is cured.

3. In the event that the Group fails to provide the initial notice to Specified Claimants within the period set forth in Exhibit 1, the Group shall pay a fine of \$100,000 per day until the failure of compliance is cured.

4. In the event that the Group fails to implement the changes to the claim organization or the changes to the claim procedures provided for in paragraph B.3.a., paragraph B.3.c. or paragraph B.3.g. within the times specified therein, the Group shall pay a fine of \$100,000 per day until the failure of compliance is cured.

5. In the event that the Group fails to conduct the training provided for in paragraph B.3.h. within the time specified therein, the Group shall pay a fine of \$100,000 per day until the failure of compliance is cured.

6. Upon material completion of the Claim Reassessment Process, should the Lead Regulators upon examination determine that claim reassessment decisions were made in a manner inconsistent with the procedures of the Claim Reassessment Unit, the Group shall pay a fine of \$145,000,000. The Group shall be deemed in compliance with the Handbook's maximum tolerance standard for claim procedures (presently 7%) unless the number of claim files with errors results in an error rate for either their collective subject *group* or *individual* claims hereunder that exceeds such maximum tolerance standard. Such error rates shall be determined by the Lead Regulators based on a review of statistically credible random separate samples of each of the *group* and *individual* claim reassessment decisions for the Group. A total fine of \$145,000,000 shall be payable under this paragraph and/or paragraph D.7, but not both, in the event that the error rate exceeds the maximum tolerance standard for either or both of the *group* and/or *individual* claim samples. The Lead Regulators will use their best efforts to complete this determination by July 1, 2007.

7. Upon completion of the examination described in paragraph C.2, should the Lead Regulators determine that claims denied or benefits terminated after the Implementation Date did not meet the standard for compliance set forth in paragraph B.3.j, the Group shall pay a fine of \$145,000,000. Such error rates shall be determined by the Lead Regulators based on review of a statistically credible random separate sample of each of the *group* and *individual* subject claims denied or benefits terminated after the Implementation Date. A total fine of \$145,000,000 shall be payable under this paragraph and/or paragraph D.6, but not both, in the event that the number of claim files with errors results in an error rate that exceeds the maximum tolerance standard for either or both of the *group* and/or *individual* claim samples. The Lead Regulators will use their best efforts to complete this examination by July 1, 2007.

8. The purpose of any fines imposed pursuant to paragraphs D.1 through D.5 is to encourage timely implementation of the matter set forth in each paragraph.

9. Within fifteen (15) days of being advised in writing by the Lead Regulators that the required two-thirds of Participating States have approved and consented to this Agreement (unless the Company consents to a lower number) and the other conditions of effectiveness set forth in paragraph C.14 having been satisfied, the Group shall pay to the Lead Regulators a fine of \$15,000,000.

10. In addition to the other penalties applicable pursuant to this Agreement, and notwithstanding the error rate threshold, the Lead Regulators and Participating Regulators retain the right to impose any regulatory penalty otherwise available by law, including fines, with respect to the Company's willful violation of the terms of this Agreement or other violation of law.

11. The obligation, as among the individual Company members of the Group, to pay any such fines shall be equal to the proportional capital and surplus of each Company to the Group's obligation, such calculation to be based on the most recently filed NAIC financial statement of each such Company.

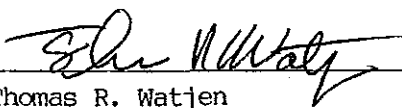
12. All fines paid under the foregoing subparagraphs shall be paid to the Lead Regulators and then allocated among the Lead Regulators and all Participating Regulators on the basis of the Company's premium volume for in-force policies of individual and group disability insurance as of December 31, 2003.

13. The Lead Regulators, the DOL and the Participating Regulators reserve the right to pursue any other remedy or remedies for violations of this Agreement. Nothing in this

Agreement shall be construed to waive or limit the rights of the Lead Regulators, the DOL and the Participating Regulators to seek such other and additional remedies.

14. The enforcement of any fine imposed hereunder and the findings upon which any such fine are based shall be subject to judicial review as otherwise provided by law.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
PROVIDENT LIFE AND CASUALTY INSURANCE COMPANY

BY:  _____
Thomas R. Watjen

THEIR: ~~President and Chief Executive Officer~~

November 18, 2004

TENNESSEE DEPARTMENT OF COMMERCE
AND INSURANCE

BY: _____
Paula A. Flowers, Commissioner

November __, 2004

MAINE BUREAU OF INSURANCE

BY: _____
Alessandro A. Iuppa, Superintendent

November __, 2004

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____
Julianne M. Bowler, Commissioner

November __, 2004

Agreement shall be construed to waive or limit the rights of the Lead Regulators, the DOL and the Participating Regulators to seek such other and additional remedies.

14. The enforcement of any fine imposed hereunder and the findings upon which any such fine are based shall be subject to judicial review as otherwise provided by law.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
PROVIDENT LIFE AND CASUALTY INSURANCE COMPANY

BY: _____

THEIR: _____

November __, 2004

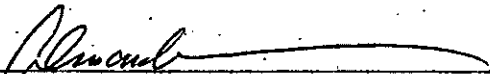
TENNESSEE DEPARTMENT OF COMMERCE
AND INSURANCE

BY: _____

Paula A. Flowers, Commissioner

November __, 2004


MAINE BUREAU OF INSURANCE

BY:  _____

Alessandro A. Iuppa, Superintendent

November 12, 2004

MAINE OFFICE OF THE ATTORNEY GENERAL

BY:  _____

G. Steven Rowe, Attorney General

November 17, 2004

Agreement shall be construed to waive or limit the rights of the Lead Regulators, the DOL and the Participating Regulators to seek such other and additional remedies.

14. The enforcement of any fine imposed hereunder and the findings upon which any such fine are based shall be subject to judicial review as otherwise provided by law.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
PROVIDENT LIFE AND CASUALTY INSURANCE COMPANY

BY: _____

THEIR: _____

November __, 2004

TENNESSEE DEPARTMENT OF COMMERCE
AND INSURANCE

BY: _____

Paula A. Flowers, Commissioner

November __, 2004

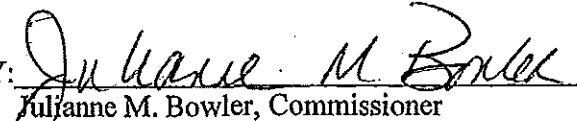
MAINE BUREAU OF INSURANCE

BY: _____

Alessandro A. Iuppa, Superintendent

November __, 2004

MASSACHUSETTS DIVISION OF INSURANCE

BY: 
Julianne M. Bowler, Commissioner

November 18, 2004

Agreement shall be construed to waive or limit the rights of the Lead Regulators, the DOL and the Participating Regulators to seek such other and additional remedies.

14. The enforcement of any fine imposed hereunder and the findings upon which any such fine are based shall be subject to judicial review as otherwise provided by law.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
PROVIDENT LIFE AND CASUALTY INSURANCE COMPANY

BY: _____

THEIR: _____

November __, 2004

TENNESSEE DEPARTMENT OF COMMERCE
AND INSURANCE

BY: Paula A. Flowers
Paula A. Flowers, Commissioner

November 18, 2004

MAINE BUREAU OF INSURANCE

BY: _____
Alessandro A. Iuppa, Superintendent

November __, 2004

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____
Julianne M. Bowler, Commissioner

November __, 2004

ELAINE L. CHAO
SECRETARY OF LABOR

ANN L. COOMBS
ASSISTANT SECRETARY
EMPLOYEE BENEFITS SECURITY ADMINISTRATION

BY: 

James M. Berages
Regional Director
Employee Benefits Security Administration

November 18, 2004

Post Office Address:

U.S. Department of Labor
Employee Benefits Security Administration
JFK Federal Building, Room 575
Boston, MA 02203
TEL:(617)565-9600
FAX:(617)565-9666

PARTICIPATING REGULATOR ADOPTION

On behalf of [Insert the State and Insurance Regulatory Agency], I, [Insert name of insurance regulatory official executing the Agreement], hereby adopt, agree and approve this Agreement.

[NAME OF INSURANCE REGULATORY AGENCY]

BY: _____
[Title of Regulator]

November __, 2004

EXHIBIT 1

CLAIM REASSESSMENT PROCESS, UNIT STRUCTURE AND OPERATING PROCEDURES

Exhibit 1 is responsive to Paragraph B.2.a of the Regulatory Settlement Agreement

I. Purpose

In accordance with the Regulatory Settlement Agreements (the "Agreements") entered into by Unum Life Insurance Company of America, The Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, the Lead Regulators and Participating Regulators, and the U.S. Department of Labor, and in accordance with a substantially identical regulatory settlement agreement entered into by First Unum Life Insurance Company, the New York Superintendent of Insurance, the Lead Regulators and the United States Department of Labor, a Claim Reassessment Process (the "Reassessment Process") and a Claim Reassessment Unit (the "CRU") have been established. This document describes the Reassessment Process and the structure and operating procedures of the CRU. Unum Life Insurance Company of America, The Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, First Unum Life Insurance Company and Provident Life and Casualty Insurance Company shall be referred to herein as "the Companies".

II. Reassessment Process

- a. **Specified Claimant:** "Specified Claimant" is defined in Paragraph B.2.b. of the Agreements.
- b. **Initial Notice to Specified Claimants:** Beginning earlier and ending no later than the fifteenth business day following the Implementation Date under the Agreements, the Companies will mail an Initial Notice to Specified Claimants advising them that they may have their claim reassessed by the CRU. The Initial Notice will be dated no earlier than the date that it is posted in the mail. Specified Claimants electing to participate must respond to the Initial Notice within 60 days of the date of the Initial Notice. The form of notices are set forth in Attachment A-1 and Attachment A-2 to this Exhibit. With respect to any Specified Claimants whose mailed notice is returned as undeliverable, the Companies shall use reasonable efforts to obtain a more recent address through appropriate means to locate individuals including additional letter-forwarding services offered by the United States Postal Service, the Internal Revenue Service and Social Security Administration and the date for response shall be adjusted accordingly.
- c. **Acknowledgement:** Specified Claimants who respond that they would like their claim reassessed (a "Confirmed Claimant") will have their response acknowledged in writing within 30 days of receipt of the response.

- d. **Reassessment Information Form:** Prior to the date when the CRU will begin reassessing a Confirmed Claimant's claim, the Confirmed Claimant will be sent a letter stating the approximate time for review of his or her claim. The Confirmed Claimant will also receive a Reassessment Information Form requesting information to support the reassessment of the claim in question. All Reassessment Information Forms must be returned within 60 days of the date of cover letter to the Reassessment Information Form, which will also be a date that is no earlier than the date the letter is posted in the mail, in order to be considered by the CRU, unless the Confirmed Claimant requests in writing an extension and explains why such an extension is needed. The cover letter is set forth as Attachment B to this Exhibit and the Reassessment Information Form is set forth in Attachment C to this Exhibit.
- e. **Acknowledgement:** Confirmed Claimants who return their Reassessment Information Forms will be sent an acknowledgement of the receipt of the completed form within 30 days of its receipt or a request for specific information needed to complete the form in order for the CRU to review the claim.
- f. **Requesting Claimants:** "Requesting Claimants" means (i) those claimants whose claims were denied or terminated prior to January 1, 2000 and no earlier than January 1, 1997 and the claimant would otherwise be included within the definition of "Specified Claimant" except for the application of the January 1, 2000 date, and (ii) those claimants whose claims were denied or terminated on or after January 1, 1997 and prior to the Implementation Date who dispute the Companies' characterization on any rational basis that such denial or termination falls into any of the reasons outlined in (i) – (iv) of the definition of "Specified Claimant" and in both cases are entitled under Paragraph B.2.b. of the Agreements to request to have their claim reassessed. Claimants who come within the definition of Requesting Claimants must make a request to the Companies within 180 days following the Implementation Date. Requesting Claimants who make a request within this time period will be provided a procedure that is essentially identical to that described in Paragraphs II. c. through II. e. above, and as otherwise generally described in this Exhibit 1 for Confirmed Claimants, except that the reassessment process for Requesting Claimants will begin after the reassessment of the Confirmed Claimants is substantially complete. The reassessment schedule for Requesting Claimants will begin with the oldest of the claims of the Requesting Claimants that were denied or terminated being reassessed first. Tracking data on Requesting Claimants will be kept separate from that of Confirmed Claimants.

III. Claim Reassessment Unit:

- a. **Structure of CRU:** The CRU will operate as a unit of the Benefit Center and will report to the most senior executive in charge of claim operations. The CRU will be staffed with personnel who have experience with group and/or individual long

term disability claims handling. Other staff available to the CRU will include clinical consultants (nurses), physicians, vocational rehabilitation specialists and attorneys. The staffing of the CRU will be based on the number of individuals needed to review and investigate, within a two year period, all requests for reassessment submitted by Confirmed Claimants.

