Maternity Express 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 pages 2-3)

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

_____ _____/_____/_____

Signature of Policyholder Date

*If you are filing **prior** to delivery please fill out Workplace Voluntary **Initial** Claim Form

Employee Information:

Employee's Name _____ Policy No. _____

Mailing Address_____ Social Security No._____

City _____ State _____ ZIP Code _____ Date of Birth _____/_____/_____

Daytime Phone number (_____) _____

Would you like to receive an email when your claim is processed? ☐ No ☐ Yes

(If Yes) Email Address to recieve message: _____

Would you like to receive a text message when your claim is processed? ☐ No ☐ Yes (your carrier's standard messaging rates apply)

(If Yes) Number to receive text (_____)_____and name of wireless carrier _____

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

Employer's Name _____Occupation _____

Date Last Worked:_____/_____/_____ Anticipated Return to Work Date: _____/_____/_____

Deduction of Premium:

If your policy is currently active and paid through the disability start date, we will deduct premiums from your disability benefit to keep your premiums paid to date and your policy in force. This will eliminate the risk that your policy be terminated for lack of premium payments and/or the need to pay past premiums when you return to work.

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*

Humana®

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: vbclaimssubmission@humana.com

Maternity Express Disability Claim Form - Employee Statement

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.

Maternity Express Disability Claim Form - Employee Statement

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.

Direct Deposit Authorization

Check Action | **Effective Date** | **Acct. Type** | **Ownership of Account**

☐ New ☐ Change ☐ Cancel

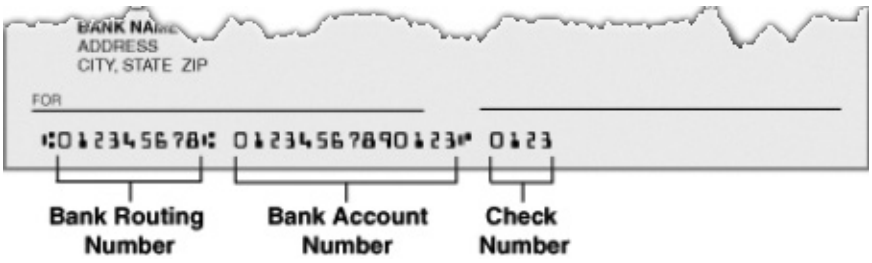
☐☐ Month – ☐☐ Day – ☐☐☐☐ Year

☐ 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 polices may qualify.

1. 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.
2. **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.
3. **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.
4. **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.
5. 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).**

Humana®

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: vbclaimssubmission@humana.com

Maternity Express Disability 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 Human a 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 or Guardian *Relationship to Applicant* *Date*

**A copy of the legal authority document must be on file with Humana.*

If you have any questions when completing this form, please call 1-855-448-6982.

Humana®

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: vbclaimssubmission@humana.com

Maternity Express Disability Claim Form – Physician Statement

Disability Information:

Date of Delivery: _____/_____/_____ Delivery Type: ☐ Vaginal ☐ C-section

First date the patient was treated for the pregnancy: _____/_____/_____

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 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

Maternity Express Disability Claim Form - Employer Statement

Employee's Name _____ Policy No. _____

Date of Birth _____/_____/_____ Employee Last Worked _____/_____/_____

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

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

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 above Statements are true to the best of my knowledge and belief

Employer's Name _____ Telephone No. (_____) _____

Address _____ Fax No. (_____) _____

Printed Name of Person Completing Form _____

Signature of Authorized Representative _____

Title _____ Date Date _____/_____/_____

Humana®

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: vbclaimssubmission@humana.com