

Workplace Voluntary 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 2)

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

_____/_____/_____
Signature of Policyholder _____ Date _____
Employee's Name _____ Policy No. _____
Mailing Address _____ Date of Birth ____/____/____
City _____ State _____ Zip Code _____ Daytime Telephone No. (____) _____
Do you have medical coverage with Humana? Yes No If yes, Medical ID No. _____
Employer's Name _____ Occupation _____

List the job duties/responsibilities of your occupation at the time of the disability **(and submit a job description)**

Is the disability related to:

Pregnancy Yes No (If Yes and prior to delivery please submit medical records and flow charts)

Accident Yes No (If Yes and the accident was related to a Motor Vehicle Accident please submit police report)

Illness Yes No

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 ____/____/____

Did your injury or illness occur at work or as result of your job? Yes No

If yes, did you inform your employer? Yes No

Reported to:

Employer Representative Name _____

Address _____ Telephone No. (____) _____

If work related, please explain _____

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim? Yes No

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



Mail to the following address:

Humana
P.O. Box 13068
Green Bay, WI 54344

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

What aspect of your condition made you unable to perform your job?

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?

No Yes (if yes please submit employer statements from ALL employers)

Employer _____ Occupation _____

Dates worked: _____ Telephone No. (_____) _____

Physician information:

Attending (Treating) physicians:

Physician's Name	Address	Phone / Fax Number

Have you ever been treated for the same or a similar condition in the past? Yes No

If yes, Please provide the prior physician information:

Physician's Name	Address	Phone / Fax Number

Other Income Information:

Please indicate any additional income you are currently receiving

Yes	No	Type	Amount	Frequency	Date Began	Date Ceased
<input type="checkbox"/>	<input type="checkbox"/>	Social Security (Disability or Retirement)	\$ _____	_____	____ / ____ / ____	____ / ____ / ____
<input type="checkbox"/>	<input type="checkbox"/>	State Disability	\$ _____	_____	____ / ____ / ____	____ / ____ / ____
<input type="checkbox"/>	<input type="checkbox"/>	Retirement (normal, early, or disability)	\$ _____	_____	____ / ____ / ____	____ / ____ / ____
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Comp/Occupational Disease	\$ _____	_____	____ / ____ / ____	____ / ____ / ____
<input type="checkbox"/>	<input type="checkbox"/>	Group Disability	\$ _____	_____	____ / ____ / ____	____ / ____ / ____
<input type="checkbox"/>	<input type="checkbox"/>	Salary	\$ _____	_____	____ / ____ / ____	____ / ____ / ____

If you are not receiving these benefits, do you plan on applying or have you applied for benefit(s) described above?

Yes No

Type _____ Date Applied: ____ / ____ / ____

Type _____ Date Applied: ____ / ____ / ____



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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 ____/____/____



- Sign and date the authorization on page 5 and include when returning the claim form
- If the disability date is within the first year of the policy, complete the information on page 3 and return with the claim form.

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, 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

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State Specific Fraud Warning Statements

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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If the claim is being filed for a disability within the first year of the policy, complete both the physician and medication information below:

Physician information:

List all physicians that treated the patient in the five years prior to the policy effective date:

Physician's Name	Address	Phone Number	Reason for Visit

Medication information:

List all medication being taken by you:

Medication	Prescribing Physician	take out	Date Prescribed



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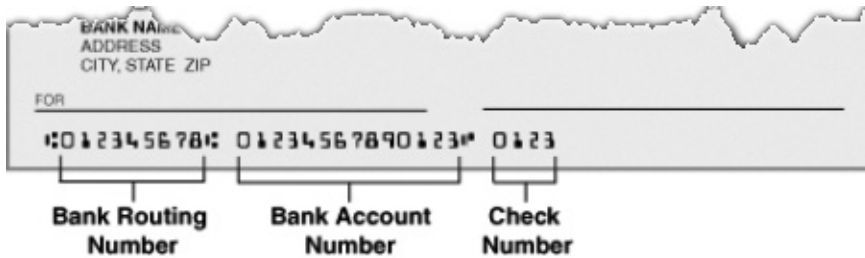
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Direct Deposit Authorization

