Disability Claim Filing Instructions

Pages 1 & 2 – Employee's Statement of Claim: Must be completed each time you file a claim. Be sure to answer every question.

- Be certain to complete the last date worked, and indicate whether or not you have returned to work and whether your return was on a part-time basis.
- Sign and date the **Authorization** for your physician to release information to Kanawha Insurance Company, a Humana Company.
- If you would like your premiums to be deducted from your benefits, indicate this on the claim form by checking the box, and signing and dating this authorization on the form.
- If disability is due to an accident, clearly indicate the accident details, including date, time, and place of accident. If disability was a result of a motor vehicle accident, please submit a copy of the policy report.

Page 3 – Employer's Statement of Claim:

- All questions must be completed by your Supervisor or an authorized Personnel Department staff member.
- Benefits will be paid based on the last date worked and expected return to work date provided by your employer and physician on this claim form. If you have not returned to work and the physician has either not determined or not provided a return to work date, the employer should provide your next appointment date with the physician, if known.
- 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.

Pages 4 & 5 – Physician's Statement for Disability Claim:

- Ask your attending physician to complete this section.
- This section must indicate the dates of disability including an expected return to work date. If the return to work date is unknown, the physician should indicate the date of your next appointment or recheck for this condition.
- All sections regarding limitations and progress should be carefully reviewed and completed based on your current condition. This will assist in determining extent of the disability and decrease the need for progress notes. Note that progress notes and/or medical records may be requested at any time to substantiate disability.
- If you are able to perform limited duty or part-time activities, this should be indicated on the form.

Pages 6 & 7 – Pre-existing Investigation Form:

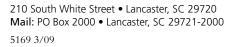
- If claim is being filed within the first year of the policy and is for an illness, you will complete this section, then sign and date the Authorization.
- If provider fax numbers are known, provide them in order to expedite this process.

All portions of the claim form must be completed to avoid unnecessary delay in the processing of your request for benefits. If you have questions when completing the claim form, call 1–877–378–1505, or email disabilityclaims@kmgamerica.com.

Mail this form to the following address:

Kanawha Insurance Company PO Box 2000 Lancaster, SC 29721-2000

Or, you may FAX the form to: 803-283-5634.





Employee's Statement of Claim (To be Completed by Employee)

Your Name			_ Policy Number (s)				
Street Address			_Social Security No.				
City				State	ZIP Code		
Telephone Number (Area Code)			Gender	Gender 🗖 Male 🗖 Female Date of Birth			
Employ	er's Nar	ne					
Occupa	tion (Li	st the duties of your occupation at the time of d	lisability)				
Date of	first syı	nptoms of illness or date of accident	_ Date that you w	ere unable to work d	ue to the disability		
Date ret	turned t	o work on a part-time basis	_ Date returned to	work on a full-time	basis		
Is your a	acciden	t or illness related to your occupation? \Box Yes \Box	N o				
If "Yes,"	' explain	1					
Have yo	ou or do	you intend to file a Workers' Compensation or	Occupational Dise	ase law claim? 🗗 Yes	🗖 No		
Describ	e the oi	nset and nature of your illness or describe how a	nd where accident	occurred			
Date yo	u were	first treated for your illness or injury					
T (1	1 D1	· · · / N1	A 11				
Ireated		ysician's Name					
		ospital Name					
-		had the same or a similar condition in the past?		-	-		
Treated	•	ysician's Name					
	Ho	ospital Name	Address				
Describ	e other	income you are currently receiving - COMPLE	TE THIS SECTION	ONLY IF YOU HAVE	E 24-HOUR COVERAGE		
Yes	No	Туре	Amount	Date Began	Date Terminated		
		Social Security (Disability or Retirement)	\$				
		State Disability	\$				
		Retirement (normal, early or disability)	\$				
		Workers' Comp./Occupational Disease	\$				
		Group Disability	\$				
		Individual Disability (through employer)	\$				
		Other	\$				
Have yo	ou or do	o you plan to apply for benefit(s) described above	ve? 🛛 Yes 🗖 No				
Туре			Date Application	Filed			
Туре _			Date Application	Filed			

Employee's Statement of Claim (To be Completed by Employee)

I authorize Kanawha to deduct any premiums due from my disability benefit check:				
\Box To pay my current policy \Box	For my entire disability			
Signature of Employee	Date			
If signed on behalf of another, give relationship		•		
Authorization				
I hereby authorize any physician, hospital, pharmacy, employer, dentist, coroner/medical examiner, law enforcement agency, insurance organization, consumer reporting agency, or other person or entity possessing any medical information, any information about insurance policies/benefits, or any other information to release all information to Kanawha Insurance Company. This includes drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as an original. The Authorization is valid for six (6) months from the date signed.				
Signature of Employee	Date			
If signed on behalf of another, give relationship				

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.

