Critical Illness Claim Form – Insured 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 Subscriber Date

Member Information:

Is the claim for the: ☐ Subscriber ☐ Dependent

Subscriber's Name _____ Policy No._____

Mailing Address_____ Social Security No. _____

City _____State _____ ZIP Code_____ Date of Birth _____/_____/_____

Daytime Phone number (_____) _____

Would you like to receive a text or email when your claim is processed? ☐ Text (your carrier's standard messaging rates apply) ☐ Email

(If Text) Number to receive text (_____) _____Name of wireless carrier _____

(If Yes) Email Address to recieve message: _____

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

Claimant Name_____ Date of Birth _____/_____/_____

Type of critical illness/condition for which the claim is being made:

☐ Heart Attack	☐ Heart Transplant	☐ Stroke	☐ Coronary Artery Bypass
☐ Invasive Cancer	☐ Malignant Melanoma	☐ Carcinoma In Situ	☐ End Stage Renal Disease
☐ Severe Burns	☐ Coma	☐ Major Organ Transplant	
☐ Permanent Paralysis	☐ Occupational HIV	☐ Loss of Vision, Hearing, or Speech	

Humana®

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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.

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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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Physician information:

Attending (Treating) physician:

Physician's Name	Address	Phone Number

Has the claimant ever been treated for the same or a similar condition in the past? ☐ Yes ☐ No

If yes, Please provider the prior physician information:

Physician's Name	Address	Phone Number

Has the claimant ever been Hospitalized for this condition? ☐ Yes ☐ No

If yes, Please provider the prior physician information:

Hospital Name	Address	Phone Number

If the claim is being filed for services within the first 2 years following the policy effective date, complete the physician and medication information below:

Physician information: *List all physicians that treated the patient in the five years prior to the policy effective date:*

Physician's Name	Address	Phone Number	Reason for Visit

Medication information: *List all medication being taken by the patient:*

Medication	Prescribing Physician	Date Prescribed

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

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.

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Critical Illness Claim Form – Attending (Treating) Physician Statement

Patient Information:

Patient's Name _____ Policy No._____

Street Address_____ Date of Birth _____/_____/ _____

City _____ State _____ ZIP Code _____

Treatment Information:

Please **check** appropriate box for each condition below for which you are treating this patient, and enclose the information listed under the Medical Documentation Requirements section.

Illness/Condition	Medical Documentation Requirements
Vascular	
☐ Heart Attack	• Medical records from the emergency room and cardiologist • EKG report(s) • Cardiac enzymes levels • Imaging studies • Echo cardiogram(s)
☐ Heart Transplant	• Medical records from the transplant team • Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human-to-human replacement of the whole heart
☐ Stroke	• Medical records from the neurologist • Neuroimaging report(s) • Modified Rankin Scale results 90 days after stroke
☐ Coronary Artery Bypass Surgery	• Diagnosis of coronary heart disease made by angiography test(s) in which the recommended treatment plan includes a CABG.
Cancer	
☐ Invasive Cancer	• Pathologist's report
☐ Malignant Melanoma	• Pathologist's report
☐ Carcinoma In Situ	• Pathologist's report
Other	
☐ Major Organ Transplant	• Medical records • Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing organ
☐ End Stage Renal Failure	• Medical records from the nephrologist • Proof of renal dialysis
☐ Loss of Vision	• Medical records from ophthalmologist; including refractions, visual acuity, and visual field • Proof must document that the blindness was due to Accidental Injury or Sickness; and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis.
☐ Loss of Speech	• Medical records from a neurologist • Clinically-proven that the loss of ability to speak has continued without interruption for a period of at least six (6) consecutive months
☐ Loss of Hearing	• Medical records from an audiologist • Proof of irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months after diagnosis

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Treatment Information:

Other continued

☐ Coma	• Medical records from neurologist • Proof of complete and continuous unconsciousness state not less than 24-96 hours induration which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes
☐ Severe Burns	• Medical records from plastic surgeon • Proof that covered person has sustained third degree burns covering at least 20% of the surface area of their body
☐ Permanent Paralysis due to Accident	• Medical records • Proof that loss is expected to be permanent; been present continuously for at least 180 days; caused by injury sustained in an accident; evidenced by the total and irreversible loss of use of two or more limbs; marked by loss of muscle function in two arms, two legs, or one arm and one leg
☐ Occupational HIV	• Medical records • Proof that the cause of HIV must be from an Accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the 12 months preceding diagnosis; accident occurred while covered person was following the normal occupational duties and reported in accordance with the established occupational procedure for such accidents; the covered person must have undergone a blood test within 5 days of the accident which indicate the absence of HIB or antibodies to such a virus; within 12 months of the accident, the covered person must undergo a follow up blood test indicating the presence of HIV or antibodies to such a virus

Diagnosis (including any complications)_____ ICD-9/ICD-10 Code_____

Date the symptoms first appeared: _____/_____/_____ Date of the first visit:_____/_____/_____

Date of the definitive diagnosis: _____/_____/_____ Date of surgery (CABG):_____/_____/_____

Has the patient been treated for this same or a similar condition prior to this occurrence? ☐ Yes ☐ No

If yes, list the date(s) of prior treatment:_____

Was this patient referred to you? ☐ Yes ☐ No

If yes, please provide the referring physician information:

Referring Physician Name _____ Phone No. (_____) _____

Referring Physician Address _____

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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 _____

Signature of Attending Physician _____ Date _____/_____/_____

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