Waiver of Premium Claim Form - Employee Statement

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.

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 2-3)

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

____ ______/______/______

Signature of Policyholder Date

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 have Disability coverage with Kanawha/Humana? ☐ Yes ☐ No If yes, Plan ID No. ______________

If no, are you currently receiving disability payments through another carrier or SSDI? ☐ Yes ☐ No

Disability carrier name ______________________

Address: ______________________

Phone number (______) ______________________ Plan ID No. ______________

Claim Information:

Employer’s Name (at the time disability started) ______________________

Street Address ______________________ Phone Number (______) ______________

City ____________ State ____________ ZIP Code __________

Occupation (at the time disability started) ______________________

List the job duties/responsibilities of your occupation at the time of the disability

____

____

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 ______/______/______

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?

____

____

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

Waiver of Premium Claim Form - Employee Statement

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: ____

Physician information:

Attending (Treating) physicians:

Physician's Name	Address	Phone Number

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.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, 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.

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.

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.

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Waiver of Premium Claim Form - Employee Statement

State Specific Fraud Warning Statements

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.

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.

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.

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 the state law.

Waiver of Premium Claim Form - Employee Statement

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

Patient's Name ____ Contract No. _____________________

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 Human a Insurance Company or Humana Insurance of Kentucky or Kanawha Insurance Company P.O. Box 10708, Green Bay 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 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 for ☐ all records or ☐ records for dates of service ________ to ________

____ ______________________________ _________/__________/_________

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.*

If you have any questions when completing this form, please call 1-866-427-7478.

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

Waiver of Premium Claim Form - Employer Statement

Employer Information:

Employer's Name ____________________
Employer Address ____________________ City ____________ State ____________ ZIP Code ____________
Contact Name ____________________ Phone Number (______) ____________
For Group Sponsored Plans, what is the group number ____________________

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 ______/______/______
What class is the Employee in (if applicable) ____________________
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 ______/______/______
Are they still an employee? ☐ Yes ☐ No If No, when did employment terminate ______/______/______
Reason for termination of employment? ____________________

Benefit Information for Employer Sponsored Life Plans Only:

Effective Date of Coverage: ______/______/______ Termination Date of Coverage (if applicable) ______/______/______
Life Value Amounts (if applicable):

Basic Life Insurance	Amount of Insurance	Supplement/Voluntary Life Insurance	Amount of Insurance
Employee	$	**Employee**	$
Spouse	$	**Spouse**	$
Child	$	**Child**	$

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Waiver of Premium Claim Form - Employer Statement

Employee's Occupation Information, continued:

Occupation at Time Last Worked____

(Please attach a copy of the job description to this form)

Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job using the definitions below for the frequency: Indicate the average weight when applicable.

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Frequency of Occurrence				
Activity:	**N/A**	**Occasionally**	**Frequently**	**Continuously**	
Standing	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Bending, twisting or stooping	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Operating heavy machinery	☐	☐	☐	☐	
Reaching/working overhead	☐	☐	☐	☐	
Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐	
Pushing or pulling	☐	☐	☐	☐	______lbs.
Lifting or Carrying	☐	☐	☐	☐	______lbs.

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?

____ ________ %

____ ________ %

____ ________ %

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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______________________________ Date ______/_______/______

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Waiver of Premium Claim Form - Physician Statement

Disability Information:

Patient's Name ________________________ Date of Birth ______/_______/______ Height_________ Weight_________

Is the disability related to: ☐ Illness ☐ 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 appear or accident occurred : ______/_______/______

Is the condition due to an injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown

Treatment Information:

Diagnosis (including any complications)______________________________________ICD-9 Code(s) _________________

Date of patient's first visit for this condition ______/_______/______

Date of last patient visit: ______/_______/______ **(Please submit records from this visit)**

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify) ____

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 programs/medications)

____

Is the patient on any medications? ☐ Yes ☐ No If "Yes", list medications.

Medications:____

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", surgery date ______/_______/______

CPT Code(s)/ procedure performed ____

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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Waiver of Premium Claim Form - Physician Statement

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____

____

____

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	☐	☐	☐	☐	☐	☐	☐	☐

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

If Yes, complete the DSM-IV-TR axis diagnosis section below

Axis I ____ Axis II _____ Axis III ____ Axis IV _____ Axis V _____ GAF, or the DSM-V; WHODAS 2.0 Score ___________

Date Assessed _______/________/_______

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", 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:

____

____

____

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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______________ Tax ID ____________________

Email Address ______________________________ Fax No. (_______)____________________

Signature of Attending Physician* ______________________________ Date ______/_______/__________

*Note form must be signed by medical doctor duly licensed in the state where services are rendered

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