

## Disability Claim Filing Instructions

**Page 1 – Employee’s Statement of Claim:** Must be completed each time you file a claim. Be sure to answer every question.

- ✦ Make sure you complete the last date worked and indicate whether or not you have returned to work and whether this 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 for 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, make sure that details are indicated 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 2 – 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 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 3 & 4 – 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 5 & 6 – 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 e-mail [disabilityclaims@kmgamerica.com](mailto: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.

# Claim Form for Disability Income Insurance Policy

**HUMANA**  
Specialty Benefits

## 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 First) \_\_\_\_\_ Gender  Male  Female Date of Birth \_\_\_\_\_

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

Occupation (List the duties of your occupation at the time of disability) \_\_\_\_\_

Date of first symptoms of illness or date of accident \_\_\_\_\_ Date that you were unable to work due to the disability \_\_\_\_\_

Date returned to work on a part-time basis \_\_\_\_\_ Date returned to work on a full-time basis \_\_\_\_\_

Is your accident or illness related to your occupation?  Yes  No

If "Yes," 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 \_\_\_\_\_

Date you were first treated for your illness or injury \_\_\_\_\_

Treated by: Physician's Name \_\_\_\_\_ Address \_\_\_\_\_

Hospital Name \_\_\_\_\_ Address \_\_\_\_\_

Have you ever had the same or a similar condition in the past?  Yes  No If "Yes," complete the following.

Treated by: Physician's Name \_\_\_\_\_ Address \_\_\_\_\_

Hospital Name \_\_\_\_\_ Address \_\_\_\_\_

I authorize Kanawha to deduct any premiums due from my disability benefit check:

To pay my current policy  For my entire disability  For this payment only

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 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 \_\_\_\_\_

# Claim Form for Disability Income Insurance Policy

**HUMANA**  
Specialty Benefits

## 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 Coverage (if known) \_\_\_\_\_

Date Employee Last Worked \_\_\_\_\_ Occupation at Time Last Worked \_\_\_\_\_

Work schedule at time last worked: Number of days per week \_\_\_\_\_ Number of hours per day \_\_\_\_\_

Reason for stopping work  Sickness  Granted LOA  Laid Off  Retired  Accident  
 Dismissed  Resigned  Vacation  Other

Has employee returned to work?  Yes  Part-time Date \_\_\_\_\_  
 Full-time Date \_\_\_\_\_  
 No If "No", please provide expected return to work date: \_\_\_\_\_

If a return to work date has not been provided to your office by the employee's physician, indicate date of next appointment \_\_\_\_\_

Is this a Section 125 Plan? (Premiums deducted pre-taxed)  Yes  No

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

Did claim result from job activity?  Yes  No

Has Workers' Compensation or Occupational Disease law claim been filed?  Yes  No

Workers' Compensation or Occupational Disease law weekly amount \$ \_\_\_\_\_ (Please include first report of accident.)

Employer's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

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 appear or accident happen? \_\_\_\_\_

Date patient ceased work due to disability \_\_\_\_\_

Has patient ever had same or similar condition?  Yes  No If "Yes", please describe \_\_\_\_\_

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

Name and address of other treating physicians \_\_\_\_\_

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

If pregnancy, estimated date of delivery \_\_\_\_\_ Subjective symptoms \_\_\_\_\_

Objective findings (including current x-rays, EKG, laboratory data and any clinical findings) \_\_\_\_\_

Date of first visit \_\_\_\_\_ Date of last visit \_\_\_\_\_

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

Has patient:  Recovered  Improved  Remained Unchanged  Regressed

Is patient:  Ambulatory  House Confined  Bed Confined  Hospital Confined

Has patient been hospital confined?  Yes  No If "Yes", please give name of hospital and dated, if known \_\_\_\_\_

### (If Applicable)

Cardiac Functional Capacity Limitations (American Heart Association):  Class 1 (None)  Class 2 (Slight)  
 Class 3 (Marked)  Class 4 (Complete)

Blood Pressure (Last Visit) \_\_\_\_\_

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%)

Remarks \_\_\_\_\_

# Claim Form for Disability Income Insurance Policy



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: \_\_\_\_\_

Is patient now disabled?                  Patient's job    Yes    No                  Any other work    Yes    No

Date patient became disabled \_\_\_\_\_

When do you expect a fundamental or marked change?    1 Month    2-3 Months    4-6 Months    Never

Applies to:    Patient's job    Any other work

When can employment resume in regular occupation?   Date \_\_\_\_\_    Full-time    Part-time

When can employment resume in another occupation?   Date \_\_\_\_\_    Full-time    Part-time

If return to work date is unknown at this time, please indicate date of next appointment. \_\_\_\_\_

Remarks \_\_\_\_\_

Printed Name of Attending Physician \_\_\_\_\_

Physician's License Number \_\_\_\_\_

Degree \_\_\_\_\_ Telephone Number \_\_\_\_\_

Street Address \_\_\_\_\_

City or Town \_\_\_\_\_ State or Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Signature of Attending Physician \_\_\_\_\_ Date \_\_\_\_\_

As the employee, it is your responsibility to make sure your employer and physician complete their sections of this form. For your convenience, you may email this form directly to KMG America or feel free to contact our Customer Service Center toll free, if you have questions.

Claims Email:    [disabilityclaims@kmgamerica.com](mailto:disabilityclaims@kmgamerica.com)  
Customer Service: 877-378-1505

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If a claim is being filed during the first year of the policy, complete the following, then sign and date the authorization on page 6.

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

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*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 Print 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 Kanawha HealthCare Solutions, Inc.