- b. **Claim Review Schedule:** The CRU will review the claims of Confirmed Claimants based upon the date the claim was originally denied or terminated with the oldest claims being reviewed first.
- c. **Standard of Review:** The CRU will apply a de novo standard of review using the claims handling procedures, including those provided for in the Regulatory Settlement Agreement which will have been implemented as of the date of any reassessment by the CRU.
- d. **Investigation and Decision Process:** The CRU will gather any appropriate information not contained in the claim file or in information provided by the Confirmed Claimant including, but not limited to, medical, occupational and financial information. Medical analysis will involve utilizing internal and external resources as appropriate, including peer calls and independent medical examinations and will adhere to established protocols. Once a claim decision is determined, it will be reviewed by either the Manager of the CRU or a Quality Compliance Consultant, as appropriate, and communicated to the Confirmed Claimant.
- e. **Reopened Claims:** Any claim that is reopened and will require additional claim handling will be referred to the appropriate unit of claims operations.
- f. **Tracking and Reporting:** The CRU will electronically track information related to the Claim Reassessment Process. The information will include, but not be limited to:
 - i. Names of Specified Claimants and state of residence
 - ii. Date of Mailing Initial Notice to Specified Claimants
 - iii. Names of Confirmed Claimants
 - iv. Date Acknowledgement sent to Confirmed Claimants
 - v. Date Reassessment Information Form sent
 - vi. Date completed Reassessment Information Form is received.
 - vi. Beginning date for reassessment of each Confirmed Claimant's claim.
 - vii. Decision date for each reassessment.
 - viii. Outcomes of reassessment decisions.

Matters listed above that involve mailings to the claimant will be dated no earlier than the date in which they are posted in the mail. Reports will be provided to the Regulatory Compliance Unit and will be produced to reflect results on a state by state

basis using the residence of the claimant as the basis of the state for which a claim is reported as well as on a group basis.

IV. Monitoring of Claim Reassessment Process and CRU

- a. The Regulatory Compliance Unit will request that internal audits of the CRU process and decision-making be conducted on a quarterly basis, and establish a schedule of internal audits, including the number of reassessed files and other subjects to be audited. These internal audits will be conducted by the internal audit unit under guidelines approved by the Senior Vice President of the Claims Operations. The results of those audits will be provided to the Regulatory Compliance Unit for reporting to the Regulatory Compliance Committee of the Parent Company's Board of Directors, the Lead Regulators and Senior Management of the Parent Company.
- b. **Lead Regulator Review:** Decisions by the CRU and its procedures are also subject to review by the Lead Regulators and the DOL as they deem appropriate.

Exhibit 1 -- Attachment A-1

(General Notice to Claimants Eligible for Reassessment)

[Date]

[Name]
[Address]
[Address]

Re: Claim No. _____

Dear [personalized]:

As part of a multistate settlement with insurance regulators and the United States Department of Labor (the "DOL"), The Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, First UNUM Life Insurance Company and UNUM Life Insurance Company of America ("the Companies") have agreed to implement a Claim Reassessment Process, under which your long term disability claim as captioned above has been determined to be eligible. For that reason, if you believe that you may be eligible for benefits for which you have not been paid, you are entitled to request that the Companies review their previous decision to deny your disability income claim or terminate benefits being paid on such claim. The settlement with insurance regulators and the DOL sets forth the procedures under which the Companies will conduct the Claim Reassessment Process. This Process will be monitored by the insurance regulators and, as to claimants who are or were covered under an employee benefit plan, by the DOL. A copy of the Regulatory Settlement Agreement is available on the website of UnumProvident Corporation.

If you wish to elect to participate in the Claim Reassessment Process, you must do one of the following within 60 days of the date of this letter:

- Fill out and return the enclosed sheet in the envelope provided; OR
- Visit [www.unumprovident.com/\[TO BE DETERMINED\]](http://www.unumprovident.com/[TO BE DETERMINED]) with your claim number ready (provided at the top of this page); OR
- Place a toll-free call to 800.xxx.xxxx and provide your name, current address and claim number. This phone number is provided for your convenience in making your election to participate, but no other information is available currently through this special temporary line.

Your decision to participate in the Claim Reassessment Process will be acknowledged by the Companies.

The Companies will review claims of those electing to participate based on the original dates of when the claim was denied or closed with the oldest closure dates being reviewed first. The Companies will send you a second notice at a time that is closer to the period when your claim will be reviewed indicating the approximate time period of that review and requesting that you complete and return a Reassessment Information Form to provide information needed for the review of your claim.

Once you have completed and returned your Reassessment Information Form, the Companies will acknowledge its receipt and indicate any specific information that is still needed in order for the Companies to reassess your claim. Once our prior claim decision has been reassessed and any additional investigation is completed, the Companies will advise you in writing whether your claim will be re-opened and further benefits paid.

You are under no obligation to participate in the Claim Reassessment Process. Should you decide not to participate you will not lose any rights that you otherwise have. However, should you choose to participate, you will need to agree that if (and only if) the reassessment results in a reversal or other change in our prior decision denying or terminating benefits, you will not pursue legal action against the Companies to the extent (and only to the extent) such action would be based on any aspect of the prior denial or termination that is reversed or changed.

If you have already commenced legal action relating to your prior claim(s) decision, please provide a copy of this letter to your attorney as soon as possible so that he or she might advise you concerning the alternatives. If, after consulting with your attorney, you decide to participate in the reassessment, you will need to agree to take such action as is necessary to seek to stay such litigation pending the outcome of the reassessment process. If the court does not agree to a stay and a final verdict or judgement is entered prior to completion of the reassessment, the Companies will have no further obligation to reassess your claim. If the court stays the litigation relating to your claim, you will need to agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, you will withdraw and dismiss with prejudice your litigated claims, including extracontractual claims, to the extent (and only to the extent) such claims are based on any aspect of the prior denial or termination that is reversed or changed. In other words, to the extent that following the reassessment there remains a complete or partial denial of benefits, a claimant's right to initiate or continue litigation regarding that portion of the prior denial that has not been reversed or changed shall not be waived. As to any portion of a prior denial that is reversed or changed and you have agreed to withdraw the action as described above, the Companies will attempt to reach agreement with you regarding the payment of any reasonable attorney's fee to which you may be entitled under law, and if we are unable to reach such an agreement, you will not be prejudiced from pursuing such fees in a court of law. After you have discussed this with your attorney, we encourage your attorney to

contact the attorney representing the Companies to discuss these matters so that you might make an informed decision regarding participation in the reassessment process and your other alternatives.

These agreements relating to commencing legal action and any pending litigation, which will be included with the Reassessment Information Form for you to sign, will not apply to the extent that our prior decision denying or terminating benefits is not reversed as a result of the Claim Reassessment Process and any applicable statute of limitations will be tolled during the pendency of the reassessment process.

Sincerely,

[Name]

[Title]

Exhibit 1 -- Attachment A-2

(Notice to Claimants w/Claim Closure Coded as RTW)

[Date]

[Name]
[Address]
[Address]

Re: Claim No. _____

Dear [personalized]:

As part of a multistate settlement with insurance regulators and the United States Department of Labor (the "DOL"), The Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, First UNUM Life Insurance Company and UNUM Life Insurance Company of America ("the Companies") have agreed to implement a Claim Reassessment Process, under which your long term disability claim as captioned above *may* be eligible.

Our records show you returned to work and that places you in a special category relating to eligibility for the Claim Reassessment Process. If you believe your claim was *inappropriately denied or terminated* you may be eligible for benefits for which you have not been paid and are entitled to request that the Companies review their previous decision to close your claim. The settlement with insurance regulators and the DOL sets forth the procedures under which the Companies will conduct the Claim Reassessment Process. This Process will be monitored by the insurance regulators and, as to claimants who are or were covered under an employee benefit plan, by the DOL. A copy of the Regulatory Settlement Agreement is available on the website of UnumProvident Corporation.

If you wish to elect to participate in the Claim Reassessment Process, you must do one of the following within 60 days of the date of this letter:

- Fill out and return the enclosed sheet in the envelope provided; OR
- Visit [www.unumprovident.com/\[TO BE DETERMINED\]](http://www.unumprovident.com/[TO BE DETERMINED]) with your claim number ready (provided at the top of this page); OR
- Place a toll-free call to 800.xxx.xxxx and provide your name, current address and claim number. This phone number is provided for your convenience in making your election to participate, but no other

information is available currently through this special temporary line.

Your decision to participate in the Claim Reassessment Process will be acknowledged by the Companies.

The Companies will review claims of those electing to participate based on the original dates of when the claim was denied or closed with the oldest closure dates being reviewed first. The Companies will send you a second notice at a time that is closer to the period when your claim will be reviewed indicating the approximate time period of that review and requesting that you complete and return a Reassessment Information Form to provide information needed for the review of your claim.

Once you have completed and returned your Reassessment Information Form, the Companies will acknowledge its receipt and indicate any specific information that is still needed in order for the Companies to reassess your claim. Once our prior claim decision has been reassessed and any additional investigation is completed, the Companies will advise you in writing whether your claim will be re-opened and further benefits paid.

You are under no obligation to participate in the Claim Reassessment Process. Should you decide not to participate you will not lose any rights that you otherwise have. However, should you choose to participate, you will need to agree that if (and only if) the reassessment results in a reversal or other change in our prior decision denying or terminating benefits, you will not pursue legal action against the Companies to the extent (and only to the extent) such action would be based on any aspect of the prior denial or termination that is reversed or changed.

If you have already commenced legal action relating to your prior claim(s) decision, please provide a copy of this letter to your attorney as soon as possible so that he or she might advise you concerning the alternatives. If, after consulting with your attorney, you decide to participate in the reassessment, you will need to agree to take such action as is necessary to seek to stay such litigation pending the outcome of the reassessment process. If the court does not agree to a stay and a final verdict or judgement is entered prior to completion of the reassessment, the Companies will have no further obligation to reassess your claim. If the court stays the litigation relating to your claim, you will need to agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, you will withdraw and dismiss with prejudice your litigated claim, including extracontractual claims, to the extent (and only to the extent) such claims are based on any aspect of the prior denial or termination that is reversed or changed. In other words, to the extent that following the reassessment there remains a complete or partial denial of benefits, a claimant's right to initiate or continue litigation regarding that portion of the prior denial that has not been reversed or changed shall not be waived. As to any portion of a prior denial that is reversed or changed and you have agreed to withdraw the action as described above, the Companies will attempt to reach agreement with you regarding the payment of any reasonable attorney's fee to which you may be entitled under law, and if we are unable to reach such an agreement, you will not be prejudiced from pursuing such fees in a court of

law. After you have discussed this with your attorney, we encourage your attorney to contact the attorney representing the Company to discuss these matters so that you might make an informed decision regarding participation in the reassessment process and your other alternatives.

These agreements relating to commencing legal action and any pending litigation, which will be included with the Reassessment Information Form for you to sign, will not apply to the extent that our prior decision denying or terminating benefits is not reversed as a result of the Claim Reassessment Process and any applicable statute of limitations will be tolled during the pendency of the reassessment process..

Sincerely,

[Name]
[Title]

ATTACHMENT B

[Date]

[Name]

[Address]

[Address]

Re: Claim No. _____

Dear [personalized]:

You previously elected to participate in our Claim Reassessment Process with respect to the captioned claim. As we previously indicated, we are proceeding with the reassessment of claims based on their original dates of denial or closure. We are now ready to begin the reassessment of your claim, and appreciate your patience.

Our records indicate that your claim was closed or terminated on _____. We ask for your assistance in ensuring that your claim file is updated beyond that date, including your work history, medical information and details of other income or earnings you have received. Please use the attached Reassessment Information Form to provide this information. Also, please include any additional information you feel would be helpful to assist us in reassessing your claim.

The instructions on the Reassessment Information Form explain where to send your completed form. You will need to complete and return your Reassessment Information Form within 60 days of the date of this letter, which is no earlier than the date we will post it in the mail. We will send you an acknowledgement notifying you that we have received your completed Reassessment Information Form within 30 days of its receipt. If you need additional time to complete the Reassessment Information Form, please provide your reasons for needing an extension of time in writing to us within 60 days of the date of this letter.

