Continuing Short Term Disability 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 6-7)

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

_____ _____/_____/_____

Signature of Policyholder Date

Employee Information (To be completed by the employee):

Policyholder's Name _____ Policy No. _____

Mailing Address_____ Social Security No._____

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

Daytime Phone number (_____) _____

Since your disability, have you been able to perform any work? ☐ Yes ☐ No If yes, please complete the following:

Employer _____ Occupation _____

Dates worked: _____

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

Anticipated Return to Work Date: _____/_____/_____

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

Employer _____ Occupation _____

Dates worked: _____Telephone No. (_____) _____

Deduction of Premium:

If your policy is currently active, we will deduct premiums from your disability benefit to keep your premiums paid to date. This will eliminate the risk that your policy be terminated for lack of premium payments.

If you do not want premiums deducted from your benefit, select the waiver option below, then sign and date your request.

☐ I **do not** want premiums deducted from my disability benefit.

_____ _____/_____/_____

Signature of Employee *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

Direct Deposit Authorization

Check Action | **Effective Date** | **Acct. Type** | **Ownership of Account**

☐ New ☐ Change ☐ Cancel

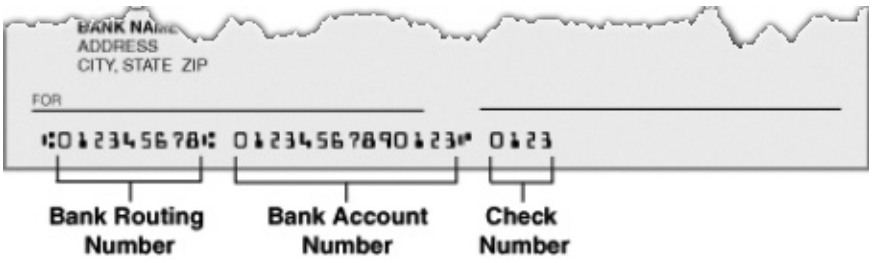
☐☐ Month – ☐☐ Day – ☐☐☐☐ Year

☐ Checking ☐ Savings

☐ Self ☐ Joint ☐ Other

Bank Name _____

Bank Routing Number _____ Bank Account Number _____



I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize Kanawha Insurance Company to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____ _____/_____/_____

Signature Date

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

_____ _____/_____/_____

Signature Date

Terms And Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program please read the following terms and conditions for participation carefully before making your decision. Not all polices may qualify.

1. Once the Form is received by Kanawha Insurance Company, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify Kanawha Insurance Company of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE, and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be cancelled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to Kanawha Insurance Company or cannot be made to your account, Kanawha Insurance Company will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be cancelled by your financial institution or Kanawha Insurance Company. **Your participation will be cancelled automatically if you terminate participation in the above Account(s).**

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Continuing Short Term Disability Claim Form - Physician Statement-To be completed by the physician

Patient Information:

Employee's Name _____ Policy No. _____
Mailing Address_____ Social Security No._____
City _____ State _____ ZIP Code _____ Date of Birth _____/_____/_____
Daytime Phone number (_____) _____ Height _____Weight_____

Treatment Information:

Current Diagnosis (including any complications) & symptoms _____
Diagnosis Code(s) (ICD-9; ICD-10)_____(If a mental health diagnosis, 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: _____/_____/_____

Date of last patient 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

Patient's **current treatment plan** for this condition (including any rehab programs)

_____

List any **current Medications** (include date of change if applicable)

_____

Have any subsequent surgeries been performed? ☐ 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 _____

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 Visit) _____ Comments _____

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_____

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Impairment continued:

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 25%, 50%, 75%, 100%)
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 100lbs	☐	☐	☐	☐	☐	☐	☐	☐

Prognosis and Restrictions:

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

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? _____/_____/_____ ☐ 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._____/_____/_____

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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 6 and 7)

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

Continuing Short Term Disability Claim Form - Employee Statement

State Specific Fraud Warning Statements

Humana:

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:

Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

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.

Arkansas, Louisiana, 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.

Arizona:

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California:

For your protection California law requires the following statement to appear on this form: Any person who knowingly presents 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

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.

Kentucky, 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.

Continuing Short Term Disability Claim Form - Employee Statement

State Specific Fraud Warning Statements

Kansas:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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.

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 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 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.

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 the state law.