

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 54344

Customer Service: 1-866-427-7478
Or 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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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.



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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 Humana 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 Relationship to Applicant Date
or Guardian

*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.



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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 ____/____/____
 No Full-time Date ____/____/____
 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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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.

Activity:	Frequency of Occurrence				
	N/A	Occasionally	Frequently	Continuously	
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"/>	
Bending, twisting or stooping	<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"/>	
Operating heavy machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching/working overhead	<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"/>	
Pushing or pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ lbs.
Lifting or Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ 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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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	<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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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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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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