Prior to reassessment of your claim, you must sign the Reassessment Information Form in each of the indicated places. This will confirm your agreement that if (and only if) the reassessment results in a reversal or other change in our prior decision denying or terminating benefits, that you will not pursue legal action against the Company to the extent (and only to the extent) such action would be based on any aspect of the prior denial or termination that is reversed or changed. It will also confirm your agreement that if you have already commenced legal action relating to your prior claim(s) decision, you will

seek to stay such litigation pending completion of the reassessment of your claim, and your further agreement that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, then you will withdraw any litigated claim, including extracontractual claims to the extent, (and only to the extent) such claim is based on any aspect of the prior denial or termination that is reversed or changed. In other words, to the extent that following the reassessment there remains a complete or partial denial of benefits, a claimant's right to initiate or continue litigation regarding that portion of the prior denial that has not been reversed or changed shall not be waived.

If we do not receive your completed Reassessment Information Form or request for extension within the timeframe noted above, we will assume that you no longer wish to participate in the Claim Reassessment Process and your claim will remain closed.

Once we have received your Reassessment Information Form and any other information we need to review, the reassessment of your claim could take from four to twelve weeks, depending on the complexity of your particular situation. We will contact you regarding any additional information that we may need. While your claim will be given a thorough review, please understand that participation in the Claim Reassessment Process does not necessarily mean that you will receive benefits or that a different decision will be reached.

If you have any questions regarding your claim and the Claim Reassessment Process, please feel free to call (1-800-____-____). Thank you very much for your cooperation.

Sincerely,



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

REASSESSMENT INFORMATION FORM

Attachment C

Instructions:

- A. Claimant Statement: Provide an update of certain personal information as indicated in this section.
- B. Employment Statement: Provide details regarding any work activity from the date your claim was closed through the present. Depending on the terms of your policy, to qualify for benefits you may need to demonstrate a loss of functional duties and/or a loss in income. In order to properly assess your claim we will need to have information regarding all work you have performed. If you are claiming a loss in income while working, provide all supporting documentation available including tax returns and related IRS Forms W-2 and/or 1099; otherwise, this financial information is not needed to reassess your claim.
- C. Medical Information Details: Provide all details regarding medical treatment received since your claim was closed. This enables us to obtain any additional medical information we may need from your medical treatment providers. To assist us in the Claim Reassessment Process, enclose any medical records or information you may have in your possession.
- D. Other Income Benefits: Provide us with details concerning any other income benefits you may have received or are receiving. Please complete this section of the form and attach any supporting information you may have, including benefit awards, summaries etc.

You must sign and date each of the following sections of the form in order for us to begin the Claim Reassessment Process.

- E. Certification: Sign and date this form.
- F. Conditional Waiver and Release: Sign and date this form.
- G. Authorization: Sign and date this form.

Also please enclose any additional information that you feel will assist us in reassessing your claim.

The completed form should be sent to:

UnumProvident
Claim Reassessment Unit
PO Box XXXX
Portland, Maine 04104-5028



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

A. CLAIMANT'S PERSONAL INFORMATION (PLEASE PRINT)

| | | | |
|---|---|--|------------------------|
| Claimant's Name (as printed on your Social Security Card) | Home Telephone Number Including Area Code | Date of Birth | Social Security Number |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Home Address (Street, City, State, Zip) | | | |
| Policy Number: | Claim Number: | | |
| Preferred e-mail address where you can be reached | | | |



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

Explain why you believe that our previous decision to deny or terminate your claim was incorrect.



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

B. CLAIMANT'S EMPLOYMENT INFORMATION (PLEASE PRINT)

| | |
|--|--|
| Name of Employer A. | Employer's Telephone Number |
| Dates of Employment | |
| Employer's Address (Street, City, State, Zip) | |
| Your occupation and work schedule with this employer | |
| Weekly or Monthly Earned Income Before Taxes \$ | (please provide documentation of earnings) |

| | |
|--|--|
| Name of Employer B. | Employer's Telephone Number |
| Dates of Employment | |
| Employer's Address (Street, City, State, Zip) | |
| Your occupation and work schedule with this employer | |
| Weekly or Monthly Earned Income Before Taxes \$ | (please provide documentation of earnings) |

| | |
|--|--|
| Name of Employer C. | Employer's Telephone Number |
| Dates of Employment | |
| Employer's Address (Street, City, State, Zip) | |
| Your occupation and work schedule with this employer | |
| Weekly or Monthly Earned Income Before Taxes \$ | (please provide documentation of earnings) |



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

C. CLAIMANT'S MEDICAL INFORMATION (PLEASE PRINT)

Please provide full and complete responses, indicating "none" where applicable. If more space is needed, please attach lists as necessary.

1. Name(s) and complete address(es) of any medical care provider you consulted for any condition since your claim was closed.

| Name of Doctor | Complete Address (Street, City, State, Zip) | Dates of Treatment | Telephone/Fax# |
|----------------|---|--------------------|----------------|
|----------------|---|--------------------|----------------|

2. Indicate the name(s) and complete addresses of any hospital/clinic where you received medical treatment, consultation, care or services (including diagnostic measures) since your claim was closed.

| Name of Hospital/Clinic Telephone/Fax# | Complete Address (Street, City, State, Zip) | Dates Treated |
|---|---|---------------|
|---|---|---------------|

3. List any medications and prescribed drugs taken since your claim was closed.

| Name of drug or medicine | Prescription Number | Pharmacy | Date | Physician |
|--------------------------|---------------------|----------|------|-----------|
|--------------------------|---------------------|----------|------|-----------|

4. Please provide the complete address of any pharmacy listed in response to Question#3.

| Name of Pharmacy | Complete Address(Street, City, State, Zip) | Telephone/Fax # |
|------------------|--|-----------------|
|------------------|--|-----------------|



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

D. CLAIMANT'S OTHER INCOME BENEFITS (PLEASE PRINT)

Check the other income benefits you have received, or are receiving, or are eligible to receive as a result of your disability and complete the information requested.

Please also report any changes to previously reported benefits.

If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

| | | | |
|--|---|---|--|
| Social Security/Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No | Social Security/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No | Canada Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No | State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Workers' Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No | Pension/Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No | Pension/Disability <input type="checkbox"/> Yes <input type="checkbox"/> No | Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| No-fault insurance <input type="checkbox"/> Yes <input type="checkbox"/> No | Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No – Ins. Co. Name and Policy # | | |
| Other (include Individual Disability or Group Disability Benefits) <input type="checkbox"/> Yes <input type="checkbox"/> No – Ins. Co. Name and Policy # | | | |



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

Claim Fraud Warning Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio, 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, Maine, Tennessee and Virginia 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 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 fraud in 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 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.

E. The information which I have provided on this Reassessment Information Form is true and complete to the best of my knowledge and belief.

Signature _____

Date _____



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

F. Conditional Waiver and Release

By choosing to participate in the Claim Reassessment Process, I hereby agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, I will not pursue any legal action to the extent (and only to the extent) such action is based on any aspect of the prior denial or termination that is reversed or changed. If I receive any additional benefits as a result of this reassessment, I hereby waive and release any right to sue UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives, for their prior failure to pay those same benefits to me. If I have already commenced legal action relating to my prior claim(s) decision, I will take such action as is necessary to stay such litigation pending the reassessment process, if the court will agree to such a stay, and I agree that if (and only if) the reassessment results in a reversal or other change in the prior decision denying or terminating benefits, then I will withdraw any litigated claim, including any extra-contractual claims, to the extent (and only to the extent) such claims are based on any aspect of the prior denial or termination that is reversed or changed. To the extent that following the reassessment there remains a complete or partial denial of benefits, my right to initiate or continue litigation regarding that portion of the prior denial that has not been reversed or changed is not waived. In addition, any applicable statute of limitations is tolled during the pendency of the reassessment of my claim; however, I understand that my participation in the Claim Reassessment Process will not revive or reinstate the statute of limitations with respect to the previous claim decision.

This waiver and release will not apply to the extent that any prior decision is not reversed as a result of the Claim Reassessment Process.

Signature _____

Date _____

* This waiver and release is valid for the following UnumProvident subsidiaries: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, The Paul Revere Life Insurance Company.



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit
PO Box xxx, Portland, ME 04104-5028

Claim Questions: 1-866-xxx-xxxx

Fax to: 1-866-xxx-xxxx

- G. NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization with the completed Reassessment Information Form.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). Information about my health 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 information on financial or credit history or earnings will not be sought from an employer if it is not relevant to evaluating my claim(s) for benefits.

I understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. 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 my claim, whichever period is shorter. A photographic or electronic copy of this authorization is 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 UnumProvident 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 this authorization, UnumProvident 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 Company.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claims(s) and this may be the basis for denying my claim(s).

Signature _____

Date _____

Print Name _____

Social Security Number _____

If signed on behalf of the claimant as personal representative, please indicate relationship here _____ . If signed on behalf of the claimant as designee under power of attorney, as guardian, or as conservator, please attach a copy of the document granting authority.

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

EXHIBIT 2

CHANGES IN CLAIM ORGANIZATION

Exhibit 2 is responsive to Paragraph B.3.a. of the Regulatory Settlement Agreement.

Current Organization

In the current organization of the Companies' claims operation the primary responsibility for making a claim decision rests with a Disability Benefit Specialist ("DBS") who generally receives guidance on a given claim from a Consultant who has more claim handling experience. The DBS also has access to additional internal resources, including nurses, physicians, vocational rehabilitation specialists, accountants and lawyers. The DBS's are in units that report to Managers and Directors, who have more claims handling experience but generally perform management roles and are not involved in individual claim files. Consultants generally do not have management responsibilities.

Changes in Claim Organization

In order to address areas of concern noted in the Multistate Examination Report and increase the effectiveness of the claims operation in processing claims, changes are being made to increase the claim handling experience of personnel involved at the earliest stage of reviewing a claim, add to the accountability for compliance and increase the involvement of higher level management in approving claim decisions. The primary changes are as follows:

- 1) The Consultant position is being eliminated, and the individuals serving in that position are being reassigned to various other positions, including DBS, Manager, newly created positions in the Claim Reassessment Unit, and the newly created Quality Compliance Consultant positions.
- 2) Individuals serving in the existing Manager positions will become more directly involved in daily activities and decisions associated with claims; will be directly accountable for claim decisions made in their unit; will ensure that appropriate actions are taken and information received on claims before a decision is made; and will be responsible for developing the technical expertise of the staff in their unit. Managers generally have at least five years of claim handling experience.
- 3) A new position, Quality Compliance Consultant ("QCC") will be created to focus upon compliance, documentation, accountability for compliance, issues of fairness to claimants, and avoidance of improper claim practices. The position description for QCC is set forth in Exhibit 3.

Exhibit 3

Position Title: **Quality Compliance Consultant**

Job Code: New role to organization

Job Level:

Exemption Status: Exempt

General Summary

This highest level technical position is directly responsible for ensuring quality (appropriate file documentation and decision rationale) and compliance. They are relied upon to provide guidance, training and direction to the Disability Benefits team with a strong partnership with Legal.

Principal Duties and Responsibilities

Claim Management

- Enhance organizational performance through ensuring quality of claim documentation and decision rationale
- Develop and build in-depth technical expertise in the Disability Benefits team
- Analyze and conduct needs assessment to assist with development of strategies to improve quality of performance
- Utilize and convey expertise in multiple product lines (STD, LTD, IDI)
- Mentor claims personnel
- Utilize appropriate resources, as needed, to arrive at thorough, fair and objective decisions
- Proactively review files to assess quality and compliance
- Ensure corporate and claimant compliance with ERISA standards, as applicable

Customer Service and Partnering

- Provide feedback to Disability Benefits Specialists, Managers, and Directors on quality of specific claim documentation and decision rationale
- Build and maintain partnerships with management team members and legal team
- Partner with Legal to provide quantitative and qualitative feedback on overall quality of claim documentation and decision rationale
- Partner with QPS (Appeals, Audit and Training) to identify trends and develop action plans to improve overall quality of claim management
- May perform other duties as assigned

Job Specifications

- Any combination of education or experience equivalent to ten years disability experience and/or seven years disability claims experience preferred
- Demonstrated success in managing highly complex claims
- Undergraduate degree required
- Strong preference for one or more Insurance Industry designations (ALHC, FLMI, ACS, etc.)
- Proven ability to successfully coach and mentor others
- Strong decision making and problem solving skills
- Ability to effectively and professionally interact/partner with internal and external representatives and resources
- Exceptional written and oral communications
- Superior analytical skills with an understanding of the functional requirements of the organization
- Demonstrated understanding of disability claim operations

Exhibit 4

Improved Procedures for Evaluating Multiple Conditions or Co-Morbid Conditions

1. Guiding Principles (see also UnumProvident Clinical, Vocational, and Medical Services Statement Regarding Professional Conduct)

Benefit Center professionals will evaluate all data available regarding a claim
Both objective and subjective
Both supporting impairment and supporting capacity

Benefit Center professionals will consider and afford appropriate weight to all diagnoses and impairments, and their combined effect on the whole person, when evaluating medical data in a claim file.

