Humana

Maternity Express Disability Claim Form Filing Instructions

Page One – Filing Instructions

- Complete the appropriate sections of the claim form.
- Include the signed and dated authorization.
- Submit to the address or fax to the number below.

Page Two – Disability Claim Form - Employee's Statement

- Complete all questions in all sections of the Employee Statement
- Review the deduction of premium information.

Page Three – Authorization to Release Information

- The Authorization to allow physicians to release medical records to Kanawha Insurance Company, a Humana Company.
- Please make certain the Claimant or Authorized representative sign and date the form.

Page Four – Physician's Statement for Disability Claim

- Ask your attending physician to complete this section.
- This section must indicate the dates of delivery and delivery type.

Page Four – Disability Claim Form - Employer's Statement of Claim

- All questions must be completed by your Supervisor or an authorized Personnel Department staff member.
- To ensure that taxes are handled properly, the questions regarding Section 125 (whether premiums are deducted pre-tax or post-tax) and employer/employee contribution needs to be carefully reviewed and answered.

- **Submit the Employee, Employer and Physician statement in order to prevent delays in processing. All three sections are required before benefits for disability can be reviewed.**
- Retain a copy of all information submitted for your records.

If you have any questions when completing this form, please call 1-877-378-1505.

Mail the completed form to the following address:

Kanawha Insurance Company
A Humana company
P.O. Box 13068
Green Bay, WI 54344

Or FAX to:
1-502-405-7107

Humana.

Maternity Express Disability Claim Form - Employee Statement

Section I – Employee Information:

Employee's Name _____ Policy No. _____

Street 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. _____

Employer's Name_____ Occupation _____

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

Section II –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 premium deducted from your benefit, select the waiver option below, then sign and date your request.

☐ I do not want premium deducted from my disability benefit.

Signature of Employee _____ Date_____ /_____/_____

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 5 and 6)

The above statements are true to the best of my knowledge and belief.

_____ _____ /_____/_____

Signature of Employee *Date*

Humana.

Authorization to release information - For the Use and Disclosure of Protected Health Information

TO: Any physician, medical practitioner, hospital, pharmacy benefits manager, 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.

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 authorization 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 Kanawha Insurance Company, a Humana 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 redisclosed 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 Kanawha Insurance Company P.O. Box 13068 Green Bay, WI 54344. This revocation shall become effective on the date it is received by 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.

_____ _____ _____ /_____/_____

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/Kanawha HealthCare Solutions, Inc.

Mail to: Humana/Kanawha Insurance Company
PO Box 13068
Green Bay, WI 54344

Customer Service: 1-877-378-1505
Fax Number: 1-502-405-7107

Humana.

Maternity Express Disability Claim Form – Physician Statement

Section I – Disability Information:

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

LMP: ____ /____/_____ or Presumed date of conception: ____ /____/_____

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 5 and 6)

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 _____

Signature of Attending Physician_____ Date ____ /____/_____

Maternity Express Disability Claim Form - Employer Statement

Employee's Name _____ Policy No. _____

Date Employee Last Worked _____ /_____/_____

Is this a Section 125 Plan? (Premiums deducted pre-taxed) ☐ 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 5 and 6)

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 _____ /_____/____

Humana.

State Specific Fraud Warning Statements

Kanawha Insurance Company:

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.

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, New Jersey

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, Ohio, 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.

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 Mexico

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 civil fines and criminal penalties.

North Carolina

Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon

Any person who knowingly and with intent to defraud, commits a fraud against an insurer by submitting a claim containing an intentionally materially false or deceptive misstatement, misrepresentation, omission, or conceals any fact material to the interest of Humana, may have committed fraud which is a crime and which may result in the loss of coverage and/or denial of claim under this policy and may subject such person to prosecution for fraud, including criminal and civil penalties. Eligibility for coverage on this policy may be denied or rescinded under this provision without time limit in the event of fraud.

Beginning two years after the effective date of this policy no misstatements, except fraudulent misstatements, may be used to void this policy.

Tennessee, Virginia and Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.