Accelerated Benefit Claim Form - Employee Statement

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 or Kanawha Insurance Company.

This claim form should be used with the intents and purposes for claiming for an accelerated benefit in which the member has been advised by their attending or treating physician that their condition is terminal.

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 4-5)

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

_____ _____/_____/_____

Signature of Subscriber Date

Employee Information

Subscriber'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 accelerated benefits under any other policies issued to you by Humana, its subsidiaries, or affiliates? ☐ Yes ☐ No If yes, please provide ID No. _____

Claim Information:

Employer's Name _____

Street Address_____ Phone Number (____) _____

City _____ State _____ ZIP Code _____

Occupation _____

Date of the first symptoms of the illness or date of accident_____/_____/_____

Date you were first treated _____/_____/_____

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

_____

_____

Physician Information:

Attending or Treating Physicians:

Physician's Name	Address	Telephone & Fax Number	
		T	F
		T	F
		T	F

- **Submit the Employee, Employer and Physician statements in order to prevent delays in processing. All three sections are required before the Accelerated Benefit Claim can be reviewed.**
- **Sign and date the authorization on page 2 & 3 and include when returning the claim form.**
- **Retain a copy of all information submitted for your records**

Humana®

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

Customer Service: 1-855-448-6982
Or Fax to: 1-502-405-7107
Email to: vbclaimssubmission@humana.com

Accelerated Benefit Claim Form - Employee Statement

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

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 1-855-448-6982.

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Accelerated Benefit Claim Form - Employee Statement

Benefit Agreement - Employee

For value received, the receipt of which is hereby acknowledged, I, the undersigned, as the member, do hereby agree to the payment of fifty (50) percent of the life insurance in force on the life of the member as an Accelerated Benefit. I do hereby release all of my right, title and interest as to this fifty (50) percent of the life insurance in force and do acknowledge that at the time of the payment of the life insurance as a claim due to the death of the member, the life insurance amount will be reduced by said Accelerated Benefit.

In consideration of the Humana Insurance Company or Humana Insurance Company of Kentucky or Kanawha Insurance Company's payment to me of the Accelerated Benefit, I, the member, do hereby release, discharge and hold Humana Insurance Company or Humana Insurance Company of Kentucky or Kanawha Insurance Company and its affiliates and subsidiaries, their agents, officers, directors, and employees, harmless from any and all claims, demands, or causes of action which might arise out of Humana Insurance Company or Humana Insurance Company of Kentucky or Kanawha Insurance Company's payment including indemnification against any awards, judgments or settlements, including litigation costs and attorney fees.

Payment from an Accelerated Benefit may be taxable. Assistance should be sought from your personal tax advisor. Humana is not responsible for any tax or other effects from an Accelerated Payment or loss of eligibility for any State or Federal Program.

A photocopy or facsimile of this authorization shall be valid as the original.

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____/_____/_____

Signature *Printed Name* *Date*

Release of Benefit Agreement – Irrevocable Beneficiary or Irrevocable Assignment

I, _____ , Irrevocable Beneficiary or Irrevocable Assignor designated for Policy Number _____ insuring the Life of _____ , do hereby surrender rights to 50% of the Life Insurance benefit to be paid to _____ as an Accelerated Death Benefit. I release Humana Insurance Company, Humana Insurance Company of Kentucky or Kanawha Insurance Company from all claims to this benefit that I may have as the Irrevocable Beneficiary or the Irrevocable Assignor.

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____/_____/_____

Irrevocable Beneficiary or Irrevocable Assignor Signature *Printed Name* *Date*

Accelerated Benefit Claim Form - Employee Statement

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.

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.

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State Specific Fraud Warning Statements

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.

Accelerated Benefit Claim Form - Employer Statement

Employer Information:

Employer's Name _____

Employer Address _____ City _____ State _____ ZIP Code _____

Contact Name _____ Phone Number (_____) _____

Group Number _____ Fax 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 _____/_____/_____

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? _____

For Group sponsored life plans include the life value amounts_____

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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Accelerated Benefit Claim Form - Physician Statement

Patient Information:

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

Height_____ Weight_____

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

Treatment Information:

All sections regarding condition, functional ability, and prognosis should be carefully reviewed and completed based on the Insured's current condition.

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) _____

Subjective symptoms_____

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

Impairment:

Is your patient capable of performing the following activities of daily living independently?

Activity:	**Yes**	**No**
Bathing	☐	☐
Dressing	☐	☐
Continence/Toileting	☐	☐
Eating	☐	☐
Transferring	☐	☐

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Prognosis:

Note that progress notes and/or medical records may be requested at any time to substantiate condition.

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_____

Life expectancy: ☐ 6 months or less ☐ 9 months or less ☐ 12 months or less ☐ 24 months or less

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

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 _____

Signature of Attending Physician _____ Date _____/_____/_____

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