

## Dismemberment 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 a dismemberment benefit in which the member has been advised by their attending or treating physician that it is permanent and irretrievable loss.

### 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 – Dismemberment Benefit Claim Form - Employee Statement

- Complete all questions in all sections of the Employee Statement.
- Include a copy of the Police and/or Toxicology Report, if applicable.
- Sign and date the claim form.

### Page Three - Authorization to Release Information

- The Authorization to allow physicians to release medical records to Humana.
- Please make certain the Insured or Authorized representative signs and dates the form.

### Page Four – Dismemberment Claim Form – Employer Statement

- All questions must be completed by the Insured’s Supervisor or an authorized Personnel Department staff member.
- Sign and date the form.

### Page Five – Dismemberment Benefit Claim Form - Physician Statement

- Ask the Insured’s attending physician to complete this section.
- All sections regarding condition, functional ability, and prognosis should be carefully reviewed and completed based on the Insured’s current condition.
- **Progress notes and/or medical records are needed to substantiate the loss and/or paralysis.**

### Pages Six and Seven – State Specific Fraud Warning Statements



- **Submit the Employee, Employer and Physician statements in order to prevent delays in processing. All three sections are required before the Dismemberment Benefit Claim can be reviewed.**
- Sign and date the authorization on page 3 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](mailto:GBLife_Disability@humana.com)

## Dismemberment 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 (\_\_\_\_) \_\_\_\_\_  
 Do you have medical coverage with Humana?  Yes  No If yes, Medical ID No. \_\_\_\_\_  
 Do you wish to apply for dismemberment benefits under any other policies issued to you by Humana, its subsidiaries, or affiliates?  Yes  No If yes, please provide ID No. \_\_\_\_\_

### Section II – Claim Information:

Employer's Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Date of the Accident \_\_\_\_/\_\_\_\_/\_\_\_\_ Date you were first treated \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Describe how and where accident occurred. \_\_\_\_\_

**Note: Include a copy of the Police and/or Toxicology Report, if applicable.**

### 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 6 & 7)

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Signature of Insured Date



- Sign and date the authorization on page 3 and include when returning the claim form.

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## Dismemberment Benefit Claim Form - Employer Statement

### Section I – Employer Information:

Employer's Name \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Contact Name \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Group Number \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

### Section II – 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 \_\_\_\_/\_\_\_\_/\_\_\_\_  
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?  
\_\_\_\_\_

***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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## Dismemberment Benefit Claim Form - Physician Statement

### Section I – Patient Information:

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

### 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) \_\_\_\_\_

Type of loss and/or paralysis:

\_\_\_\_\_

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

**Note:** Please include a copy of the patient's medical records pertaining to the type of loss and/or paralysis.

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 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 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.

### **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, Delaware, Idaho, Maine, Maryland, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Virginia, 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.

### **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.

## **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.

## **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.

## **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.

## **Puerto Rico**

Any person who knowingly and with 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) dollars and not more than ten thousand (\$10,000) dollars, or fixed term 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.