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Workplace Voluntary Disability Claim Form Filing Instructions

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.

Page One – Filing Instructions

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

Pages Two and Three – Disability Claim Form - Employee's Statement

- Complete all questions in all sections of the Employee Statement.
- If the disability is due to an accident, clearly indicate the accident details, including date, time, and place of accident. If disability was a result of a motor vehicle accident, please submit a copy of the police report.
- Sign and date the claim form.
- If provider fax numbers are known, please include them in the provider information.
- Review the deduction of premium information.

Page Four - Physician Information

- If the claim is being filed for a disability beginning within the first year following the policy effective date, the claimant must complete this page with all physician seen and medications taken within the year prior to the effective date of the plan.

Page Five - Authorization to Release Information

- The Authorization to allow physicians to release medical records to Kanawha Insurance Company, a Humana Company.
- Please make certain the Claimant or Authorized representative sign and date the form.

Page Six – Disability Claim Form - Employer's Statement

- All questions must be completed by your Supervisor or an authorized Personnel Department staff member.
- To ensure that taxes are handled properly, the questions regarding Section 125 (whether premiums are deducted pre-tax or post-tax) and employer/employee contribution needs to be carefully reviewed and answered.

Pages Seven, Eight, and Nine – Physician's Statement of Disability

- Ask your attending physician to complete this section.
- This section must indicate the dates of disability and an expected return to work date. If the return to work date is unknown, the physician should indicate the date of your next appointment or recheck for this condition.
- All sections regarding impairment, functional ability, prognosis and restrictions should be carefully reviewed and completed based on your current condition. This will assist in determining extent of the disability and decrease the need for progress notes.
- **Note that progress notes and/or medical records may be requested at any time to substantiate a disability.**
- If you are able to perform limited duty or part-time activities, the physician should be indicated on the form.

- **Submit the Employee, Employer and Physician statement in order to prevent delays in processing. All three sections are required before benefits for disability can be reviewed.**
- Sign and date the authorization on page 5 and include when returning the claim form.
- If the disability date is within the first year of the policy, complete the information on page 4 and return with the claim form.

If you have any questions when completing this form, please call 1-877-378-1505.
Mail the completed form to the following address:

Mail to: Humana
PO Box 13068
Green Bay, WI 54344

Customer Service: 1-877-378-1505
Fax Number: 1-502-405-7107

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Workplace Voluntary Disability Claim Form - Employee Statement

Section I – Employee Information:

Employee'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. _____

Section II – Claim Information:

Employer's Name_____ Occupation _____

List the job duties/responsibilities of your occupation at the time of the disability (and submit a job description)

_____

_____

Is the disability related to: ☐ Illness ☐ Pregnancy ☐ Accident

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

First date you were unable to work as a result of your disability _____ /_____/_____

Did your injury or illness occur at work or as result of your job? ☐ Yes ☐ No If yes, did you inform your employer? ☐ Yes ☐ No

Reported to: Employer Representative Name_____

Address_____ Telephone No. (_____)_____

If work related, please explain_____

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim? ☐ Yes ☐ No

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

_____

_____

What aspect of your condition made you unable to perform your job?

_____

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

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

Employer _____ Occupation _____

Dates worked: _____

Section III – Physician Information:

Attending (Treating) physicians:

Physician's Name	Address	Phone Number

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Section III – Physician Information, continued:

Have you ever been treated for the same or a similar condition in the past? ☐ Yes ☐ No

If yes, Please provide the prior physician information:

Physician's Name	Address	Phone Number

Section IV – Other Income Information:

Please indicate any additional income you are currently receiving

Yes	No	Type	Amount	Frequency	Date Began	Date Ceased
☐	☐	Social Security (Disability or Retirement)	$_____	_____	___/___/____	___/____/____
☐	☐	State Disability	$_____	_____	___/___/____	___/____/____
☐	☐	Retirement (normal, early, or disability)	$_____	_____	___/___/____	___/____/____
☐	☐	Worker's Comp/Occupational Disease	$_____	_____	___/___/____	___/____/____
☐	☐	Group Disability	$_____	_____	___/___/____	___/____/____
☐	☐	Salary	$_____	_____	___/___/____	___/____/____

If you are not receiving these benefits, do you plan on applying or have you applied for benefit(s) described above? ☐ Yes ☐ No

Type _____ Date Applied: ___/___/____

Type _____ Date Applied: ___/___/____

Section V –Deduction of Premium.

If your policy is currently active, <u>we will deduct premiums from your disability benefit</u> 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 <u>do not</u> want premiums deducted from my disability benefit.

Signature of Employee _____ Date_____/_____/_____

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 10 and 11)

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

_____ _____/_____/_____

Signature of Employee *Date*

- Sign and date the authorization on page 5 and include when returning the claim form.
- If the disability date is within the first year of the policy, complete the information on page 4 and return with the claim form.