Where multiple conditions or co-morbid conditions are present, each medical professional and all other Benefit Center professionals evaluating the claim share responsibility to ensure that all diagnoses and impairments are considered and afforded appropriate weight.

When multiple medical professionals review a file, each medical professional and all other Benefit Center professionals share responsibility for coordinating their opinions and ensuring that each understands how the various opinions fit together in a coherent view of the claimant's medical condition, capacity, and restrictions/limitations.

2. Changes in procedures

Several techniques will be used to ensure that claimants with multiple conditions are fully and fairly evaluated regarding the totality of their limitations. These alternatives include

- Designated clinical consultant in each impairment unit to receive and manage consultation requests from other units
- Access to multi-disciplinary meetings to consider totality of impairments
- Referral to generalist or primary care physician (internist, occupational physician, or family practitioner) to consider effects of all conditions on overall function and limitations

Each of these techniques is currently in use at two or more locations, and all locations use at least two of these techniques.

A Medical Analysis Checklist (see format below) has been developed as a tool for Benefit Center professionals. The checklist should be used when multiple on-site physicians have reviewed a file, and is available as a tool for organizing a whole person analysis of impairments for any claimant.

3. Training

Clinical, Vocational, and Medical Directors at each claim processing location will identify areas for company-sponsored continuing nursing and physician education.

Medical Analysis Checklist

The checklist may be useful at several points during a claim, including liability determination, change of definition, and contemplated claim closure. It provides a "snapshot" at a particular point in time of all recent treaters, diagnoses/syndromes/problem areas identified, restrictions and limitations arising from each, and our contractual assessment of those restrictions and limitations. For illustrative purposes only, an example is offered below on how the form might be used.

Claimant: Jeff Styles Soc Sec #: 345 - 67 - 8912 Date: 8 / 11 / 2004

| Physicians Consulted In Last Year | | Diagnoses or Syndromes | Restriction Identified | Limitation Identified | Assessment |
|--------------------------------------|----------------------|---------------------------|--|---|---|
| Physician | Date Last Seen | | | | |
| Thos. Moore, MD | 7/9/04 | 1. Cardiomyopathy | | Sedentary work only | Mr. Styles' insured occ as foreman required frequent walking; at change of def we have identified gainful sedentary positions in his region |
| | | | Must be able to elevate feet above chest 10" every hour | | Voc reports this is an accommodation permitted by most employers, and confirmed by those offering gainful positions |
| | | | No lifting over 10# | | Available in gainful positions |
| | | 2. Atrial fibrillation | No work near microwaves or large electrical power sources due to implanted defibrillator | No lifting over 20# | Available in gainful positions |
| Roger Grise, PhD | 6/7/04 | 3. Depression | | Impairments in interpersonal relations; concentration; deep pessimism | Dr. Grise reports depressive symptoms have remitted; GAF now 72; limitations considered resolved per OSP assessment of 7/29/04; Dr. G agrees per letter of 8/4/04 |
| James Fisher, MD | 4/12/04 | 4. Fatigue | No prolonged standing or walking (>30"); | | Re-conditioning via PT improved endurance as of 7/29/04 per Dr. Liu |

| | | | | | |
|-------------------|--------|--------------------------------|--|-----------------------------------|---|
| | | | requires variable schedule and up to 1 hr of rest per 4 hrs worked | | |
| Frederick Liu, MD | 5/7/04 | 5. Diabetes mellitus | Regular meals; no overtime; needs regular schedule | | Gainful occupations permit regular hours |
| | | 6. Epilepsy | | | Never asserted as cause of disability; has been well controlled since 1993 by medication |
| | | 7. Chronic pain (fibromyalgia) | | Cannot work more than 2 hrs daily | Through cog-behav program delivered through Dr. Grise, Mr. Styles has improved his conditioning and attitude and now reports he is ready for a gradual RTW. Dr. Liu concurs and will manage rehab program |

EXHIBIT 5

UnumProvident Clinical, Vocational, and Medical Services Statement Regarding Professional Conduct

Dear Benefits Center Clinical, Vocational, or Medical Professional:

UnumProvident is committed to standards for the prompt, fair and reasonable evaluation and settlement of claims. As participants in the claims process we play an integral role in achieving these service standards and must be willing to subscribe to the Benefits Center Philosophy:

With a commitment to integrity, quality and superior service, we will:

- Make appropriate decisions by providing a thorough, fair and objective evaluation of all claims.
- Pay all valid claims in a timely manner with a high level of service.
- Partner with our customers in their efforts to return to work or to independent living.

The Benefits Center Philosophy cannot be fully realized without our full commitment to our professional ethical standards. Likewise, UnumProvident's commitment is that these standards not be compromised in the course of our work activities on its behalf. Ultimately, however, professional ethical conduct is an individual responsibility. The measure of our success is how we conduct ourselves each day.

Please review and retain the attached "UnumProvident Clinical, Vocational, and Medical Resource Statement Regarding Professional Conduct." I/we am/are confident in your commitment to conduct yourselves in accordance with these high standards.

Sincerely,

Chief Ethics Officer

**UnumProvident Clinical, Vocational, and Medical Professionals'
Statement Regarding Professional Conduct**

Clinical, vocational, and medical professionals within the Benefits Center will:

- Comply with all applicable laws, ethical codes, and standards of professional conduct.
- Communicate with partners and internal customers promptly and professionally.
- Discuss medical and/or vocational facts in an open and honest manner.
- Provide fair and reasonable evaluations considering all available medical and/or vocational evidence, both objective and subjective, both supporting impairment and supporting capacity.
- Consider all diagnoses and impairments, and their effect on the whole person, when evaluating medical and/or vocational data in a claim file.
- Work with or refer files to other appropriate medical personnel when specialization prevents one professional from considering all impairments and diagnoses in an evaluation of the whole person.
- Complete "Fair Claims Settlement Practice" training annually.
- Represent medical and/or vocational facts accurately.
- Provide reasonable, clear, and accurate explanations of professional opinions so that clear and full explanations of decisions based on those opinions are available to the claimant.
- Avoid redundant or unnecessary requests for information, e.g. duplicate information, data not reasonably required for adequate analysis, or data not material to the analysis of the claim.
- Report any significant barriers to achieving the Benefits Center Philosophy and its application to your management, directly to the company's Chief Ethics Officer or through the Business Practices & Ethics Hotline as outlined in UnumProvident's Code of Business Practices & Ethics.

I have read and understand the principles and guidelines above. I agree to abide by these principles in my work on behalf of UnumProvident Corporation, and to consult with peers, managers, and ultimately the Chief Ethics Officer if I am unclear regarding my responsibilities under these principles or encounter barriers to abiding by them. In addition, prior to making each determination as to a claimant's impairment, for which I have been trained, I will certify that I have reviewed all medical, clinical, vocational and other evidence provided to me bearing upon impairment.

Name

Date

EXHIBIT 6

Guidelines for Independent Medical Evaluations

A. Attending Physician ("AP") Related. If a determination is made that the medical information in the claim file lacks clarity or sufficiency in assessing the insured's medical condition in order to validate the claim under the requirements of the applicable policy or if the Company has reason to question the opinions or information provided by a claimant's AP, the appropriate Company medical professional should contact the AP either by phone or by letter for clarification or additional information. If a telephone contact cannot be arranged, a letter outlining the question(s) and issues should be sent to the AP, which invites a reply either by phone or by letter.

Following such contact, if the Company's medical professional and the AP are unable to reach an agreement on the medical issue or issues and its or their effect on the claimant's capacity for work an independent medical evaluation should be sought under the following guidelines unless the decision is made to pay or continue to pay the claim:

1. An independent record review should be sought whenever the lack of agreement primarily concerns an issue of data interpretation, and therefore an examination of the claimant would not be useful to understand the allegedly impairing condition.
2. An independent medical examination ("IME") of the claimant should be sought whenever there is lack of agreement and the opinion of the Company's medical professionals involved in the claim file is the primary basis for the denial or termination of benefits unless the following conditions are satisfied in which instance an IME need not be sought, and the claim file is documented with regard to these conditions being satisfied:
 - i. The Chief Medical Officer ("CMO") of the Company or one of the Company's certified medical specialists with the highest level credentials in the specialty field in the Company relating to the claim and designated by the CMO to perform such reviews ("DMO") has reviewed the specific claim, focusing particularly on the area or areas of disagreement between the AP and the Company's medical professionals involved in the claim file,
 - ii. The CMO or the DMO reviewing the specific claim file performs his or her separate analysis of the issue or issues upon which there is disagreement, including any other information in the file deemed by the reviewing CMO or DMO to be relevant to the claim decision, and

- iii. The CMO or the DMO reviewing the specific claim file concludes that there is reasonable medical certainty supporting the position of the Company's medical professionals involved in the claim file and in disagreement with the AP, after having determined that the AP's opinion is not well supported by medically acceptable clinical or laboratory diagnostic techniques and is inconsistent with the other substantial evidence in the claim file.

If the CMO or the DMO reviewing the specific claim file is unable to reach the conclusion set forth in subparagraph 2.iii. above, then an IME should be performed.

If the CMO or DMO agree with the AP's opinion, there is agreement as to the current existence of a disabling condition and no IME is needed at the present time.

B. An IME (or in circumstances relating to an issue of data interpretation in which case an independent record review) should be sought whenever any of the following occurs unless the decision is made to pay or continue to pay the claim:

1. A prior IME found disabling limitations and the current impairment is based on the same limitations;
2. A Company medical professional or other Company resource, e.g., legal/compliance, Benefit Specialist responsible for the claim, states that an IME is needed;
3. There is a difference of opinion between two or more of the Company's medical professionals with respect to the existence of a disabling condition; or
4. The claimant or the AP requests an IME, either directly or through the claimant's representative.

C. An IME must be obtained and conducted on the basis of objective, professional criteria:

1. The Company shall select individuals to conduct IME's solely on the basis of objective, professional criteria, and without regard to results of previous IME's conducted by such individuals; and,
2. Neither the Company nor any of its officers or employees shall attempt to influence the impairment determinations of professionals conducting IME's.

Exhibit 7

PROOF OF LOSS—DISABILITY CLAIMS

Introduction: The Companies' disability contracts require claimants to file a completed claim form when they are making a claim for benefits. This completed claim form satisfies the claimant's initial obligation to provide proof of loss as discussed below. Thereafter, the Company and the claimant work together to expedite the identification, retrieval and review of all information necessary to validate the payment of benefits under the applicable policy. The following details the proof of loss process:

Initial Proof of Loss: As part of the claim submission process, the claimant must provide information concerning the impairing condition. This information includes:

- Claim forms, medical records, letters from physicians and other sources
- Employment records, tax records and other professional records

Ongoing Proof of Loss: Once initial information is provided, the claimant has a legal obligation to cooperate with the Company's efforts to obtain any material information needed to assess the claim on an ongoing basis.

Company's Obligation to Verify and Validate: When a claimant submits a claim, the Company must first verify that the claimant is eligible for coverage under the applicable policy(ies). The Company also must validate the nature of the impairment and how it limits or restricts the claimant from engaging in his or her occupation. The Company's obligation may be fulfilled by seeking additional information, which can include:

- Additional medical records and/or tests
- Financial records for purposes of determining income loss and benefit levels
- Records related to employment as well as occupational duties
- Other lawful methods of information-gathering that assist in validating the claim

The Company is entitled to request a written authorization from the claimant in order to obtain additional medical or other information. The Company has an obligation to use such authorization to seek needed information at its own expense. The claimant is obliged to cooperate by providing information or documents in his or her possession and by otherwise participating in the claim investigation (e.g. attendance at an Independent Medical Examination.)

Communications with the Claimant: Throughout the claim administration process, the Company must alert the claimant as to any information or documents which are needed to pay benefits under the applicable policy.

Independent Medical Examinations and testing: In some instances, it may be appropriate for the Company to invoke its contractual right to request that the claimant submit to an Independent Medical Examination, which may include additional medical tests. Specific guidelines for such Examinations are set forth in Exhibit 6.

Claim Handling Decisions: After the Company has made a good faith effort to obtain all material information necessary to make an informed claim decision, the information is analyzed and weighed in a fair and balanced manner. If the Company has sufficient evidence to validate the payment of benefits under the applicable policy's requirements, the claim will be paid.