Check Action			Effective Date				Acct. Type		Ownership of Account				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
New	Change	Cancel	Month	Day		Year	Checking	Savings	Self	Joint	Other		

Bank Name _____

Bank Routing Number _____ Bank Account Number _____



I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize Kanawha Insurance Company to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____/_____/_____
 Signature Date

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

_____/_____/_____
 Signature Date

Terms And Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program please read the following terms and conditions for participation carefully before making your decision. Not all policies may qualify.

- Once the Form is received by Kanawha Insurance Company, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
- It is your responsibility to notify Kanawha Insurance Company of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE, and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
- You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be cancelled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
- If an electronic transfer is returned** to Kanawha Insurance Company or cannot be made to your account, Kanawha Insurance Company will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
- This agreement may be cancelled by your financial institution or Kanawha Insurance Company. **Your participation will be cancelled automatically if you terminate participation in the above Account(s).**



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Workplace Voluntary Disability Claim Form - Employer Statement

All questions must be completed by your Supervisor or an authorized Personnel Department staff member.

Employee Information:

Employee's Name _____ Date of Birth ____/____/____
Social Security No. _____ Policy No. _____ Current Annual Salary _____

Claim Information:

Date Employee Last Worked ____/____/____

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 ____/____/____

Is this a Section 125 Plan? (If **YES** is selected taxes will be taken out of member's disability checks) Yes No

Employee's percentage (%) of premium contribution: Employee pays _____% Employer pays _____%

Is the Employee receiving any form of salary continuance while on disability? Yes No

If yes, weekly benefit amount _____ Date benefits cease: ____/____/____

Is the Employee's condition work related or did the injury occur at work? Yes No

Has Workers' Compensation or Occupational Disease claim been filed? Yes No
(If yes, Include a copy of the accident report)

Is the Employee allowed to work from their home: Yes No

Is there light work available for the employee to do: Yes No
(If yes, explain on line below)

If "yes" explain: _____

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? (**and submit a job description**)

_____%
_____%
_____%

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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 _____ Email _____ Date ____/____/____



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Workplace Voluntary Disability Claim Form - Physician Statement

Disability Information:

Patient's Name _____ Date of Birth ____/____/____ Height _____ Weight _____

Is the disability related to: Illness Pregnancy 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 appeared 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) _____

Diagnosis Code(s) (ICD-9; ICD-10) _____ (If a mental health diagnosis, complete the DSM-IV-TR axis diagnosis section below)

Employee's Name _____ Occupation _____

Do you have medical coverage with Humana? Yes No If yes, Medical ID No. _____

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

Date Assessed ____/____/____

Date of patient's first visit for this condition ____/____/____ Date of last patient visit ____/____/____

Frequency of visits: Weekly Monthly Other (specify) _____

Objective findings (including current x-rays, EKG, laboratory data, any clinical findings and complications)

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 program/medications)

Have any medications been changed? Yes No If "Yes", Date Changed ____/____/____

Medication Change: _____

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", Scheduled Date ____/____/____

CPT Code(s)/ procedure scheduled _____

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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Impairment:

Cardiac Functional Capacity Limitations (American Heart Association – if applicable): Class 1 (None) Class 2 (Slight)
 To be completed for cardiac disability 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 _____

Mental Impairments (To be completed for Mental Health disabilities)

- 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 on an average working day.

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"/>



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Prognosis and Restrictions:

Is patient currently disabled from their job? Yes No

If the patient works from their home, would this change their disability status or the length of disability? Yes No

If yes, please 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.*

If filing for disability prior to delivery please submit medical records and flow charts.

Life expectancy: 6 months or less 9 months or less 12 months or less Greater than 12 months

Additional Comments:

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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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