

## Group Life Claim Form

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.

### Instructions

Please submit the following documentation:

1. Group life claim form.
  - Part One—completed by the employer
  - Part Two—completed by the beneficiary
2. The enrollment form or most recent beneficiary designation.
3. A certified copy of the official death certificate.
4. For accidental death benefits, we require the official complete police report, blood toxicology report, and an autopsy report if one was conducted.
5. If the beneficiary is:
  - A minor—we require copies of the guardianship papers naming the legal guardian of the minor’s estate.
  - An estate—we require the Letters Testamentary or Letters of Administration appointing the personal representative of the estate.
  - Deceased—we require a copy of the deceased beneficiary’s official death certificate.

We may require additional information or documents to process the claim.

**Please mail all documentation to:**

Humana Insurance  
Company P.O. Box 13068  
Green Bay, WI 54307-3068

# Part One—Employer Statement

To be completed by employer

## Employment Information

Name of employer	Group number	
Address of employer	Employer Phone	
City	State	Zip
Name of employee/retiree	Date of birth of employee/retiree	
Address of employee/retiree		
City	State	Zip
Job title	Original Date of employment	
Date employee last worked full-time hours		
Reason employee stopped work (if more than 31 days)		
Annual base salary \$	Hours worked per week	
Date of last salary payment to employee	Amount paid	

## Deceased Information

Deceased is: ☐ Employee ☐ Retiree ☐ Spouse ☐ Child

Name of deceased, if spouse or child	Member identification number
Other names by which the decedent may have been known (e.g. maiden name, hyphenated name or an alias)	
Address of deceased, if spouse or child	
City	State Zip
Date of birth	Date of death Effective date of insurance
Does the deceased have any other life insurance coverage with Humana, Inc., its subsidiaries or affiliates? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are Accidental Death Benefits being claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please submit copies of the police report and the coroner's report (including laboratory findings) if an autopsy was conducted.	

## Self Administered employer groups – please complete this section

Insurance class:

Amount of basic life \$	Amount of Accidental Death Benefit \$
Amount of optional (voluntary) insurance \$	Date of last increase in insurance

## Signature (all groups)

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.

Authorized signature of employer: \_\_\_\_\_ Date \_\_\_\_\_

## Part Two—Beneficiary Statement

### To be completed by beneficiary

If the beneficiary is a minor, please provide Letters of Guardianship for the minor's estate.

If the beneficiary is the estate, please provide the Letters Testamentary or Letters of Administration appointing the personal representative of the estate.

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.

#### Beneficiary Information

Name of beneficiary	Date of birth	
Social Security Number/Tax ID number	Phone	
Address of beneficiary		
City	State	Zip
Relationship to deceased		
Signature of beneficiary: _____		Date _____

Name of beneficiary	Date of birth	
Social Security Number/Tax ID number	Phone	
Address of beneficiary		
City	State	Zip
Relationship to deceased		
Signature of beneficiary: _____		Date _____

Name of beneficiary	Date of birth	
Social Security Number/Tax ID number	Phone	
Address of beneficiary		
City	State	Zip
Relationship to deceased		
Signature of beneficiary: _____		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.

**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.