**CIC SECTION 12938 REPORT OF THE MARKET CONDUCT EXAMINATION
OF THE CLAIMS PRACTICES OF THE
UNUM LIFE INSURANCE COMPANY OF AMERICA
NAIC # 62235 CDI # 2039-6
PROVIDENT LIFE AND ACCIDENT INSURANCE
COMPANY
NAIC # 68195 CDI # 0950-6
PAUL REVERE LIFE INSURANCE COMPANY (THE)
NAIC # 67598 CDI # 1083-5**

**AS OF JULY 31, 2007
Adopted March 28, 2008**

[Made available in accordance with CIC Section 12938]

STATE OF CALIFORNIA



**DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

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DEPARTMENT OF INSURANCE

Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013



March 28, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

UNUM Life Insurance Company of America

NAIC # 62235

Provident Life and Accident Insurance Company

NAIC # 68195

Paul Revere Life Insurance Company (The)

NAIC# 67598

Hereinafter, the Companies listed above also will be referred to as UNUM.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

FOREWARD

The examination covered the claims handling practices of the reassessment of claims arising out of the **California Settlement Agreement (CSA)** and claims subject to and closed after the California Settlement Agreement. The CDI reviewed 191 reassessed claims that went through the reassessment process. The CDI reviewed 30 Post-CSA claims closed between 12/1/05 and 05/1/06 and 60 Post-CSA claim files closed between 08/01/06 and 07/31/07. The Post-CSA claim files were selected on a targeted basis. The examination was made to discover, in general, if these and other operating procedures of UNUM conform to the California Settlement Agreement as well as the contractual obligations in the policy forms and provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of the California Settlement Agreement as well as alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. Violations of other relevant laws were not found in this examination.

The report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The Report does include a summary of findings in relation to the California Settlement Agreement. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that resulted in an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by UNUM for use in California including any documentation maintained by UNUM in support of positions or interpretations of fair claims settlement practices. This included review of training materials and written directives provided to the California Settlement Agreement Claims Reassessment Unit as well as ongoing claims staff. This included both claims adjustment staff and vocational assessment personnel.
2. A review of the application of such guidelines, procedures, and forms.
3. A linear review of the actions taken by UNUM to comply with the California Settlement Agreement.

The claim file review was conducted at the offices of UNUM in Glendale, California and Portland, Maine.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims reviewed were reassessed between July 1, 2006 and March 31, 2007, commonly referred to as the “review period”. The examiner reviewed 191 reassessed claim files. The Reassessment samples included files from all four reassessment locations (Portland, Maine; Chattanooga, Tennessee; Worcester, Massachusetts and Glendale, California). This included 137 Group Long Term Disability Claims and 54 Individual Disability Income Claims. Of the 191 claims reviewed 28 had gone through the CSA Independent Review process. The examiners cited seven alleged claim handling violations of the California Settlement Agreement or California Insurance Code Section 790.03. Seven violations in a population of 191 claims reviewed does not trigger additional regulatory penalties in accordance with the California Settlement Agreement for reassessed claims (consistent with the 7% threshold in the Multi-State Regulatory Settlement Agreement).

In addition, examiners reviewed 90 post-CSA claims. Of these claims 30 were closed between 12/1/05 and 05/1/06. The balance of 60 claims the examiners reviewed were closed between 08/01/06 and 07/31/07. The CDI was not able to identify any alleged violations of the California Settlement Agreement or California Insurance Code Section 790.03 in these 90 files.

DEFINITIONS

California Settlement Agreement (CSA): Settlement agreement between the Department of Insurance of the State of California and UNUM (Unum Life Insurance Company of America, Provident Life and Accident Insurance Company and The Paul Revere Life Insurance Company) effective November 1, 2005.

California Department of Insurance (CDI)

Claims Reassessment Unit (CRU): UNUM employees who reviewed and reassessed claims per the California Settlement Agreement.

Independent Review (IR): Independent file review process as prescribed in the California Settlement Agreement.

Notice Files: Folders containing notices sent in relation to the California Reassessment. No claims information is contained in these files.

UNUM: Group of insurers including UNUM Life Insurance Company of America, Provident Life and Accident Insurance Company, Paul Revere Life Insurance Company.

RIF: Reassessment Information Form

LTD: Long Term Disability

SUMMARY OF EXAMINATION AND COMPANY ACTIONS

UNUM took a series of actions as required by the California Settlement Agreement. Following is a summary of the actions taken by UNUM and the steps taken by the California Department of Insurance to assure oversight of the Reassessment Process and compliance with the California Settlement Agreement.

UNUM provided written instructions and training to implement the administrative changes required by the CSA.

As a part of the Market Conduct Examination, the CDI reviewed written instructions and training materials provided to the claims handling personnel. These included administrative changes in claims handling as outlined in the CSA. This included both “online” as well as written instructions provided to the adjusters. These instructions were provided to the California Reassessment claims examiners as well as the claims examiners handling ongoing claims. The materials reflected adherence with the administrative changes outlined in the California Settlement Agreement. These instruction materials remain available to UNUM adjusters as an online reference tool.

Prior to the commencement of the California Reassessment process, the CDI performed a review of thirty group LTD claims closed after the California Settlement Agreement to assure compliance with the CSA in relation to ongoing claims. No exceptions were identified in this targeted review. The CDI subsequently reviewed an additional 45 group LTD claims and 15 Individual Disability Income claims closed between 08/01/06 and 07/31/07. No alleged instances of noncompliance with the California Settlement Agreement or California Statutes were identified in these files.

UNUM maintained a separate call center designed specifically for questions regarding the reassessment process. Reassessment claimants calling any of the departments at UNUM were directed to the Reassessment call center. The call center employees were provided with instructions regarding the notice and participation requirements of the California Reassessment.

The CSA required UNUM to send various notices to potential claimants of the California Reassessment. The CDI was provided a list of 11,071 eligible claimants to the California Reassessment. The CDI extracted and reviewed 40 random “notice” files from the eligible claimant list. Documents reviewed included the initial notices of reassessment eligibility sent claimants, “opt in” notices that were returned, and request for information forms that were sent out and returned. The Request for Information Forms included the appropriate authorization and anti-fraud statements per the CSA. The appropriate reassessment forms were also identified in the 191 files reviewed by the CDI that were included in the California Reassessment.

The CDI also reviewed 10 of 51 “notice” files where viable addresses could not be determined. Of the 10 “notice” files reviewed there was one exception. One form had been sent to the correct street but the incorrect apartment number. It was

noted that UNUM had taken adequate measures to identify viable addresses for claimants where mail was returned as undeliverable. UNUM agreed to review the 50 files to verify any additional errors, with no additional errors found.

The examiner in charge reviewed training materials regarding the UNUM Business and Ethics Hotline, which is staffed by an external vendor and monitored by the UNUM Chief Ethics Officer. In the training materials, employees are encouraged to report any wrongdoings relating to UNUM employees' business practices. All employees are required to take ethics training. Callers to the Ethics Hotline may remain anonymous if they choose to do so. Unethical activities in claims handling are subject to these Ethics standards.

As required by the CSA, UNUM performed internal audits during the course of the CSA Reassessment process. The CDI discussed in general terms the results of these audits and their results were similar, in terms of the exceptions identified, as this CDI exam.

One area focused upon was the appropriate use of Independent Medical Examinations, Functional Capacity Examinations, and Medical Records Reviews. The CDI had discussed with UNUM the importance of reviewing medical records of all attending physicians and having the appropriate level of expertise involved in the review and evaluation of those medical records. In claims where a potentially disabling diagnosis has been documented but appropriate functional testing has not been performed, the Company has agreed to consider an appropriate functional test. The Company has indicated that on a companywide basis, the combined number of functional tests and medical record reviews (Independent Medical Examinations, Functional Capacity Examinations and Medical Record Reviews) has increased significantly from 2003 to 2006. The Post CSA files do reflect that claimants are notified of their right to request an IME and given the option of an IME when there is a medical difference in opinion between the claimant's physicians and the UNUM medical consultants.

The CSA Reassessment exam included the review of 191 claims that had gone through the reassessment process. During the reassessment review, the CDI identified seven alleged violations in the population reviewed. Five of these are specific exceptions to the CSA and 2 were violations of the California Insurance Code. Three general areas of concern were also identified during the course of the review and the CDI sent an interim correspondence to UNUM regarding continued compliance with the CSA. UNUM acknowledged our concerns and in response, provided written refresher training to the CRU examiners, reiterating the need for the CRU examiners to comply with the CSA. It was noted that the UNUM training materials and written instructions provided to the CRU adjusters prior to the start of the reassessment process addressed the issues identified in the exceptions. The compliance unit reiterated to the claims reassessment unit the need to comply. UNUM provided us with copies of the written refresher materials it sent to members of the reassessment unit as well as the staff handling ongoing claims after we had presented our concerns.

The CDI assigned two dedicated complaint handlers in the Consumer Services Division to handle Complaints regarding the UNUM reassessment process. There were no procedural patterns or practices that were identified in the complaint handling process that reflected non-compliance with the CSA.

Ongoing UNUM complaints were also tracked on the CDI internal tracking system. There were 195 complaints to the CDI pertaining to UNUM ongoing claims for the period 08/01/03 to 08/01/04. During the post CSA period of 08/01/06 to 08/01/07 the CDI processed 89 complaints for ongoing claims. This reflected a 54% drop in complaints after the Companies had performed the changes required in the CSA.

UNUM sent out 33,566 notices to California Claimants allowing them to “opt in” to the CSA Reassessment. UNUM received 11,098 responses indicating the claimant’s wished to have their claims reassessed. UNUM sent the Reassessment Information Form (RIF) packets to all 11,098 respondents. The California claimants returned 2,654 RIF packets and these claims were reassessed. Of the 2,654 claims that were reassessed, 1,376 denials were upheld, 123 were unchanged due an incomplete RIF, 611 were reopened and an additional payment was made, and 544 were opened and ongoing payments continue today.

Of the 2,654 claims that were reassessed, 298 California claimants requested a second opinion via the Independent Review process. Of the 298 files that were reviewed, the Independent Reviewer indicated in agreement with UNUM by upholding the denial in the reassessment in 278 instances.

Of the twenty files where the Independent reviewer was not in agreement with UNUM reassessment decision, 17 were paid by UNUM. Two files went unpaid as UNUM continues to be in disagreement and one claim is pending. It is noted that, of the 17 paid, two claims involved clerical errors made during the reassessment process and did not involve UNUM reassessment decisions relating to the claimant’s eligibility status in relation to their disabling conditions and additional payment as required by the insuring contract and the CSA. Three claims involved additional information being received in the IR process after the initial UNUM reassessment decision had been made. The CDI has forwarded the two unpaid files to the California Department of Insurance legal staff for further review.

As of December 31, 2007, the monies paid or reserved for California consumers as a result of the California Settlement Agreement and Reassessment process totaled \$112,046,062. Also, as of February 29, 2008, 2,654 claims have gone through the California Reassessment process and 1,155 California consumers have received additional payment of disability benefits.

The CDI continues to monitor UNUM’s compliance with the CSA via the CDI complaint process. In the event that any pattern or trend of non-compliance is identified, additional Market Conduct Examinations will be performed.

DETAILS OF THE EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

| UNUM CSA REASSESSMENT FILES REVIEWED | | | |
|---|-----------------------|--------------------|---------------|
| LINE OF BUSINESS / CATEGORY | Denials Upheld | Claims Paid | Totals |
| Group Long Term Disability Claims | 113 | 24 | 137 |
| Individual Disability Income Claims | 53 | 1 | 54 |
| TOTALS | 166 | 25 | 191 |

| TABLE OF TOTAL CITATIONS CSA REASSESSMENT CLAIMS REVIEWED | | | |
|--|---|------------------|-------------------------------------|
| Citation | Description | Group LTD | Individual Disability Income |
| Failure to comply with the California Settlement Agreement | Company failed to apply the California definition of Total Disability as: as a disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his or her usual occupation in the usual and customary way. | 5 | 0 |
| CIC §790.03(h)(5) | The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. | 2 | 0 |
| Total Citations | | 7 | 0 |

| UNUM LINE OF BUSINESS / CATEGORY | CALIFORNIA REASSESSMENT FILES REVIEWED | FILES WITH ALLEGED VIOLATIONS | PERCENTAGE FILES WITH ALLEGED VIOLATIONS IN RELATION TO THE TOTAL NUMBER OF FILES REVIEWED |
|---|---|--------------------------------------|---|
| Group Long Term Disability Claims (reassessment) | 137 | 7 | 5.11% |
| Individual Disability Income Claim (reassessment) | 54 | 0 | 0 |
| TOTALS | 191 | 7 | 3.66% |

| UNUM (POST CSA CLOSURES) | | | |
|---|---------------------------------|-----------------|------------------|
| LINE OF BUSINESS / CATEGORY | CLAIMS FOR REVIEW PERIOD | REVIEWED | CITATIONS |
| Group Long Term Disability (12/01/05 to 05/01/06) | 999 | 30 | 0 |
| Group Long Term Disability (08/01/06 to 07/31/07) | 1443 | 45 | 0 |
| Individual Disability Income (08/01/06 to 07/31/07) | 457 | 15 | 0 |
| TOTALS | 2899 | 90 | 0 |

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of the California Settlement Agreement as well as Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved. Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked to take appropriate corrective action in all jurisdictions where applicable. The Company has agreed to take appropriate corrective actions in all jurisdictions. The total monies paid or reserved in relation to the seven alleged violations was \$1,605,700.10.

