Waiver of Premium Claim Form - Employee Statement

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as "We or "Humana."

Life, Specified Disease/Critical Illness, Hospital Indemnity, and Accident Insurance products insured by Kanawha Insurance Company, Humana Insurance Company, Humana Insurance Company of New York or Humana Insurance Company of Kentucky.

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on pages 3-7)

The below Statements are true to the best of my knowledge and belief.

_____ _____ / _____ / _____

Signature of Policyholder Date

Employee Information:

Policyholder's Name _____ Policy No. _____

Mailing Address _____ Social Security No._____

City _____ State _____ ZIP Code _____ Date of Birth _____ / _____ /_____

Daytime Phone number (_____)_____

Do you have medical coverage with Humana? ☐ Yes ☐ No If yes, Medical ID No. _____

Do you have Disability coverage with Kanawha/Humana? ☐ Yes ☐ No If yes, Plan ID No. _____

If no, are you currently receiving disability payments through another carrier or SSDI? ☐ Yes ☐ No

Disability carrier name _____

Address:_____

Phone number (_____)_____Plan ID No._____

Claim Information:

Employer's Name (at the time disability started)_____

Street Address_____City_____

State_____ZIP Code_____Phone Number (_____)_____

Occupation (at the time disability started)_____

List the job duties/responsibilities of your occupation at the time of the disability

_____

_____

Date of the first symptoms of the illness or date of accident_____/_____/_____

Date you were first treated_____/_____/_____

First date you were unable to work as a result of your disability_____/_____/_____

Describe the onset and nature of your illness or describe how and where accident occurred.

_____

_____

Humana®

Mail to: Humana
PO Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax to: 1-920-339-4794
Email to: GBLife_Disability@humana.com

Waiver of Premium Claim Form - Employee Statement

What aspect of your condition made you unable to perform your job?

_____

_____

Have you returned to work? ☐ Yes ☐ No If yes, date returned:_____/_____/_____

☐ Full Time ☐ Part Time

Are you employed with any other company other than the employer listed above? ☐ Yes ☐ No

Employer_____Occupation_____

Dates worked:_____

Physician information:

Attending (Treating) physicians:

Physician's Name	Address	Phone Number

State Fraud Warning Statements

Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution of fraud. By providing these notices, neither Humana nor its subsidiaries imply that they are authorized to write insurance in all 50 states.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties. The authorization shall remain in effect for the term of your coverage. You or your designated representative is entitled to receive a copy of this claim form.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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.

Delaware: Any Person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

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

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to prosecution for fraud and guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines.

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

Maryland: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

Texas: 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.

Utah: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Waiver of Premium Claim Form - Employee Statement

Authorization to release information - For the Use and Disclosure of Protected Health Information

Patient's Name _____ Contract No. _____

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals to disclose my protected health information to Humana Insurance Company, Humana Insurance Company of Kentucky or Kanawha Insurance Company.
3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records,client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
5. I authorize only designated staff of Humana Insurance Company or Humana Insurance Company of Kentucky or Kanawha Insurance Company, to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Human a Insurance Company or Humana Insurance of Kentucky or Kanawha Insurance Company P.O. Box 10708, Green Bay WI 54307-0708. This revocation shall become effective on the date it is received by Humana Insurance Company or Humana Insurance of Kentucky or Kanawha Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

I certify that I have received a copy of this Authorization and authorize the use and/or disclosure of my protected health information as contemplated herein for ☐ all records or ☐ records for dates of service _____ to _____

_____ _____ _____/_____/_____

Signature *Printed Name* *Date*

I have legal authority* under the laws of the State of _____to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

_____ _____ _____/_____/_____

Name of Authorized Representative/Parent or Guardian *Relationship to Applicant* *Date*

**A copy of the legal authority document must be on file with Humana.*

If you have any questions when completing this form, please call 1-866-427-7478.

