Humana Short-Term Income Protection – Claim Form

Instructions

Please read and follow the instructions carefully.

1. If this is the initial claim for benefit payments for this disability, please have all parts of this claim form completed:
   - Employer statement —to be completed by the employer
   - Employee statement —to be completed by the employee
   - Attending physician statement —to be completed by the attending physician

2. To avoid unnecessary delays, be sure all parts of this claim form are completed according to the instructions, and do not separate the pages. If any part of the claim form is not completed in full, the form will be returned to the employee

3. If this is not the initial claim for this disability, please complete the sections as requested by Humana.

4. **Please mail all documentation to:** Humana, Inc.
   Group Life and Disability
   Claims P.O. Box 13068
   Green Bay, WI 54307-3068

5. If you choose to fax the claim form, our fax number is (920) 339-4794. Please make sure to fax both sides of form.

We may require additional information in the future to determine continuation of benefits.
At this time, we will notify you, your attending physician, and/or your employer accordingly.

Humana Short-Term Income Protection – Claim Form

Employer statement

To be completed by employer

Employer Information

Company Name

Address of employer | Phone number

City | State | Zip

Group number | Tax ID number

Employee Information

Name of employee

Certificate (member) number | Social Security Number (if different)

Was employee insured under your prior short-term income protection plan? ☐ Yes ☐ No

Job/occupation title

Description of major job duties (please attach job description

Job classification: Check the strength demand below which best describes the employee's job:

☐ Sedentary work: Lift 10 lbs. maximum and occasionally carry small objects. Some occasional walking or standing may be required.

☐ Light work: Lift 20 lbs. maximum and frequently lift/carry up to 10 lbs. or if less lifting, but significant walking/standing or sitting that requires push/pull on arm/leg controls.

☐ Medium work: Lift 50 lbs. maximum and frequently lift/carry up to 25 lbs.

☐ Heavy work: Lift 100 lbs. maximum and frequently lift/carry up to 50 lbs.

☐ Very heavy work: Lift in excess of 100 lbs. maximum and frequently lift/carry up to 50 lbs.

Employee's average basic salary immediately preceding disability $ | Hourly wage $

☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly | Hours worked per week

Date last worked | Number of hours worked that day

Work schedule at time of disability days/week | Hours/day

Employee's status on last worked day: ☐ Active ☐ FMLA ☐ Personal leave of absence
☐ Retired, date: ☐ Terminated Date: ☐ Laid off, date:

Was sick time, vacation time, or salary continuation paid? ☐ Yes ☐ No

If yes, provide specific dates paid

Does the employer contribute 100% of the premium for the insured employee's weekly income average? ☐ Yes ☐ No

If not, what percentage of the premium for such coverage is contributed by the employer % by employee %

Are employee premium contributions made under Section 125 of the Internal Revenue Code (i.e. cafeteria plan paid with pre-tax dollars) ☐ Yes ☐ No

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Employer statement, continued

Disability Information

What is the nature of the disability (if known)? If pregnancy, date of delivery or expected date of delivery (if known)

Did the sickness or injury arise out of the course of employment? ☐ Yes ☐ No

If yes, has a Worker's Compensation claim been filed?

☐ Yes If yes, and the claim was denied by the Worker's Compensation carrier, Please provide a copy of the approval or denial letter with this claim.

☐ No If no, please explain

Has the employee returned to work? ☐ Yes ☐ No

If yes, when ☐ With restrictions ☐ Full capacity

If the employee is partially disabled, are you able to make reasonable accommodations? ☐ Yes ☐ No

If you have partial disability coverage and the employee returned to work part-time, you must include the number of hours and days worked_____as well as the earned wages during the week $_____. This information must be sent or faxed to Humana at the end of each week. at the end of each week.

Note: please call Humana immediately if there are any changes in the status of the disability. Example: return to work date

Signature of authorized employer representative and title

Mail to: Humana
P.O. Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax Number: 1-920-339-4794

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Humana

Employee statement

To be completed by employee

Name | Home phone number ( )

Address of employee

City | State | Zip

Group number | Certificate (member) number

Date of Birth | Gender ☐ Male ☐ Female | Dominant hand ☐ Left ☐ Right | Height | Weight

Current Job title | Number of hours you work per week

Describe the daily duties of your job

Describe the nature of your disability

What is the first date you were unable to work because of this disability?

What is the first date you were treated by a qualified practioner?

When do you expect to return to work?

Physician's name(s) / specialty(ies) / address(es) (if more space is needed, please use back of form)

Type of disability ☐ Accident ☐ Illness ☐ Pregnancy

If pregnancy, what was the date of delivery? | Or expected date of deliver?

Have you been continuously disabled? ☐ Yes ☐ No If no, what date did you return to work ☐ Full time ☐ Part time

Did you use sick or vacation time? ☐ Yes ☐ No If yes, what were the specific dates used?

Is this disability injury related? | Has this claim been filed with any other insurance carrier? ☐ Yes ☐ No

☐ No ☐ Yes If yes, please describe how, when and where the injury occurred

Is this disability work related? ☐ Yes ☐ No

If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No If your claim was approved or denied by the Workers' Compensation carrier, please provide a copy of the approval or denial letter with your claim.