ACCIDENT AND DISABILITY- CSA REASSESSMENT CLAIMS

1. **In five instances, the Companies failed to comply with the California Settlement Agreement in its application of the CSA Definition of Total Disability. The Company failed to apply a guidepost of Total Disability as a disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his or her occupation in the usual and customary way.** In four of these instances, the Pre-CSA claims handler identified a similar occupation that did not include the substantial and material acts necessary to pursue the claimant's own occupation. The similar occupation was then utilized as the guidepost in evaluation of the claim. The UNUM Reassessment Adjuster did not recognize the inappropriate application of the wrong occupational descriptions. In one instance, the Pre-CSA medical assessment failed to evaluate the intermittent disabling condition in relation to performing an occupation with reasonable continuity. The medical evaluation had indicated the claimant could operate at a baseline functional level required of their occupation. The UNUM Reassessment Adjuster failed to recognize that a baseline functional assessment does not address an intermittent disabling condition. The Department alleges these acts are in violation of the California Settlement Agreement.

Summary of Companies' Response: UNUM acknowledges that these isolated instances regrettably occurred during the unprecedented, complex and recently completed process of reassessing older disability claims under the California Settlement Agreement ("CSA"). After a thorough review of the subject files, it was determined that additional investigation was required. In one instance, further vocational analysis confirmed that our original decision was correct. In the remaining instances, further analysis resulted in additional payments being issued. These isolated instances were limited to our recently completed claims reassessment. The companies noted that the examiners had no criticisms of post-CSA claims closures.

2. **In two instances, the Companies failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** In one instance, the UNUM Reassessment Adjuster failed to recognize a provision in a rehabilitation agreement that UNUM had agreed to consider additional disability benefits when the claimant attempted to perform a new occupation for a new employer. Benefits during this period were not taken into consideration during the reassessment of the claim. In one instance, the claim uphold letter of the UNUM Claim Reassessment Unit reflects that the UNUM Reassessment adjuster failed to adequately integrate into their decision key medical records contained in the claim file. This appears to be an isolated incidence. The Department alleges these acts are in violation of CIC §790.03(h) (5).

Summary of Companies' Response: UNUM acknowledges that these isolated instances regrettably occurred during the unprecedented, complex and recently completed process of reassessing older disability claims under the California Settlement Agreement ("CSA"). Further analysis of each of these two claims resulted in additional payments being issued. These isolated instances were limited to our recently completed claims reassessment. The companies noted that the examiners had no criticisms of post-CSA claims closures.

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**BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA
SAN FRANCISCO**

In the Matter of the
Certificates of Authority of

UNUM LIFE INSURANCE COMPANY
OF AMERICA,

PROVIDENT LIFE AND ACCIDENT
INSURANCE COMPANY, and

THE PAUL REVERE LIFE INSURANCE
COMPANY,

Respondents.

CALIFORNIA SETTLEMENT AGREEMENT

File No. DISP05045984

File No. DISP05045985

File No. DISP05045986


TO THE DEPARTMENT OF INSURANCE OF THE STATE OF CALIFORNIA:

**I.
INTRODUCTION**

Respondents UNUM LIFE INSURANCE COMPANY OF AMERICA (“Unum”),
PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY (“Provident”), and THE
PAUL REVERE LIFE INSURANCE COMPANY (“Paul Revere”) (all three collectively,
“Respondents”), and the California Department of Insurance (the “Department”) do hereby enter
into this California Settlement Agreement (“CSA”) in the above-entitled consolidated matters
and stipulate as follows:

A. The Insurance Commissioner of the State of California (“Insurance
Commissioner”) has jurisdiction over the each of the Respondents, as insurers holding

1 Certificates of Authority issued under the Laws of the State of California;

2 B. The Department conducted examinations into Respondents' rating, underwriting
3 and claims practices, including one examination by its Field Rating and Underwriting Bureau
4  covering the period January 1, 2002 to December 15, 2003, and two examinations by its Field
5 Claims Bureau of Respondents' claim files as follows: an initial, routine examination which
6 included a review of Respondents' claims handling practices during the period February 1, 2001
7 through January 31, 2002, and a targeted review of open and closed long term disability claim
8 files covering the period January 1, 2000 through June 30, 2003. In addition, the Department
9 surveyed recent court cases, interviewed certain individuals, reviewed evidence and testimony in
10 civil cases, reviewed individual Requests for Assistance submitted to the Department by
11 Respondents' claimants, and conducted other investigative activities. The CSA constitutes the
12 resolution of the Department's investigation, which includes all of the above;

13 C. Respondents acknowledge receipt of a copy of the Accusation issued by the
14 Department ("Accusation") in the above entitled matter, but deny the allegations contained
15 therein;

16 D. This CSA is made solely for the purpose of reaching a compromise settlement,
17 without litigating the issues, and it is the intent of the parties that any conduct or statements made
18 in negotiation hereof, including this CSA, shall be inadmissible for any purpose in any
19 proceeding unrelated to enforcement of the terms of this CSA;

20 E. Respondents neither admit nor concede any actual or potential fault, wrongdoing
21 or liability in connection with allegations contained in the Accusation or any of the findings of
22 the Insurance Commissioner ("Findings") set forth in his Order of the Commissioner;

23 F. Respondents acknowledge that certain of the allegations contained in the
24 Accusation, if heard and proved, could constitute grounds for the Insurance Commissioner to
25 suspend Respondents' certificates of authority and licenses pursuant to the Insurance Code of the
26 State of California ("Insurance Code");

27 G. Respondents acknowledge that certain of the allegations contained in the
28 Accusation as to claims handling, if heard and proved, could constitute grounds for the Insurance

1 Commissioner to impose civil penalties and to issue an Order to Cease and Desist from engaging
2 in those methods, acts, or practices found to be unfair or deceptive pursuant to the provisions of
3 the Insurance Code, which are referred to in the *Public Report of the Market Conduct*
4 *Examination of the Department of Insurance, Market Conduct Division, Field Claims Bureau*
5 (*“Public Report”*), incorporated in its entirety by reference herein. **{Please see link on**
6 **“UnumProvident Settlement” page on CDI website.}**

7 H. Respondents agree that the imposition of civil penalties and the award of costs of
8 investigation and future enforcement provided for herein shall have the same force and effect as
9 if imposed after a hearing or hearings held pursuant to the relevant provisions of the Insurance
10 Code and Government Code of the State of California (“Government Code”).

11 I. By entering into this CSA, Respondents waive Notice of Hearing and hearing, and
12 all other rights which may be accorded pursuant to Chapter 5, Part 1, Division 3, Title 2
13 (Sections 15000-11528, inclusive) of the Government Code and by the Insurance Code with
14 regard to the matters agreed to and settled herein.

15 16 II.

17 DEFINITIONS

18 The following terms, for purposes of the CSA and as used herein, are defined as follows,
19 unless otherwise specifically defined herein. This CSA contains definitions other than these set
20 forth in this Section II.

21 A. "California Claimant" for purposes of Section III of the CSA shall mean a
22 California Early Period Claimant or California Later Period Claimant; otherwise California
23 Claimant shall be an insured of a Respondent in circumstances where California law is the
24 applicable law governing the insurance policy covering the insured or the claims handling
25 standards and procedures with respect to the insured.

26 B. "California Contract" for the purposes of Section IV and V of this CSA shall
27 mean a policy of disability income insurance issued by a Respondent which is subject to the
28 jurisdiction of and approved by the Department.

1 C. "California Early Period Claimant" shall mean any California resident whose
2 individual or group long term disability income claim was denied or whose benefits were
3 terminated by any one of the Respondents on or after January 1, 1997 and before January 1,
4 2000.

5 D. "California Later Period Claimant" shall mean any California resident whose
6 individual or group long term disability income claim was denied or whose benefits were
7 terminated by any one of the Respondents on or after January 1, 2000 and prior to September 30,
8 2005. This shall include California residents who already have elected to participate in the RSA
9 Reassessment, and California residents who are eligible and elect to participate in the CSA
10 Reassessment.

11 E. "CSA Effective Date" shall mean the date of the Order of the Commissioner
12 adopting the CSA and shall apply to all sections of this CSA except for the following sections
13 which shall be effective on November 1, 2005:

14 1. Section V.C.

15 2. Section V.D.

16 F. "CSA Implementation Date" shall mean a date which is thirty (30) days after the
17 CSA Effective Date.

18 G. "CSA Notice" shall mean the notice of availability of the CSA Reassessment that
19 is to be sent to California Claimants pursuant to the provisions of the CSA.

20 H. "CSA Reassessment" shall mean the reassessment process as conducted under the
21 standards established in the CSA, and may include standards incorporated by reference to the
22 RSA and those established by Respondents when those non-CSA standards do not conflict with
23 the CSA standards.

24 I. "Order of the Commissioner" shall mean the Decision and Order of the Insurance
25 Commissioner on Settlement relating to the CSA, which is attached hereto as **Exhibit "A"** and
26 which Order of the Commissioner is executed simultaneously with the execution of the CSA.

27 J. "RSA Notice" shall mean the notice of availability of the RSA Reassessment that
28 was sent on a nationwide basis to claimants in all states pursuant to the provisions of the

1 Multistate Regulatory Settlement Agreement ("RSA").

2 K. "RSA Reassessment" shall mean the reassessment process as conducted solely
3 under the standards established by Respondents pursuant to the RSA.

4
5 **III.**

6 **MULTISTATE REGULATORY SETTLEMENT AGREEMENT**

7 **AND CSA REASSESSMENT**

8 **A. Relation Between the RSA and CSA**

9 On September 2, 2003, Maine, Massachusetts, and Tennessee, the Respondents'
10 principal domiciliary states ("Domestic Regulators"), ordered a multistate targeted examination
11 of the Respondents' claims handling practices ("multistate exam") to determine if the individual
12 and group long term disability income claims handling practices of the companies reflected
13 systemic "unfair claims settlement practices," as defined in the National Association of
14 Insurance Commissioners (NAIC) *Unfair Methods of Competition and Unfair and Deceptive*
15 *Acts and Practices in the Business of Insurance Model Act (1972)* or *NAIC Claims Settlement*
16 *Practices Model Act (1990)*. Ultimately, the terms of the resolution thereof were documented in
17 a Regulatory Settlement Agreement (RSA) with each of the Respondents, dated November 18,
18 2004, each RSA identical to the other. A separate and virtually identical RSA was entered into
19 with First Unum Life Insurance Company, an insurance company subsidiary domiciled in New
20 York, and the New York Superintendent of Insurance.


21 Included in the RSA was a Plan of Corrective Action that included (1) changes in
22 corporate governance, (2) the RSA Reassessment, and (3) changes in claim organization and
23 procedures. Also included in the RSA were provisions for immediate and contingent payment of
24 fines; certain administrative provisions regarding, among other things, participation in the RSA
25 by those non-domestic states electing to participate; and notice to certain claimants nationwide
26 that they may be eligible to have their claims reassessed.

27 The RSA Reassessment is available on a nationwide basis to certain long term disability
28 insurance policyholders under individual policies and to certain long term disability insurance

1 certificate holders under group policies issued to their employers or organizations to which they
2 belong. In addition to the Domestic Regulators, the United States Department of Labor (DOL) is
3 a party to the RSA and has jurisdiction over the Respondents' group insurance plans pursuant to
4 the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1134, which
5 applies to group long term disability income insurance policies that are sponsored or endorsed by
6 employers for their employees.

7 California elected not to participate in the RSA. However, in accordance with its terms
8 and ERISA, California residents are entitled to participate in the RSA Reassessment.

