

# Continuing 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:

What was your occupation at the time of your disability? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

What aspect of your condition makes you unable to perform your occupation or any occupation?

\_\_\_\_\_  
\_\_\_\_\_

Have you returned to work?  Yes  No If yes, date returned: \_\_\_\_/\_\_\_\_/\_\_\_\_  Full Time  Part Time

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_



**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

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## 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.

**Humana**<sup>®</sup>

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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.



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# Continuing Waiver of Premium Claim Form - Employee Statement

## 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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# Continuing Waiver of Premium Claim Form - Physician Statement

## Patient Information:

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date you advised the patient they should cease work: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Treatment Information:

Current Diagnosis (including any complications) & symptoms \_\_\_\_\_

Diagnosis Code(s) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

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

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 \_\_\_\_\_

Reason for hospitalization (if different from reason for disability): \_\_\_\_\_

## 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) \_\_\_\_\_

**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 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 100 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"/>

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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



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## 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. \_\_\_\_/\_\_\_\_/\_\_\_\_

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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