Are you receiving any income(s)? ☐ Yes ☐ No If yes, please provide the following information for any that apply:
Social Security Disability or Retirement income: $ | Workers' Compensation income: $
Other disability/employment/retirement incomes (including incomes from other group insurance policies, salary, etc.): $
If you are receiving any income, please provide the names and addresses, policy number(s) and dates payments began and/or ceased.

Prior to this disability claim, to the best of your knowledge, did you receive medical care, services, treatment, advice or diagnosis for this disability? ☐ Yes ☐ No If yes, please provide details (i.e. dates of service, providers of service).

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Short-term income protection claim form – employee statement, continued.

Authorization

To any physician, medical or dental practitioner, hospital, clinic, pharmacy, medical care facility, insurance company, health maintenance organization, employer, plan administrator, consumer reporting agency:

I authorize you to release to representatives of Humana Insurance Company, personal information about me including: medical history diagnosis, treatment and prognosis as to any mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information to evaluate my claim for short term disability benefits.

I understand the information obtained by use of the authorization will be used by Humana Insurance Company to determine eligibility for benefits. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid. This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by sending written notice to:

Humana, Inc.
Group Life and Disability Claims
P.O. Box 13068
Green Bay, WI 54307-3068

Any revocation of this authorization will not affect any use or disclosure or Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Signature of insured employee **Date**

Humana Short-Term Income Protection – Claim Form

Attending physician statement

To be completed and signed by the attending physician

Employee Information

Patient name

Group number | Certificate (member) number

Type of disability ☐ Accident or injury ☐ Illness ☐ Work-related ☐ Pregnancy/maternity

Date you first attended patient | Date you last attended patient

All treatment dates

Date sickness or injury began | Date symptoms first appeared

Diagnosis(es) | ICD-9 code(s)

Description(s)

Please describe subjective symptoms for this disability

Please describe objective findings for this disability

If patient was hospitalized, provide admit and discharge dates: Admit | Discharge

Was patient treated in an emergency room? ☐ Yes ☐ No Date treated in emergency room

Name of hospital

Name of physician (if different from attending physician)

Is this illness or injury intentionally self-inflicted or attempted suicide? ☐ Yes ☐ No If yes, please submit records

Is this illness or injury resulting from weight control or treatment of obesity not caused by an organic condition? ☐ Yes ☐ No

Has surgery been done? ☐ Yes ☐ No Date of surgery ☐ Inpatient ☐ Outpatient

Procedure performed

To the best of your knowledge, has the patient received medical care, services, treatment, advice, recommendations or diagnosis for this condition prior to the disability onset? ☐ Yes ☐ No

If yes, please provide the name(s), address(es) and telephone number(s) of the referring physician:

Physician name | Phone number ( )

Address | City | State | Zip

Physical restrictions (if applicable)

☐ Class 1 No limitation of functional capacity: capable of heavy work. No restrictions. (0-10%)
☐ Class 2 Medium manual activity (15-30%)
☐ Class 3 Slight limitation of functional capacity: capable of light work. (33-55%)
☐ Class 4 Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity. (60-70%)
☐ Class 5 Severe limitation of functional capacity: incapable of minimum (sedentary) activity. (75-100%)

What are the patient's restrictions/limitations?

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Attending physician statement, continued

Mental restrictions (if applicable)

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

Total disability (if applicable)

What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session, etc.)

Has the patient been totally disabled since this date?

☐ Yes If yes, what is the patient's expected return to work date?
☐ No If no, what date was the patient no longer totally disabled?

Is the patient a candidate for partial disability? ☐ Yes ☐ No If yes, refer to partial disability section below.

Partial disability (if applicable)

If employer is able to make accommodations, how many hours per week can patient resume part-time work?

What are the patient's restrictions?

What is the patient current treatment plan (i.e. physical therapy, number of visit per week, length of sessions, etc.)

At what date was the patient partially disabled?

What is the patient's expected return to work date?

Maternity (if applicable)

Is this disability due to pregnancy? ☐ Yes ☐ No

If disability is prior to delivery, what are the specific complicating factors?

What is the expected delivery date?

If disability is after delivery, what was the patient's date of delivery?

Type of delivery? ☐ Vaginal ☐ C-section What is the patient's expected return to work date?

Name Phone Number ( )

Address

City State Zip

Specialty

Signature of attending physician **Date**

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State Specific Fraud Warning Statements

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.

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, New Jersey

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, Ohio, 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.

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 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.

North Carolina

Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

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, commits a fraud against an insurer by submitting a claim containing an intentionally materially false or deceptive misstatement, misrepresentation, omission, or conceals any fact material to the interest of Humana, may have committed fraud which is a crime and which may result in the loss of coverage and/or denial of claim under this policy and may subject such person to prosecution for fraud, including criminal and civil penalties. Eligibility for coverage on this policy may be denied or rescinded under this provision without time limit in the event of fraud.

Beginning two years after the effective date of this policy no misstatements, except fraudulent misstatements, may be used to void this policy.

Tennessee, Virginia and 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.