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

Continued on back

GN-51057-HH 9/05

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**

GN-51057-HH 9/05

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.

If you live in any state not listed above, the following applies to you: any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

GN-51057-HH 9/05