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.

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Claim Form for Disability Income Insurance Policy

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 ❒ 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 _____

Describe other income you are currently receiving – COMPLETE THIS SECTION ONLY IF YOU HAVE 24-HOUR COVERAGE

Yes	No	Type	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 you or do you plan to apply for benefit(s) described above? ❒Yes ❒ No

Type _____ Date Application Filed _____

Type _____ Date Application Filed _____

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Claim Form for Disability Income Insurance Policy

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

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 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 _____

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Claim Form for Disability Income Insurance Policy

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 _____%

How is employee paid? ❒ Straight Salary ❒ Hourly ❒ Salary and Commissions
❒ Salary & Bonus ❒ Commissions Only

Employee's Basic **Monthly** Earnings $ _____ (If salary is based on less than 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 individual disability insurance if the premiums are paid by or through the employer.)

Salary Continuance	❒Yes ❒ No	Weekly Amount _____	Date Benefits Cease _____
Short or Long Term Disability	❒Yes ❒ No	Weekly Amount _____	Date Benefits Cease _____
Individual Disability Benefits*	❒Yes ❒ No	Weekly Amount _____	Date Benefits Cease _____
Other	❒Yes ❒ No	Weekly Amount _____	Date Benefits Cease _____

**Only include Individual Disability Insurance if premiums are paid by or through the employer.*

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 _____

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Claim Form for Disability Income Insurance Policy

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 dates, 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
Customer Service: 877-378-1505

Claim Form for Disability Income Insurance Policy

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.

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.

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Claim Form for Disability Income Insurance Policy

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 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.