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

Signature of Employee _____ Date ___



Employer's Statement of Claim (To be Completed by Employer)

Employee's Name	Policy Number (s)
Street Address	
City	State ZIP Code
Social Security Number	Date of Birth
Employee Date of Hire Effective Date of Cover	age (if known)
Date Employee Last Worked Occupation at Time Last	st Worked
Work schedule at time last worked: Number of days per week	_ Number of hours per day
Reason for stopping workImage: SicknessImage: Granted LOAImage: Laid OffImage: DismissedImage: DismissedImage: ResignedImage: Vacation	
🗖 Full-time Date	return to work date
If a return to work date has not been provided to your office by the employee's physici	
Is this a Section 125 Plan? (Premiums deducted pre-taxed)	
Employee's percentage (%) of premium contribution: Employee pays	% Employer pays%
How is employee paid? Straight Salary Hourly S Salary & Bonus Commissions Only	alary and Commissions
Employee's Basic Monthly Earnings \$ (If salary is based on less that	n 12 months, indicate number of months)
COMPLETE THIS SECTION ONLY IF EMPLOYEE HAS 24-HOUR COVERAGE Has insured received other disability payments since time last worked? (Include any are paid by or through the employer.)	individual disability insurance if the premiums
Salary Continuance	Date Benefits Cease
Short or Long Term Disability 🛛 Yes 🗖 No Weekly Amount	
Individual Disability Benefits* 🛛 Yes 🗖 No Weekly Amount	
Other Image: Constraint of the second seco	Date Benefits Cease
Did claim result from job activity?	
Has Workers' Compensation or Occupational Disease law claim been filed?	
Workers' Compensation or Occupational Disease law weekly amount \$	
Employer's Name Telephone Nu	
Address	
Printed Name of Person Completing Form	
Signature of Authorized Representative	
Title Date	

Attending Physician's Statement for Disability

Patient's Name		Date of Birth			
When did symptoms first a	ppear or accident happen?				
Date patient ceased work d	ue to disability				
Has patient ever had same	Has patient ever had same or similar condition?				
		e patient's employment? 🛛 Yes 🗂 No 🗂 Unknown			
Diagnosis (including comp	lications)				
If pregnancy, estimated date	e of delivery	Subjective symptoms			
Objective findings (includi	ng current x-rays, EKG, laborator	y data and any clinical findings)			
Date of first visit		Date of last visit			
Frequency of visits: \Box We	ekly 🗖 Monthly	□ Other (specify)			
Has patient: 🗖 Re	covered 🗖 Improved	□ Remained Unchanged □ Regressed			
Is patient:	bulatory D House Confined	Bed Confined Hospital Confined			
Has patient been hospital c	onfined? 🛛 Yes 🗖 No If "Y	es", please give name of hospital and dates, if known			
(If Applicable) Cardiac Functional Capaci	y Limitations (American Heart A	Association): Class 1 (None) Class 2 (Slight) Class 3 (Marked) Class 4 (Complete)			
Blood Pressure (Last Visit)					
Physical Impairments (As c	efined in Federal Dictionary of C	Occupational Titles):			
Class 1 - No Limitation	of functional capacity capable of	heavy work. No restriction. (0% - 10%)			
Class 2 - Medium manu	1al activity. (15% - 30%)				
Class 3- Slight limitatio	n of functional capacity; capable c	of light work. (35% - 55%)			
Class 4 - Moderate limit	tation of functional capacity; capa	ble of clerical/administrative sedentary activity. (60% - 70%)			
Class 5 - Severe limitati	on of functional capacity; capable	of minimum sedentary activity. (75% - 100%)			
Remarks					

Mental Impairments (if applicable)

How does the condition affect interpersonal relationships on the job? (Define "stress" as it applies to this patient.)

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)

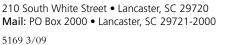
Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked limitations)

Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment. (Severe limitations)

Remarks:	
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Is patient now disabled?	Patient's job 🛛 Yes	🗖 No	Any other work	x 🛛 Yes 🗖	No
Date patient became disabled					
When do you expect a fundamen	e	🗖 1 Month	🗖 2-3 Months	🗖 4-6 Mor	nths 🗖 Never
	Any other work	_		— —	-
When can employment resume in					Part-time
When can employment resume in	another occupation?	Date		□ Full-time	Part-time
If return to work date is unknown	n at this time, please indic	ate date of next	appointment		
Remarks					
Printed Name of Attending Physi	cian				
Physician's License Number					
Degree		Telephone	Number		
Street Address					
City or Town		_ State or Provin	nce		_ ZIP Code
Signature of Attending Physician_			D	ate	
As the employee, it is your res your convenience, you may er					

disabilityclaims@kmgamerica.com Claims Email: Customer Service: 877-378-1505





free, if you have questions.

If a claim is being filed during the first year of the policy, complete the following, then sign and date the authorization on page 7.

Physician's Name Address Telephone Number _____ FAX Number Approximate Date Consulted _____ Diagnosis _____ Physician's Name Address Telephone Number FAX Number Approximate Date Consulted _____ Diagnosis _____ Physician's Name Address _____ Telephone Number _____ FAX Number Approximate Date Consulted Diagnosis Physician's Name Address Telephone Number _____ FAX Number _____ Approximate Date Consulted _____ Diagnosis _____ List all prescribed medication now being taken by the patient. Name of Medication Prescribing Physician Date First Prescribed

List all physicians that treated the patient in the last year:

Any person who, with 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 is subject to prosecution and punishment for insurance fraud.



Authorization

For the Use and Disclosure of Protected Health Information

I authorize the use and/or disclosure of my protected health 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. Only 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. I authorize only designated staff of Kanawha HealthCare Solutions, Inc., a Humana Company to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
- 4. 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.
- 5. 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 HealthCare Solutions, Inc., P.O. Box 610, Lancaster, SC 29721. This revocation shall become effective on the date it is received by Kanawha HealthCare Solutions, Inc. 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.
- 6. This Authorization is valid for twelve (12) months from the date of execution hereof.

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 beh		
, the individual to who above applies, and execute this Authorization in my capacity as A	om the use and/or disclosure of protecte uthorized Representative thereof.	ed health information	

Name of Authorized Representative/Parent or Guardian

Relationship to Applicant

Date

* A copy of the legal authority document must be on file with Kanawha HealthCare Solutions, Inc.

