Humana group life claim form—waiver of premium

Humana Insurance Company
Group Life Claims
P.O. Box 10708
Green Bay, WI 54307-0708
1-866-836-6144

Statement of employer

Company name

Policy number | Member identification number

Effective date of insurance | Cancellation date (if applicable) | Date of hire or employment

Date last worked full-time hours | Hours worked per week: | Amount of life insurance/class

Monthly salary | Beneficiary designation(s)

Is insured receiving any other weekly or monthly disability benefits? ❑ Yes ❑ No | If yes, give details:

Source of benefits | Amount | Date benefits began or will begin

Are there any reasons for you to question the validity of the claim? ❑ Yes ❑ No | If yes, give details:

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Signature of employer representative | **Date** | **Telephone number**

Statement of covered employee

Name of employee

Present address

City | State | Zip

Date of birth | Social Security Number | Telephone number ( )

Job/occupation title

Describe the daily duties of your job:

Date you last reported to work | Date you expect to return | full time | part time

Date of first medical treatment for this disablilty

Are you engaged in any other gainful employment? ❑ Yes ❑ No

Explain

Was an accident involved? ❑ Yes ❑ No | Were you at work when it happened? ❑ Yes ❑ No

What physicians have treated or prescribed for you for this sickness or injury?

Name	Address	Name/address of hospitals confined to during this disablity

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Group life claim form—waiver of premium, continued

Are you receiving any benefits as a result of your disability? ❑ Yes ❑ No If yes, check applicable boxes:

			Amount	Date benefits began or will begin
❑ Yes	❑ No	Group disability (disability or retirement)		
❑ Yes	❑ No	Workers' compensation		
❑ Yes	❑ No	Retirement (normal, early or disability)		
❑ Yes	❑ No	State Disability (please send copy of award letter)		
❑ Yes	❑ No	Other, desribe:		

If you are not receiving benefits from any of the above mentioned sources, have you filed or do you intend to file for such benefits?
❑ Yes ❑ No give details:

Birthdate of all dependent children(dependent children are (1) all children under age 18, (2) full-time students under age 22 and (3) handicapped children regardless of age if disability began before age 18.)

Spouse's date of birth

Do you wish to apply for the waiver of premium benefit under any other policy issued to you by Humana Insurance Company, its affiliates or subsidiaries? ❑ Yes ❑ No If yes, provide policy number:

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 waiver of premium 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 Insurance Company
Group Life and Disability Claims
P.O. Box 10708
Green Bay, WI 54307-0708

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.

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. I have read the fraud statement applicable as found on the Group Life Waiver of Premium Fraud Statement.

Signature of insured employee **Date**

Group life waiver of premium fraud statements

Please refer to the statements that apply based upon the state where you live:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For you protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas or 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 and confinement in prison.

California: For your protection, California law requires the following to appear on 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 a policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Department 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 or claim or an application containing any false, incomplete, or misleading information is guilty of a felony.

Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: Any person who knowingly and with intent to defraud an insurer company, files a statement or claim containing any false, incomplete, or misleading information, commits a felony.

Kentucky: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files an application or claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Maine, Tennessee or Virginia: 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.

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 Section 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 insurance company or another 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 act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application of false claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: 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.

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.

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Humana attending physician's statement—waiver of premium

Humana Insurance Company
Group Life Claims
P.O. Box 10708
Green Bay, WI 54307-0708
1-866-836-6144

The patient is responsible for any cost, if applicable, for this form to be completed.

1. Patient information

Patient name | Date of birth

Employer name

Member identification number | Group/policy number

2. History

When did symptoms first appear or accident happen (month/date/year)?

Date patient ceased work because of disability (month/date/year)

Has patient ever had the same or similar condition? ❑ Yes ❑ No If yes, state when and describe

Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No ❑ Unknown

Names and addresses of other treating physicians:

3. Diagnosis

Date of last examination (month/date/year)

Diagnosis (including any complications)

Subjective symptoms

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

4. Treatment

Dates of treatment

Frequency ❑ Weekly ❑ Monthly ❑ Other (specify)

Nature of treatment (including surgery and medications prescribed, if any)

5. Cardiac (if applicable)

Functional capacity? (American Heart Association)

❑ Class 1 (no limitaion) ❑ Class 2 (slight limitation) ❑ Class 3 (marked limitation) ❑ Class 4 (complete limitation)

Blood pressure (last visit) systolic: diastolic:

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6. 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?

7. Mental restrictions (if applicable)

Define "stress" as it applies to this claimant:

What stress and problems in interpersonal relations has claimant had on job?

- ❑ 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.

What are the patient's restrictions/limitations?

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

8. Prognosis/rehabilitation

Is patient now totally disabled? (Totally disabled means that during the first 12 months of disability the employee is prevented, due to bodily injury or sickness, from performing each and every material and substantial duty of his or her respective job. — patient's job: ❑ Yes ❑ No — any other work: ❑ Yes ❑ No

If no, when is patient able to go to work (month/date/year) — patient's job: — any other work:

If yes, will this disability prevent the patient from engaging in any meaningful occupation for the remainder of his/her life? ❑ Yes ❑ No

What duties of patient's job is he/she incapable of performing?

Do you expect a fundamental or marked change in the future? — patient's job: ❑ Yes ❑ No — any other work: ❑ Yes ❑ No

If yes, when do think patient will be able to resume work? — patient's job: — any other work:

Is patient a suitable candidate for a rehabilitation program? ❑ Yes ❑ No

Can present job be modified to allow for handling with impairment? ❑ Yes ❑ No

When could trial employment commence? (month/date/year) — patient's job: ❑ full time ❑ part time — any other work: ❑ full time ❑ part time

Would vocational counseling and/or retraining be recommended? ❑ Yes ❑ No

Remarks

Signature (attending physician)

Name Telephone

Degree/specialty

Address

City State Zip

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Signature _____ Date_____

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New York: Any person who knowingly and with intent to defraud insurance company or another 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 act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

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