

Workplace Voluntary Continuing Disability 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 page 1)

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 (_____) _____

Since your disability, have you been able to perform any work? Yes No If yes, please complete the following:

Employer _____ Occupation _____
Dates worked: _____

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: _____ Telephone No. (_____) _____

Deduction of Premium:

If your policy is currently active, we will deduct premiums from your disability benefit to keep your premiums paid to date. This will eliminate the risk that your policy be terminated for lack of premium payments.

If you do not want premiums deducted from your benefit, select the waiver option below, then sign and date your request.

I do not want premiums deducted from my disability benefit.

_____/_____/_____
Signature of Employee 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.



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

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

State Specific Fraud Warning Statements

Alaska, Delaware, Idaho, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Virginia, Washington, West Virginia, Indiana:

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.

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.



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Workplace Voluntary Continuing Disability Claim Form - Physician Statement

Patient Information:

Employee's Name _____ Policy No. _____
Mailing Address _____ Social Security No. _____
City _____ State _____ ZIP Code _____ Date of Birth ____/____/____
Daytime Phone number (____) _____ Height _____ Weight _____

Treatment Information:

Current Diagnosis (including any complications) & symptoms _____
Diagnosis Code(s) (ICD-9; ICD-10) _____ (If a mental health diagnosis, 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: ____/____/____
Date of last patient 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

Patient's **current treatment plan** for this condition (including any rehab programs) _____

List any **current Medications** (include date of change if applicable) _____

Have any subsequent surgeries been performed? 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 _____

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 Visit) _____ Comments _____

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 _____



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Impairment continued:

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 25%, 50%, 75%, 100%)
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Twisting/bending/stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Operating heavy machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keyboard use/repetitive hand motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Prognosis and Restrictions:

Is patient currently disabled from their job? Yes No from any other work? Yes No

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? ____/____/____ 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. ____/____/____



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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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