9 Notwithstanding that California did not participate in negotiating or settling the multistate
10 action, the RSA required nationwide notice to both group (employment- and non-employment-
11 related) and individual claimants, including those in California, for reassessment of claims under
12 standards set forth in the RSA. Thus when implementation of the provisions of the RSA began
13 on January 19, 2005, RSA Notices began to be mailed to individual and group California Later
14 Period Claimants. Many California Later Period Claimants responded by requesting
15 reassessment of their claims.

16 Respondents agree that all California Claimants who elect to participate in the CSA
17 Reassessment described below, and any California Later and Early Period Claimants who
18 previously elected to participate in the RSA Reassessment, will be reassessed under the rules and
19 procedures set forth in the CSA and the exhibits hereto. 

20 Incorporated herein by reference is the RSA for Unum, which includes the regulatory
21 settlement agreement covering A. Recitals, B. Plan of Corrective Action, C. Other Provisions, D.
22 Remedies, and Signature Pages, and exhibits to the RSA. **{Please see link on “UnumProvident
23 Settlement” page on CDI website.}**

- 24 • Exhibit 1 – Claim Reassessment Process, Unit Structure and Operating Procedures
- 25 • Exhibit 2 – Changes in Claim Organization
- 26 • Exhibit 3 – Quality Compliance Consultant
- 27 • Exhibit 4 – Improved Procedures for Evaluating Multiple Conditions or Co-Morbid
28 Conditions

- 1 • Exhibit 5 – UnumProvident Clinical, Vocational, and Medical Services Statement
- 2 Regarding Professional Conduct
- 3 • Exhibit 6 – Guidelines for Independent Medical Evaluations
- 4 • Exhibit 7 – Proof of Loss – Disability Claims

5 Except as specified below, the provisions of the RSA are adopted, incorporated by
6 reference and made applicable to all three Respondents herein. Respondents hereby agree that
7 they will comply with the provisions of the RSA except as supplemented or modified by the
8 CSA and the Order of the Commissioner with respect to California Claimants.

9 **B. Eligibility and Notice**


10 1. Eligibility.

11 a. Any California Early Period Claimant or any California Later Period Claimant shall be
12 eligible to participate in the CSA Reassessment whose claim was denied or whose benefits were
13 terminated *for reasons other than* the following:

- 14 (i) death of the claimant,
- 15 (ii) claim was withdrawn,
- 16 (iii) claimant did not satisfy the elimination period,
- 17 (iv) maximum benefits were paid,
- 18 (v) claimant who had his or her claim resolved through litigation or settlement, or
- 19 (vi) claimant who has pending litigation against a Respondent challenging the denial or
20 termination of his or her claim, which lawsuit was filed after the date of receipt of notice of the
21 CSA Reassessment or a claimant whose lawsuit was filed prior to the date of receipt of notice of
22 the CSA Reassessment in which lawsuit there has been a verdict or judgment on the merits prior
23 to completion of the reassessment on the claim.


24 Eligibility for CSA Reassessment includes California Later Period Claimants who have
25 already elected to participate pursuant to an effective election under the RSA and California
26 Claimants who are eligible to participate under this provision and who make their election within
27 the time period set forth in the notice provided under the CSA as set forth below.

1 b. Any California Early Period Claimant who is otherwise eligible under Section
2 III.B.1.a. but is not entitled to receive notice from the Respondents under Section III.B.2. below,
3 may request to have his or her claim reassessed under the CSA Reassessment so long as such
4 request is made to the Respondents no later than June 30, 2006.

5 c. Any California Claimant who disputes on any rational basis a Respondent's
6 characterization that such denial or termination falls into any of the reasons set forth in Section
7 III.B.1.a. (i) through (iv) above may request to participate in the CSA Reassessment so long as
8 such request is made to the Respondents no later than June 30, 2006. A Respondent's upholding
9 of the characterization and consequent rejection of the claim from the CSA Reassessment shall be
10 subject to the Independent Review (IR)  process described in Section III.C. of the CSA and
11 **Exhibit "B"** hereto.

12 2. Notice. - Respondents shall mail a CSA Notice in the form of **Exhibit "C"**
13 regarding the CSA Reassessment no later than the CSA Implementation Date to any California
14 Claimant who is eligible under Section III.B.1., above and who is either:

15 a. a California Later Period Claimant except for those who have already made a valid
16 election to participate in the RSA Reassessment, in which case they shall not be sent a CSA
17 Notice, although their claims shall be reassessed under provisions applicable to the CSA
18 Reassessment, or

19 b.  California Early Period Claimant and such claimant's original claim was denied or
20 terminated based upon the Respondent's interpretation of certain of California judicial decisions
21 or Department positions impacting disability insurance benefits and the application of such
22 decisions and positions to claims eligible for reassessment under this CSA.

23 3. CSA Reassessment. Respondents will review the oldest claims of eligible
24 California Claimants who have elected to participate in the CSA Reassessment first, taking into
25 account the entire period from 1997 through September 30, 2005 as the appropriate period in
26 which to consider what is oldest but also considering that submission and receipt of information
27 necessary for the reassessment is an ongoing process so that the date when completed information
28 is received is a relevant consideration in putting a re-submitted claim into the sequence for

1 review. It is also recognized that the RSA Reassessment involves review of the 2000 and later
2 claims prior to review of any claims in the 1997-1999 period, whereas the schedule under this
3 CSA requires consideration of the oldest first from 1997 through September 30, 2005.

4 Administration of the CSA Reassessment will review what is deemed oldest first under the RSA
5 with what is deemed oldest first under this CSA for California Claimants by integrating the two
6 beginning dates and the subsequent periods in a fair and equitable manner with neither being
7 advantaged over the other while recognizing that the RSA Reassessment began several months
8 earlier than the CSA Reassessment.

9 **C. Independent Review**

10 No later than one hundred and twenty (120) days of the CSA Effective Date, there shall
11 be implemented an Independent Review (IR) process for review, at the request of the claimant,
12 of any decision of Respondents' Claim Reassessment Unit (CRU) that upholds on reassessment,
13 in whole or in part, an original claim decision either denying the claim or terminating the
14 benefits of a California Claimant, as further documented in Exhibit "B", attached hereto.

15 The IR process also shall be available for appeal from a Respondent's decision upholding
16 an original claim denial or benefit termination on (i) through (iv) grounds contained in Section
17 III.B.1.(a) above, affecting availability of CSA Reassessment to a California Claimant.

18 An individual selected by mutual agreement by the Department and the Respondent shall
19 be the IR Director, with the duties and responsibilities set forth in Exhibit "B." All costs of the
20 IR process shall be paid by Respondents.

21 Respondents shall make the final decision in the CSA Reassessment as to whether the original
22 decision is upheld, modified or reversed. The California Claimant shall have access to the claim
23 file, including the Report of the Independent Reviewer, after the decision of the CRU is final, in
24 the event he or she is dissatisfied with the decision of the CRU.

25 **D. Attending Physician's Opinion**

26 Respondent shall give significant weight to an attending physician's opinion, if the
27 attending physician is properly licensed and the claimed medical condition falls within the
28 attending physician's customary area of practice, unless the attending physician's opinion is not

1 well supported by medically acceptable clinical or diagnostic standards and is inconsistent with
2 other substantial evidence in the record. In order for an attending physician's opinion to be
3 rejected, the claim file must include specific reasons why the opinion is not well supported by
4 medically acceptable clinical or diagnostic standards and is inconsistent with other substantial
5 evidence in the record.

6 **E. Claimants Informed of Right to Request IME**

7 As part of the information advising a California Claimant how to submit a claim or early in
8 the process of reviewing an open claim and, in any event, prior to any decision being made to
9 deny a recently submitted claim or to close an open claim, California Claimants shall be
10 informed in writing that it is their right or the right of their attending physician (either directly or
11 through the claimant's representative) to request an "independent medical examination" ("IME")
12 of their medical condition, unless the decision is made to pay or continue to pay the claim.

13 **F. Monitoring Compliance with the CSA**

14 1. Examinations. The Insurance Commissioner shall conduct examinations of the
15 Claim Reassessment Unit's claim decisions and compliance with the other terms of the CSA,
16 including changes made in claim handling practices and procedures contemplated by the CSA,
17 all in the manner and at such intervals as he or she deems appropriate in accordance with the
18 Insurance Code and Regulations. In connection with such examinations, the Insurance
19 Commissioner shall have access to claim files and other paper and electronic records as
20 authorized pursuant to Insurance Code and Regulations.

21 2. Information. Respondents shall provide the Insurance Commissioner on a
22 quarterly basis with reports relating to the status of California Claimants who are eligible to
23 participate and have elected to participate in the CSA and RSA Reassessments, including
24 information concerning the results of reviews of the Claim Reassessment Unit and the use and
25 results of the IR process.

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1 **IV.**

2 **CHANGES IN CLAIMS HANDLING POLICIES**

3 In an effort to resolve disagreements between the Respondents and the Department
4 concerning certain provisions in California Contracts or their interpretation as applied in
5 handling claim decisions, which disagreements were not able to be resolved based upon usual
6 sources of statutory, regulatory or decisional authority, Respondents have agreed to make the
7 following changes in certain claims handling policies and in the terms of their California
8 Contracts, in accordance with the effective date of the provisions in Section V.

9 **A. Discretionary Authority**

10 Respondents shall discontinue use of a provision that has the effect of conferring
11 unlimited discretion on the Respondent or other plan administrator to interpret policy language,
12 or requires an “abuse of discretion” standard of review if a lawsuit ensues unless the reviewing
13 court determines otherwise (“discretionary authority provision”) in any California Contract sold
14 after the date set forth in Section V.

15 **B. Mental and Nervous Conditions**

16 Respondents shall interpret the “mental and nervous conditions” benefit in a California
17 Contract and its limitation to twenty-four (24) months to apply after the termination of any
18 physiological-based disabling condition covered by the policy and not concurrent with such
19 physiological condition and shall amend policy language in future California Contracts to better
20 reflect this interpretation of the provision.

21 **C. Self-Reported Conditions**

22 Respondents shall discontinue application of the “self-reported condition” provisions in
23 California Contracts, which has permitted Respondent to characterize certain disabling
24 conditions as “self-reported” (e.g., pain, limited range of motion, weakness), while the
25 Respondent accepted only objective test results to support disability, thus limiting payment of
26 certain benefits under the “self-reported conditions” policy provision, and discontinue inclusion
27 of “self-reported conditions” provisions in any California Contract issued after the date set forth
28 in Section V.


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V.

**STIPULATIONS REGARDING CHANGES TO
POLICY LANGUAGE AND CLAIMS HANDLING**

A. Respondents agree that they shall not target short term and long term disability claims for denial or termination of benefits on the basis of economic advantage to themselves.

B. Respondents agree that they shall promptly, fairly, and objectively investigate each short term and long term disability claim, considering the interests of the claimant at least as much as their own, pursuant to California statutory and case law and in accordance with the terms of the applicable insurance policy, so long as such terms are consistent with applicable California statutory and case law.

C.  Respondents agree that as of the CSA Effective Date, except for new forms that might be submitted to and approved by the Commissioner in the future, the Respondents will no longer market, offer, issue or deliver (1) an individual disability policy form other than Forms 650-CA and 651-CA to California residents, or (2) group disability policy or certificate forms other than Forms C.FP-1-CA and CC.FP-1-CA to California groups, as approved pursuant to the Order of the Commissioner issued as part of this CSA. However, policy forms for which quotes have been offered or applications have been taken by the CSA Effective Date may be delivered to the purchasers after the CSA Effective Date if they are sold before November 1, 2005. For business initiated and sold between October 3, 2005 and November 1, 2005, the Respondents may use existing policy forms so long as the provisions are interpreted to conform with the requirements of Section V.D. hereof. Respondents agree that, as of the CSA Effective Date, they shall comply with California Insurance Code Section 10270.507.



Policy Language Changes

Individual Policy Forms 650-CA and 651-CA and Group Policy Form C.FP-1 – CA, as noted above in section V.C., contain language that is in compliance with the laws of the State of California, and each of which has been approved for sale in the State of California. The most important policy language changes are as follows:

1 1. “Total Disability” Definitions.

2 “Total disability” shall be defined in California Contracts during the usual or own-
3 occupation period as:

4 a disability that renders one unable to perform with reasonable continuity the substantial
5 and material acts necessary to pursue his or her usual occupation in the usual and
6 customary way

7 and during the another or any-occupation period shall be defined as:

8 a disability that renders one unable to perform with reasonable continuity the substantial
9 and material acts necessary to pursue his or her usual occupation in the usual and
10 customary way and to engage with reasonable continuity in another occupation in which
11 he or she could reasonably be expected to perform satisfactorily in light of his or her age,
12 education, training, experience, station in life, physical and mental capacity.