Humana®

Mail to: Humana
PO Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax to: 1-920-339-4794
Email to: GBLife_Disability@humana.com

Waiver of Premium Claim Form - Employer Statement

Employer Information:

Employer's Name _____

Employer Address _____ City _____ State _____ ZIP Code _____

Contact Name _____ Phone Number (_____) _____

For Group Sponsored Plans, what is the group number _____

Employee Information:

Employee's Name _____ Policy No. _____

Street Address _____ Social Security No. _____

City _____ State _____ ZIP Code _____ Date of Birth _____/_____/_____

Employee's Date of Hire _____/_____/_____ Date Employee Last Worked _____/_____/_____

What class is the Employee in (if applicable) _____

Reason for stopping work: ☐ Sickness ☐ Granted LOA ☐ Laid Off ☐ Accident
☐ Dismissed ☐ Resigned ☐ Retired ☐ Other

Has employee returned to work? ☐ Yes ☐ Part-time Date _____/_____/_____
☐ No ☐ Full-time Date _____/_____/_____
If No, what is the anticipated return to work date _____/_____/_____

Are they still an employee? ☐ Yes ☐ No If No, when did employment terminate _____/_____/_____

Reason for termination of employment? _____

Benefit Information for Employer Sponsored Life Plans Only:

Effective Date of Coverage: _____/_____/_____ Termination Date of Coverage (if applicable) _____/_____/_____

Life Value Amounts (if applicable):

Basic Life Insurance	Amount of Insurance	Supplement/Voluntary Life Insurance	Amount of Insurance
Employee	$	**Employee**	$
Spouse	$	**Spouse**	$
Child	$	**Child**	$

Waiver of Premium Claim Form - Employer Statement

Employee's Occupation Information, continued:

Occupation at Time Last Worked _____

(Please attach a copy of the job description to this form)

Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job using the definitions below for the frequency: Indicate the average weight when applicable.

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Frequency of Occurrence				
Activity:	**N/A**	**Occasionally**	**Frequently**	**Continuously**	
Standing	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Bending, twisting or stooping	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Operating heavy machinery	☐	☐	☐	☐	
Reaching/working overhead	☐	☐	☐	☐	
Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐	
Pushing or pulling	☐	☐	☐	☐	_____ lbs.
Lifting or Carrying	☐	☐	☐	☐	_____ lbs.

What are the major tasks of the employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks?

_____ _____ %

_____ _____ %

_____ _____ %

_____

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 2)

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

Employer's Name _____ Telephone Number (_____) _____

Address _____ Fax Number (_____) _____

Printed Name of Person Completing Form _____

Signature of Authorized Representative _____

Title _____ Date _____/_____/_____

Humana®

Mail to: Humana
PO Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax to: 1-920-339-4794
Email to: GBLife_Disability@humana.com

Waiver of Premium Claim Form - Physician Statement

Please return the completed form with medical records detailing the patient's prognosis, treatment plan and current progress to Humana. (See address and contact information at bottom of page.)

Disability Information:

Patient's Name _____ Date of Birth ____/____/____ Height _____Weight _____

Is the disability related to: ☐ Illness ☐ Accident ☐ Mental/Nervous Condition

Date you advised the patient they should cease work: ____/____/____

If pregnancy, estimated date of delivery____/____/____

For conditions other than pregnancy, the date symptoms first appear or accident occurred : ____/____/____

Is the condition due to an injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown

Treatment Information:

Diagnosis (including any complications) _____ICD-9 Code(s) _____

Date of patient's first visit for this condition ____/____/____

Date of last patient visit: ____/____/____ (Please submit records from this visit)

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

Objective findings (including current x-rays, EKG, laboratory data and any clinical findings)

_____

Patient's progress: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

Patient is currently: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Current treatment plan for this condition (including any rehab programs/medications)

_____

Is the patient on any medications? ☐ Yes ☐ No If "Yes", list medications.

Medications: _____

Have any surgeries already been performed? ☐ Yes ☐ No If "Yes", surgery date ____/____/____

CPT Code(s)/ procedure performed _____

If "No", are any surgeries scheduled? ☐ Yes ☐ No If "Yes", surgery date ____/____/____

CPT Code(s)/ procedure performed _____

Has patient been hospital confined? ☐ Yes ☐ No

If "Yes", Admit Date ____/____/____ Discharge Date ____/____/____

Hospital Name: _____ Address _____

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

If "Yes", indicate type of condition, treatment date(s), and treatment provided:

_____

Please provide the name and address of other treating physician(s)

Physician's Name	Address	Phone Number

Humana®

Mail to: Humana
PO Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax to: 1-920-339-4794
Email to: GBLife_Disability@humana.com

Waiver of Premium Claim Form - Physician Statement

Please return the completed form with medical records detailing the patient's prognosis, treatment plan and current progress to Humana. (See address and contact information at bottom of page.)

