Humana

Accelerated Death Benefit Form Filing Instructions

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Claim Form as "Humana". Life plans insured by Humana Insurance Company or Humana Insurance Company of Kentucky.

This claim form should be used with the intents and purposes for claiming for an Accelerated Death Benefit in which the member has been advised by their attending or treating physician that their condition is terminal.

Page One – Filing Instructions

- Complete the appropriate sections of the claim form.
- Include the signed and dated authorization
- Submit to the address below.

Page Two — Accelerated Benefit Clam Form - Employee Statement:

- Complete all questions in all sections of the Employee Statement
- Sign and date the claim form.
- If physician's fax numbers are known, please include them in the physician information.

Pages Three and Four — Authorization to Release Information, Benefit Agreement and Beneficiary Release

- The Authorization to allow physicians to release medical records to Humana.
- The Benefit Agreement shows the Insured's agreement to the reduction in the life benefit.
- The Beneficiary Release is the authorization and acknowledgement of any irrevocable beneficiary or irrevocable assignor of the Accelerated Benefit and the overall reduction in the Life Benefit after the Accelerated payment.
- Please make certain the Insured or Authorized representative signs and dates the form.

Page Five — Accelerated Claim Form - Employer Statement:

- All questions must be completed by the Insured's supervisor or an authorized personnel department staff member.
- For Group sponsored life plans include the life value amounts.

Pages Six and Seven — Accelerated Death Benefit Claim Form - Physician Statement:

- The Insured's attending physician should complete this section.
- All sections regarding condition, functional ability, and prognosis should be carefully reviewed and completed based on the Insured's current condition.
- Note that progress notes and/or medical records may be requested at any time to substantiate condition.



- **Submit the Employee, Employer, and Physician statements together in order to prevent delays in processing. All three sections are required before the Accelerated Benefit Claim can be reviewed.**
- Sign and date the authorization on pages 3 & 4 and include when returning the claim form.
- Retain a copy of all information submitted for your records

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

Humana

Accelerated Death Benefit Claim Form - Employee Statement

Section I- Employee Information

Policyholder's Name _____ Policy No. _____

Mailing Address _____ Social Security No. _____

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

Daytime Phone number (_____) _____

Occupation _____

Do you wish to apply for Accelerated Death Benefits under any other policies issued to you by Humana, its subsidiaries, or affiliates?

☐ Yes ☐ No If yes, please provide ID No. _____

Employer's Name _____

Street Address _____ Phone Number (_____) _____

City _____ State _____ ZIP Code _____

Section II – Claim Information:

Date of the first symptoms of the illness or date of accident ____/____/____ Date you were first treated ____/____/____

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

_____

_____

Percent of benefit requested _____

Section III – Physician Information:

Attending or Treating Physicians:

Physician's Name	Address	Telephone & Fax Number
		T F
		T F
		T F

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 8 & 9)

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

_____ ____/____/____

Signature of Insured Date

Sign and date the authorization on pages 4 & 5 and include when returning the claim form.

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

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 or Humana Insurance Company of Kentucky.
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 andclaims 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, 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 Humana Insurance Company or Humana Insurance of Kentucky, P.O. Box 13068, GreenBay WI 54307-3068. This revocation shall become effective on the date it is received by Humana Insurance Company or Humana Insurance of Kentucky. I am aware that my revocation is not effective to the extentthat the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon thisAuthorization.

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.

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Benefit Agreement - Employee

For value received, the receipt of which is hereby acknowledged, I, the undersigned, as the member, do hereby agree to the payment of ____ % (verify percentage in your Certificate of Coverage) of the life insurance in force on the life of the member as an Accelerated Benefit. I do hereby release all of my right, title and interest as to this ____ % of the life insurance in force and do acknowledge that at the time of the payment of the life insurance as a claim due to the death of the member, the life insurance amount will be reduced by said Accelerated Benefit.

In consideration of the Humana Insurance Company or Humana Insurance Company of Kentucky's payment to me of the Accelerated Benefit, I, the member, do hereby release, discharge and hold Humana Insurance Company or Humana Insurance Company of Kentucky and its affiliates and subsidiaries, their agents, officers, directors, and employees, harmless from any and all claims, demands, or causes of action which might arise out of Humana Insurance Company or Humana Insurance Company of Kentucky's payment including indemnification against any awards, judgments or settlements, including litigation costs and attorney fees.

Payment from an Accelerated Benefit may be taxable. Assistance should be sought from your personal tax advisor. Humana is not responsible for any tax or other effects from an Accelerated Payment or loss of eligibility for any State or Federal Program.

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

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____/_____/_____

Signature *Printed Name* *Date*

Release of Benefit Agreement – Irrevocable Beneficiary or Irrevocable Assignment

I, _____, Irrevocable Beneficiary or Irrevocable Assignor designated for Policy Number _____ insuring the Life of _____, do hereby surrender rights to _____ of the Life Insurance benefit to be paid to _____ as an Accelerated Death Benefit. I release Humana Insurance Company or Humana Insurance Company of Kentucky from all claims to this benefit that I may have as the Irrevocable Beneficiary or the Irrevocable Assignor.

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____/_____/_____

Irrevocable Beneficiary or Irrevocable Assignor Signature *Printed Name* *Date*

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Accelerated Benefit Claim Form - Employer Statement

Section I- Employer Information

Employer's Name _____

Employer Address _____ City _____ State _____ ZIP Code _____

Contact Name _____ Phone Number (_____) _____

Group Number _____ Email _____

Section II- Employee Information

Employee's Name _____

Street Address _____ Social Security No. _____

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

Employee's Date of Hire ____/____/____

Date Employee Last Worked ____/____/____

Employee's Annual Salary_____ Actual Hours Worked per Week _____ Date of last paycheck ____/____/____

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

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

Reason for termination of employment?

_____

Amount of Employees Life Benefit

_____

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

Printed Name of Person Completing Form _____

Signature of Authorized Representative _____

Title _____ Date ____/____/____

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Accelerated Benefit Claim Form - Physician Statement

Section I – Patient Information:

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

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

Section II – Treatment Information:

Diagnosis (including any complications) _____

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

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

Subjective symptoms _____

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

_____

_____

_____

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

Physician's Name	Address	Phone Number

Section III – Impairment:

Is your patient capable of performing the following activities of daily living independently?

Activity:	**Yes**	**No**
Bathing	☐	☐
Dressing	☐	☐
Continence/Toileting	☐	☐
Eating	☐	☐
Transferring	☐	☐

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Section IV – Prognosis:

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 _____

Life expectancy: ☐ 6 months or less ☐ 9 months or less ☐ 12 months or less ☐ 12 - 24 months ☐ Greater than 24 months

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

Comments:

_____

_____

_____

_____

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_____

_____

_____

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 8 & 9)

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 _____

Signature of Attending Physician _____ Date ____/____/____

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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.