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If the claim is being filed for a disability within the first year of the policy, complete both the physician and medication information below:

Physician information:

List all physicians that treated you in the year prior to the policy effective date:

Physician's Name	Address	Phone Number	Reason for Visit

Medication information:

List all medication being taken by you:

Medication	Prescribing Physician	Date Prescribed

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

TO: Any physician, medical practitioner, hospital, pharmacy benefits manager, 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.

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 authorization 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 Kanawha Insurance Company, a Humana 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 redisclosed 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 Kanawha Insurance Company P.O. Box 13068 Green Bay, WI 54344. This revocation shall become effective on the date it is received by Kanawha Insurance Company. I am aware that my revocation is not effective to the extent that 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 Authorization and authorize the use and/or disclosure of my protected health information as contemplated herein.

_____ _____ _____/_____/_____

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/Kanawha HealthCare Solutions, Inc.

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Workplace Voluntary Disability Claim Form - Employer Statement

Section I – Employee Information:

Employee's Name _____ Date of Birth _____/_____/_____

Social Security No. _____ Policy No. _____ Current Annual Salary _____

Section II – Claim Information:

Date Employee Last Worked _____/_____/_____

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

Has employee returned to work? ☐ Yes ☐ Part-time Date _____/_____/_____
☐ Full-time Date _____/_____/_____
☐ No If No, what is the anticipated return to work date _____/_____/_____

Is this a Section 125 Plan? (Premiums deducted pre-taxed) ☐ Yes ☐ No

Employee's percentage (%) of premium contribution: Employee pays _____% Employer pays _____%

Is the Employee receiving any form of salary continuance while on disability? ☐ Yes ☐ No

If yes, weekly benefit amount _____ Date benefits cease: _____/_____/_____

Is the Employee's condition work related or did the injury occur at work? ☐ Yes ☐ No

Has Workers' Compensation or Occupational Disease claim been filed? ☐ Yes ☐ No *(If yes, Include a copy of the accident report)*

Is the Employee allowed to work from their home: ☐ Yes ☐ No

Is there light work available for the employee to do: ☐ Yes ☐ No *(If yes, explain on line below)*

If "yes" explain: _____

What are the major tasks of the employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks? (and submit a job description)

_____ _____%

_____ _____%

_____ _____%

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 10 and 11)

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

Employer's Name _____ Telephone Number (_____)_____

Address _____ Fax Number (_____)_____

Printed Name of Person Completing Form _____

Signature of Authorized Representative_____

Title_____ Email_____ Date _____/_____/_____

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Workplace Voluntary Disability Claim Form - Physician Statement

Section I – Disability Information:

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

Is the disability related to: ☐ Illness ☐ Pregnancy ☐ Accident ☐ Mental/Nervous Condition

Date you advised the patient they should cease work: ____ /____/_____ If pregnancy, estimated date of delivery____ /____/_____

For conditions other than pregnancy, the date symptoms first appeared or accident occurred: ____ /____/_____

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)_____

Diagnosis Code(s)_____

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)

_____

Patient's progress: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

Patient is currently: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Current treatment plan for this condition (including any rehab program/medications)

_____

Have any medications been changed? ☐ Yes ☐ No If "Yes", Date Changed ____ /____/_____

Medication Change: _____

Have any surgeries already been performed? ☐ Yes ☐ No If "Yes", Surgery Date ____ /____/_____

CPT Code(s)/ procedure performed _____

If "No", are any surgeries scheduled? ☐ Yes ☐ No If "Yes", Scheduled Date ____ /____/_____

CPT Code(s)/ procedure scheduled _____

Has patient been hospital confined? ☐ Yes ☐ No If "Yes", Admit Date ___ /___/____ Discharge Date___ /____/____

Hospital Name:_____ Address _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", indicate type of condition, treatment date(s), and treatment provided: _____

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

Physician's Name	Address	Phone Number

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Section III – 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 Four Visits) _____ _____ _____ _____

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 _ _____

_____

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: _____

_____

Section IV – 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 3, 4/6 or 6/8 hours)
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	☐	☐	☐	☐	☐	☐	☐	☐

If the disability is related to a psychological disorder, has the Global Assessment of Functioning (GAF) been performed? ☐ Yes ☐ No

If yes, date of the assessment ____ /____/_____ GAF Score _____

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Section V – Prognosis and restrictions:

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

If the patient works from their home, would this change their disability status or the length of disability? ☐ Yes ☐ No

If yes, please explain _____

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 in the patients regular occupation? ____ /____/_____ ☐ 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. ____ /____/_____

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 10 and 11)

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 ____ /____/_____

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.

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.