Impairment:

Cardiac Functional Capacity Limitations (American Heart Association – if applicable):

☐ Class 1 (None) ☐ Class 2 (Slight) ☐ Class 3 (Marked) ☐ Class 4 (Complete)

Blood Pressure (Last Four Visits) _____ _____ _____ _____

Physical Impairments (As defined in Federal Dictionary of Occupational Titles):

☐ Class 1 - No Limitation of functional capacity capable of heavy work. No restriction. (0% - 10%)
☐ Class 2 - Medium manual activity. (15% - 30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work. (35% - 55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. (60% - 70%)
☐ Class 5 - Severe limitation of functional capacity; capable of minimum sedentary activity. (75% - 100%)

Comments _____

_____

Mental Impairments

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations. (No limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in interpersonal relations. (Slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in limited interpersonal relations. (Moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked limitations)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment. (Severe limitations)

Comments _____

_____

Functional Ability:

Estimate your patient's ability to perform the following tasks based on your knowledge of the patient.

Activity:	**Never** (0%)	**Occasionally** (1-33%)	**Frequently** (34-66%)	**Continuously** (67-100%)	**Number of hours** (less than 3, 4/6 or 6/8 hours)
Standing	☐	☐	☐	☐	_____
Walking	☐	☐	☐	☐	_____
Sitting	☐	☐	☐	☐	_____
Kneeling	☐	☐	☐	☐	
Twisting/bending/stooping	☐	☐	☐	☐	
Reaching above shoulder level	☐	☐	☐	☐	
Operating heavy machinery	☐	☐	☐	☐	
Keyboard use/repetitive hand motion	☐	☐	☐	☐	

	Lifting/Carrying				**Pushing/Pulling**			
	Never (0%)	**Occasionally** (1-33%)	**Frequently** (34-66%)	**Continuously** (67-100%)	**Never** (0%)	**Occasionally** (1-33%)	**Frequently** (34-66%)	**Continuously** (67-100%)
Up to 10 lbs	☐	☐	☐	☐	☐	☐	☐	☐
11 to 20 lbs	☐	☐	☐	☐	☐	☐	☐	☐
21 to 50 lbs	☐	☐	☐	☐	☐	☐	☐	☐
51 to 100 lbs	☐	☐	☐	☐	☐	☐	☐	☐

Humana®

Mail to: Humana
PO Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax to: 1-920-339-4794
Email to: GBLife_Disability@humana.com

Waiver of Premium Claim Form - Physician Statement

Please return the completed form with medical records detailing the patient's prognosis, treatment plan and current progress to Humana. (See address and contact information at bottom of page.)

If the disability is related to a psychological disorder, has the Global Assessment of Functioning (GAF) been performed? ☐ Yes ☐ No

If Yes, complete the DSM-IV-TR axis diagnosis section below

Axis I ____ Axis II _____ Axis III ____ Axis IV _____ Axis V _____ GAF, or the DSM-V; WHODAS 2.0 Score _____

Date Assessed _____/_____/_____

Prognosis and Restrictions:

Is patient currently disabled from their job? ☐ Yes ☐ No from **any** other work? ☐ Yes ☐ No

If the patient works from their home, would this change their disability status or the length of disability? ☐ Yes ☐ No

If "Yes", explain: _____

When do you expect a fundamental or marked change in the patient's condition?

☐ Less than 1 Month ☐ 1 Month ☐ 2-3 Months ☐ 4-6 Months ☐ Other _____

What date can employment resume in the patients regular occupation? _____/_____/_____ ☐ Full-time ☐ Part-time

What date can employment resume in another occupation? _____/_____/_____ ☐ Full-time ☐ Part-time

If the return to work date is unknown at this time, please indicate date of next appointment._____/_____/_____

Describe fully how the patient's conditions/limitations are affecting their ability to work, including any physical restrictions.

_____

_____

_____

_____

Additional Comments:

_____

_____

_____

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 2)

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

Printed Name of Physician _____ Phone No. (_____) _____

Street Address _____ Specialty _____

City _____ State _____ ZIP Code _____ Tax ID _____

Email Address _____ Fax No. (_____) _____

Signature of Attending Physician* _____ Date _____/_____/_____

*Note form must be signed by medical doctor duly licensed in the state where services are rendered

Humana®

Mail to: Humana
PO Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax to: 1-920-339-4794
Email to: GBLife_Disability@humana.com