

## Workplace Voluntary 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.

### Pages Two and Three – Disability Claim Form - Employee’s Statement

- Complete all questions in all sections of the Employee Statement.
- If the 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 police report.
- Sign and date the claim form.
- If provider fax numbers are known, please include them in the provider information.
- Review the deduction of premium information.

### Page Four - Physician Information

- If the claim is being filed for a disability beginning within the first year following the policy effective date, the claimant must complete this page with all physician seen and medications taken within the year prior to the effective date of the plan.

### Page Five - 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 Six – Disability Claim Form - Employer’s Statement

- 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.

### Pages Seven, Eight, and Nine – Physician’s Statement of Disability

- Ask your attending physician to complete this section.
- This section must indicate the dates of disability and 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 impairment, functional ability, prognosis and restrictions 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 a disability.**
- If you are able to perform limited duty or part-time activities, the physician should be indicated on the form.



- **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.**
- Sign and date the authorization on page 4 and include when returning the claim form.
- If the disability date is within the first year of the policy, complete the information on page 5 and return with the claim form.

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

## Workplace Voluntary 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. \_\_\_\_\_

### Section II – Claim Information:

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

List the job duties/responsibilities of your occupation at the time of the disability (and submit a job description) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is the disability related to:  Illness  Pregnancy  Accident  
 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Did your injury or illness occur at work or as result of your job?  Yes  No If yes, did you inform your employer?  Yes  No

Reported to: Employer Representative Name \_\_\_\_\_  
 Address \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

If work related, please explain \_\_\_\_\_

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim?  Yes  No

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? \_\_\_\_\_  
 \_\_\_\_\_

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: \_\_\_\_\_

### Section III – Physician Information:

#### Attending (Treating) physicians:

Physician's Name	Address	Phone Number

### Section III – Physician Information, continued:

Have you ever been treated for the same or a similar condition in the past?  Yes  No

If yes, Please provide the prior physician information:

Physician's Name	Address	Phone Number

### Section IV – Other Income Information:

Please indicate any additional income you are currently receiving

Yes	No	Type	Amount	Frequency	Date Began	Date Ceased
<input type="checkbox"/>	<input type="checkbox"/>	Social Security (Disability or Retirement)	\$ _____	_____	___/___/___	___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	State Disability	\$ _____	_____	___/___/___	___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	Retirement (normal, early, or disability)	\$ _____	_____	___/___/___	___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Comp/Occupational Disease	\$ _____	_____	___/___/___	___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	Group Disability	\$ _____	_____	___/___/___	___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	Salary	\$ _____	_____	___/___/___	___/___/___

If you are not receiving these benefits, do you plan on applying or have you applied for benefit(s) described above?  Yes  No

Type \_\_\_\_\_ Date Applied: \_\_\_/\_\_\_/\_\_\_

Type \_\_\_\_\_ Date Applied: \_\_\_/\_\_\_/\_\_\_

### Section V – Deduction of Premium.

**If your policy is currently active, we will deduct premiums from your disability benefit to keep your premiums paid to date. This will eliminate the risk that your policy be terminated for lack of premium payments.**

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

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 11)

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Employee Date



- Sign and date the authorization on page 4 and include when returning the claim form.
- If the disability date is within the first year of the policy, complete the information on page 5 and return with the claim form.

**If the claim is being filed for a disability within the first year of the policy, complete both the physician and medication information below:**

**Physician information:**

*List all physicians that treated you in the year prior to the policy effective date:*

Physician's Name	Address	Phone Number	Reason for Visit

**Medication information:**

*List all medication being taken by you:*

Medication	Prescribing Physician	Date Prescribed

**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 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 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 2000, Lancaster, SC 29721. 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.**

<i>Signature</i>	<i>Printed Name</i>	____/____/____ <i>Date</i>
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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.

<i>Name of Authorized Representative/Parent or Guardian</i>	<i>Relationship to Applicant</i>	____/____/____ <i>Date</i>
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\* A copy of the legal authority document must be on file with Humana/Kanawha HealthCare Solutions, Inc.



## Workplace Voluntary Disability Claim Form - Physician Statement

### Section I – Disability Information:

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

Is the disability related to:  Illness  Pregnancy  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 appeared or accident occurred: \_\_\_/\_\_\_/\_\_\_

Is the condition due to an injury or sickness arising from the patient's employment?  Yes  No  Unknown

### Section II – Treatment Information:

Diagnosis (including any complications) \_\_\_\_\_

Diagnosis Code(s) \_\_\_\_\_

Date of patient's first visit for this condition \_\_\_/\_\_\_/\_\_\_ Date of last patient visit \_\_\_/\_\_\_/\_\_\_

Frequency of visits:  Weekly  Monthly  Other (specify) \_\_\_\_\_

Subjective symptoms \_\_\_\_\_

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 program/medications) \_\_\_\_\_

Have any medications been changed?  Yes  No If "Yes", Date Changed \_\_\_/\_\_\_/\_\_\_

Medication Change: \_\_\_\_\_

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", Scheduled Date \_\_\_/\_\_\_/\_\_\_

CPT Code(s)/ procedure scheduled \_\_\_\_\_

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

### Section III – 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: \_\_\_\_\_

### Section IV – 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"/>

If the disability is related to a psychological disorder, has the Global Assessment of Functioning (GAF) been performed?  Yes  No  
 If yes, date of the assessment \_\_\_\_/\_\_\_\_/\_\_\_\_ GAF Score \_\_\_\_\_



## Section V – 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, please 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: \_\_\_\_\_

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

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 11)

***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 \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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, Maryland, 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.

### **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.

### **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.