

### **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.

### Pages 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.

### Page 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.

### Pages 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 page 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



### Accelerated Death Benefit Claim Form - Employee Statement

Section I- Employee Informa	ation	
Policyholder's Name		Policy No
Mailing Address		Social Security No.
5	StateZIP Code	
'		to you by Humana, its subsidiaries, or affiliates?
	e ID No.	
Street Address		Phone Number ()
City	State ZIP Cod	e
Section II – Claim Informatio	n·	
		Date you were first treated / /
Date of the first symptoms of the illness or date of accident/ Date you were first treated/		
Describe the onset and nature or your in	less of describe now and where accident of	occurred.
Percent of benefit requested	_	
Section III – Physician Inform	nation:	
Attending or Treating Physicians:		
Physician's Name	Address	Telephone & Fax Number
J. C.		T
		F
		T   F
		Т
		F
Application or files a claim containing		ng a fraud against an insurer, submits an subject to prosecution and punishment for
The above statements are true to the best of my knowledge and belief.		
Signature of Insured	Date	
Sign and data the authorization	on on page /. S. F. and include when retu	urning 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, 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 Humana Insurance Company or Humana Insurance of Kentucky or Kanawha Insurance Company P.O. Box 10708, GreenBay 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 extentthat 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 Author information as contemplated herein for all rec			
Signature	Printed Name	/	
I have legal authority* under the laws of the State of			
Name of Authorized Representative/Parent or Guard * A copy of the legal authority document must be o		/	

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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 or Kanawha Insurance Company'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 or Kanawha Insurance Company 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 or Kanawha Insurance Company'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 me, my heirs, administrators and assigns.	and authorize this release and agreement sh	all be binding upon
Signature	Printed Name	Date
Release of Benefit Agreement – Irre	evocable Beneficiary or Irrevocable Assignmen	nt
I,	, Irrevocable Beneficiary or Irrevocable Assignor	r designated for Policy
Number insurir	ng the Life of	,
do hereby surrender rights to of the Life Insurance	e benefit to be paid to	
as an Accelerated Death Benefit. I release Humana Insur	rance Company, Humana Insurance Company o	of Kentucky or Kanawha
Insurance Company 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 me, my heirs, administrators and assigns.	and authorize this release and agreement sh	all be binding upon
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 Num	ber ()	
Group Number	Email		
Section II- Employee Information			
Employee's Name			
Street Address		Social Secu	rity No.
	77- 6	B	
CityState _	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 □ C	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 Informa	tion:		
Patient's NameDate of Birth/HeightWeight			
Is the condition due to an injury or sickr	ess arising from the patient's employment? $\ \square$ Yes	□ No □ Unknown	
Section II – Treatment Infor	nation:		
Diagnosis (including any			
complications)			
Date of patient's first visit for this condit	ion/ Date of last p	atient visit/	
Frequency of visits:	eekly 🗆 Monthly 🗆 Other (specify)		
Subjective			
symptoms			
Objective findings (including current X-	ays, EKG, laboratory data and any clinical findings)		
Diago provide the name and address	of other treating physician(c)		
Please provide the name and address		DI N. I	
Physician's Name	Address	Phone Number	
Section III – Impairment:			
Is your patient capable of performing th	e following activities of daily living independently?		
Activity:	es 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 co	ndition?
☐ Less than 1 Month ☐ 1 Month ☐ 2-3 Months ☐	4-6 Months Other
Life expectancy: $\square$ 6 months or less $\square$ 9 months or less $\square$ 12 mo	onths or less $\Box$ 12 - 24 months $\Box$ Greater than 24 months
Do you believe the patient is competent to endorse checks and dire	ect the use of the proceeds thereof? $\square$ Yes $\square$ No
Comments:	
Any Person, who with the intent to defraud or knowing that he/sh Application or files a claim containing a false or deceptive statem insurance fraud. (See State Specific Fraud Warning Statements or	nent may be subject to prosecution and punishment for
The above Statements are true to the best of m	y knowledge and belief.
Printed Name of Physician	Phone No. ()
Street Address	
City	
•	
Signature of Attending Physician	Date/

Mail to: Humana

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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.