13 This change shall be made in all new California Contracts issued after the CSA Effective Date
14 and in in-force policies upon renewal after the CSA Effective Date.

15 2. Discretionary Authority.

16 Respondents agree to withdraw from the administrative mandamus action (the appeal
17 from the administrative hearing and Insurance Commissioner's Order) regarding discretionary
18 authority policy language. Any language having the effect of a “discretionary authority
19 provision” as set forth in Section IV.A. shall not be applied to any California Contract sold after
20 the CSA Effective Date. A “discretionary authority provision” shall not be included in any new
21 policies issued as California Contracts or included in Summary Plan Descriptions (SPDs) in
22 ERISA-related Plans generated or issued by the Company, after the CSA Effective Date so long
23 as its omission from the policy form or SPD is consistent with what is permitted by applicable
24 California statutory and case law. Discretionary authority provisions in existing California
25 Contracts that were issued prior to the date of the Order of the Commissioner are not affected by
26 the CSA.

27 3. Self-Reported Conditions.

28 Policy language regarding limitations on benefits for self-reported conditions as set forth
in Section IV.C shall not be applied in existing California Contracts after the earlier of the date
of their first renewal following the CSA Effective Date or December 31, 2007. Self-reported

1 conditions provisions shall not be included in any new policies issued as California Contracts
2 after the CSA Effective Date.

3 4. Mental and Nervous Conditions.

4 Policy language limiting the duration of payment on disability caused by mental and
5 nervous conditions shall be interpreted as set forth in Section IV.B. so as not to run concurrently
6 with benefits for physiologically-based conditions in California Contracts after the earlier of the
7 date of their first renewal following the CSA Effective Date or December 31, 2007, and the
8 language in all new policies issued as California Contracts after the CSA Effective Date shall be
9 changed to better reflect the interpretation of this provision set forth in Section IV.B. As a
10 matter of clarification and current interpretation in all applicable policies, in circumstances in
11 which a physiological disability exists and is followed by a mental and nervous disability, the 24
12 month limitation in the mental and nervous disability provision starts at the onset of the mental
13 and nervous disability and does not relate back to the period of the physiological disability with
14 the result of limiting the disability period for the physiological disability to 24 months.

15 5. Pre-Existing Conditions.

16 Policy language excluding conditions “contributed [to] by” the pre-existing condition
17 shall not be applied in existing California Contracts after the CSA Effective Date. This change
18 shall be made in all new policies issued as California Contracts after the CSA Effective Date and
19 in in-force policies upon renewal after the CSA Effective Date.

20 6. Offsets.

21 Policy language regarding offsets for Social Security Disability Income (SSDI) benefits
22 shall be interpreted to mean that only SSDI benefits actually received by the claimant shall be
23 offset in California Contracts after the CSA Effective Date. This change shall be made in all
24 new policies issued as California Contracts after the CSA Effective Date and in in-force policies
25 upon renewal after the CSA Effective Date.

26 7. Mandatory Rehabilitation.

27 Policy language requiring participation in a mandatory rehabilitation program will no
28 longer be included in California Contracts after the CSA Effective Date.

1 8. Survivor Benefit.

2 The definition of "Eligible Survivor" shall be interpreted in California Contracts after the
3 CSA Effective Date to delete an age limitation for surviving children, and shall provide that if no
4 estate is formed, the benefits will escheat to the State of California. This change shall be made in
5 new policies issued as California Contracts after the CSA Effective Date.

6 **E. Claims Handling Change Implementation Dates**

7 The policy language changes reflected in Section V.D. above shall be applicable to
8 consideration of claim decisions of California Claimants in accordance with the following
9 provisions:

10 1. "Total Disability" Definitions.

11 The change described above in Section V.D.1. shall be applied to (1) claims open at CSA
12 Effective Date that were submitted to Respondents on or after June 24, 2004; (2) claims
13 participating in CSA Reassessment; and (3) new claims submitted after the CSA Effective Date.
14 That is, the claims will be handled as if this change were in place at the specified time.

15 2. Discretionary Authority.

16 The change described above in Section V.D.2. shall be applied to (1) policies sold after
17 the CSA Effective Date; and (2) claims participating in CSA Reassessment .

18 3. Self-Reported Conditions.

19 The change described above in Section V.D.3. shall be applied to (1) new claims
20 submitted after the earlier of the first renewal date of the group policy to which they relate
21 following the CSA Effective Date or December 31, 2007; and (2) claims participating in the
22 CSA Reassessment. In addition, Respondents shall enhance training for claims staff regarding
23 subjective conditions, augmenting the criteria to be used in evaluating subjective complaints.

24 4. Mental and Nervous Conditions.

25 The change described above in Section V.D.4. shall be applied to (1) new claims
26 submitted after the earlier of the first renewal date of the group policy to which they relate
27 following the CSA Effective Date or December 31, 2007; and (2) claims participating in the
28 CSA Reassessment.

1 5. Pre-Existing Conditions.

2 The change described above in Section V.D.5. shall be applied to (1) new claims
3 submitted after the CSA Effective Date, and (2) claims participating in the CSA Reassessment.

4 6. Offsets.

5 The change described above in Section V.D.6. shall be applied to (1) claims open as of
6 the CSA Effective Date; (2) claims participating in the CSA Reassessment; and (3) new claims
7 submitted after the CSA Effective Date.

8 7. Mandatory Vocational Rehabilitation.

9 The change described above in Section V.D.7. shall be applied to (1) claims open as of
10 the CSA Effective Date; (2) claims participating in the CSA Reassessment; and (3) new claims
11 submitted after the CSA Effective Date. In processing the claims covered by this change,
12 Respondents shall consider participation in vocational rehabilitation to be voluntary.

13 8. Survivor Benefit.

14 The change described above in Section V.D.8. shall be applied to (1) claims open as of
15 the CSA Effective Date; (2) claims participating in the CSA Reassessment; and (3) new claims
16 submitted after the CSA Effective Date. In addition, Respondents will inform survivors who are
17 not eligible survivors under the policy definitions of the necessity of forming an estate in the
18 event there are no eligible survivors.

19 9. Additional Review.

20 In processing the claims covered by the changes set forth in Sections IV and V, an
21 additional level of internal review by a Quality Compliance Consultant (or its equivalent) will
22 occur prior to a claim denial.

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24 **VI.**

25 **FINAL STIPULATIONS**

26 A. Respondents and the Department agree that, in lieu of other disciplinary action,
27 the Insurance Commissioner may, by his written Decision and Order to be made and filed herein,
28 without further notice to Respondents, issue an order prohibiting Respondents from engaging in

1 the conduct set forth in the Accusation (without any admission by Respondents of having
2 engaged in such conduct) and requiring Respondents to pay a civil penalty in the amount of
3 \$8,000,000.00;

4 B. Respondents agree to pay to the Department all attorney's fees and costs of the
5 Department in bringing this enforcement action, in the amount of \$598,503.00, pursuant to
6 Insurance Code, section 12921(b)(4);

7 C. Respondents agree to pay all reasonable future costs of the Department to ensure
8 compliance with the CSA, pursuant to Insurance Code, section 12921(b)(4);

9 D. Respondents agree to pay the civil penalty, attorney's fees and costs enumerated
10 above upon receipt of invoice(s) from the Department, payments to be directed to the California
11 Department of Insurance; Division of Accounting; 300 Capitol Mall, 13th Floor; Sacramento, CA
12 95814;

13 E. Respondents acknowledge that the CSA is freely and voluntarily executed by
14 Respondents, with a full realization of the legal rights set forth in the Insurance Code;

15 F. Respondents and the Department agree that the CSA is the full and final
16 settlement of the Department's investigation, scheduled and targeted Field Claims examinations,
17 and Field Rating and Underwriting examination, and the Accusation;

18 G. Neither the CSA nor any related negotiations, statements, or documents shall be
19 offered by the Department as evidence of an admission or concession of any liability or
20 wrongdoing whatsoever on the part of the Respondents;

21 H. Neither the CSA nor any of the obligations agreed to by the Respondents shall be
22 interpreted to constitute a novation or alter the terms of any policy, except as specifically stated
23 herein. Neither the CSA nor any of the obligations agreed to by the Respondents shall be
24 interpreted to reduce or increase any rights of participants in ERISA-covered plans, except as
25 specifically stated herein, including but not limited to rights to which they may be entitled
26 pursuant to 29 U.S.C. 1133 and 29 CFR 2560.503-1 of ERISA, including any appeal or review
27 rights under the plan. Other than those rights afforded under the CSA, it is the intention of the
28 parties that no additional rights are provided to the extent that any California Claimants have

1 previously exercised their rights and therefore, as provided for under ERISA, have permitted
2 those rights to lapse;

3 I. Respondents agree that, in the event of a material noncompliance with the terms
4 of the CSA, the Insurance Commissioner may, after notice and hearing, order the suspension for
5 up to one (1) year of the Certificate of Authority of the noncompliant Respondent(s);

6 J. Section III. of the CSA will terminate upon completion of Respondents' review of
7 claims for which California Claimants have chosen to participate or requested review under the
8 CSA Reassessment, except that the following provisions of Section III. shall continue in effect:

- 9 1. Subsection III.D. - Attending Physician's Opinion,
- 10 2. Subsection III.E. - Claimants Informed of Right to Request IME, and
- 11 3. Subsection III.F.1. - Monitoring Compliance with the CSA;

12 K. Section IV. and Section V. of the CSA shall be subject to change as follows:

13 1. Respondent's agreements as to Changes in Claims Handling Policies, set forth
14 in Section IV., shall each remain in effect until such time as a change in Section IV.A., IV.B. or
15 IV.C. is either (i) required by a change in applicable statute, regulation or court decision, or (ii)
16 permitted by such authorities and the Respondent provides the Department with 30 days prior
17 written notice of the proposed change, the reason therefor, and the specific source of authority
18 (applicable statute, regulation or court decision) permitting such change, and the change is
19 agreed to by the Department and such agreement by the Department shall not unreasonably be
20 withheld. The provisions of Section IV. that are not affected by the specific change shall
21 continue in effect;

22 2. Respondent's agreements as to Changes to Policy Language and Claims
23 Handling, set forth in Section V., shall each remain in effect until the earlier of (i) such time as a
24 change in one of the agreements set forth in Sections V.D. or V.E. is required by a change in the
25 applicable statute, regulation or relevant court decision; (ii) alternative policy language for
26 disability insurance policies affecting one of such designated Sections is approved by the
27 Department for Respondent or for other insurers writing disability insurance in California; (iii)
28 approval for a specific change to policy language affecting one of such designated Sections is

1 authorized by the Department; or (iv) a change to policy language or claims handling is
2 permitted by such authorities affecting one of such designated Sections and the Respondent
3 provides the Department with 30 days prior written notice of the proposed change, the reason
4 therefor, and the specific source of authority (applicable statute, regulation or court decision)
5 permitting such change, and the change is agreed to by the Department, and such agreement by
6 the Department shall not unreasonably be withheld. The provisions of Sections V.D. or V.E. that
7 are not affected by the specific change shall continue in effect;

8 L. Respondents agree to use their best efforts to complete the CSA Reassessment by
9 June 30, 2007, although, for good cause shown, the Insurance Commissioner may agree to
10 extend the time for completing that process;

11 M. Respondents acknowledge that Insurance Code, section 12921(b)(1), requires the
12 Insurance Commissioner to approve the final settlement of this matter, and that both the
13 settlement terms and conditions contained herein and the acceptance of those terms and
14 conditions are contingent upon the Insurance Commissioner's approval, which approval is
15 provided in the Order of the Commissioner, issued simultaneously with the execution of this
16 CSA and made a part hereof.

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1 Respondents and the Department hereby execute this document at Chattanooga, State of
 2 Tennessee, on the ____ day of October, 2005, and San Francisco, State of California, on the ____
 3 day of October, 2005, respectively.

4
 5 **UNUM LIFE INSURANCE COMPANY OF AMERICA**

6 **PROVIDENT LIFE AND ACCIDENT INSURANCE
 COMPANY**

7 **THE PAUL REVERE LIFE INSURANCE COMPANY**

8 By:

9
 10 _____
 Signature

11 Thomas R. Watjen

12 Printed name

13 President and Chief Executive Officer

14 Title

15 UnumProvident Corporation

16 Company

17 1 Fountain Square

18 Address

19 Chattanooga, Tennessee 37402

20 **CALIFORNIA DEPARTMENT OF INSURANCE**

21 By:

22 _____
 Signature

23 Richard D. Baum

24 Printed name

25 Chief Deputy Commissioner

26 Title

27 45 Fremont St., 23rd Floor

28 Address

San Francisco, California 94105-2204