

Supplemental Disability Claimant's Statement

This Claimant's Statement is the only form required for verification of Continued Disability until the date your Physician stated your disability should end on the original claim form. Kanawha Insurance Company, a Humana company, reserves the right to independently verify continued disability.

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 _____

What was the last date you worked? _____

Are you still totally disabled and out of work? _____

If you have returned to work, what date did you return? _____

If you are still out of work, what date do you expect to be released by your doctor and able to return to work? _____

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I certify this information in support of this claim is true and accurate.

Signature

Printed Name

Date