

Term Life/CriticalLife Filing Form Instructions (Policy Form 8013)

Page 1- Insured (Employee)'s Statement of Claim

- Must be completed each time you file a claim.
- Be sure to answer every question.

Page 2- Authorization

- Claimant or Authorized Representative must sign and date Authorization to allow physician to release medical record to Kanawha HealthCare Solutions.

Page 3- Pre-existing Investigation Form

- If claim is being filed within the first year of the policy and is for an illness, complete this page with all physicians seen or medications taken in the past 12 months.
- If provider fax numbers are known, provide them in order to expedite this process.
- Make certain authorization on page 2 is signed and dated.

Page 4, 5, and 6

- Ask your attending physician to complete this section.
- This section must indicate the details of your critical illness and the dates of diagnosis along with any referring physicians.
- Pages 5 and 6 provide the physician with the exact medical documentation to attach to their form in order to document the critical illness being claimed.

All portions of this claim form must be completed (unless you are filing only for the Health Screen Benefit) to avoid unnecessary delay in the processing of your request for benefits. If you have questions when completing this form, please call 1-877-378-1505.

If filing for the Health Screening Benefit only, no claim form is required. Please Submit the Superbill or HCFA from the physician indicating the Health Screening procedures performed, including the procedure codes. The claimant's name and policy number should also be indicated on the documentation.

Mail to the following address:

KHS

A member of the Humana Family of Companies
P.O. Box 2000
Lancaster, SC 29721-2000

Or FAX to:

803-283-5634

Level Term Life (CriticalLife) Policy Form 8013

Statement of Claim (To be completed by employee)

Name _____ Policy/Certificate Number _____

Street Address _____ City _____ State _____ ZIP _____

Telephone Number () _____ Insured's Date of Birth _____

Name of Claimant _____

Relationship to Insured _____ Claimant's Date of Birth _____

Type of Critical Illness for which claim is being made _____

Date Critical Illness was first diagnosed _____

Describe the onset and nature of your illness _____

Date you were first treated for your illness or injury _____

Name of Hospital where you were treated _____ Address _____

Name of Physician who treated you _____ Address _____

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

If Yes, name of hospital where treated _____ Address _____

Name of Physician who treated you _____ Address _____

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 Date

Kanawha Insurance Company
A Humana Company
P.O. Box 2000
Lancaster, SC 29721-2000
1-877-378-1505

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., Kanawha Insurance Company and its successors and assignees 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 29721-0610. This Evocation shall become effective on the date it is received by Kanawha HealthCare Solutions, Inc., Kanawha Insurance Company and its successors and assignees 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.

If the claim is being filed during the first year of the policy, complete the following, sign and date the Authorization on the preceding page.

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 medications 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 and application or files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.

Level Term Life Claim Form (CriticalLife) Policy Form 8013

Physician's Statement

Patients Name _____ Policy/Certificate Number _____

To be completed by the medical provider.

1. Provide the diagnosis(es), the date of diagnosis, and the ICD-9 code(s) for the conditions for which you are treating this patient.

Diagnosis	ICD-9 Code	Date of Diagnosis

2. Has this patient been treated for this same or similar condition in the past prior to this occurrence? Yes No
If Yes, provide diagnosis, the dates of treatment and referring physician(s).

Diagnosis	ICD-9 Code	Date of Diagnosis

3. Provide the name and address of any referring physician(s) for this occurrence.

Name of Physician	Address

Printed Name of Medical Provider () _____ Telephone Number () _____ Fax Number

Signature of Medical Provider _____ Date

Physician's Statement (Continued)

Claimant Name _____ Policy/Certificate Number _____

For each condition below for which you are treating this patient, enclose the information listed under the Medical Documentation Needed section.

If you require prepayment, contact us at 1-877-378-1505. Otherwise, bill our office.

Illness (Not all illnesses are applicable to all policies)	Medical Documentation Needed
Heart Attack	Diagnosis based on the following: new EKG changes consistent with and supporting the diagnosis of Heart Attack; elevation of cardiac enzymes above generally accepted laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used); imaging studies such as thallium scans, MUGA scans or stress echo cardiograms.
Stroke	Documented neurological impairment or deficits; evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test); permanent neurological deficit measured three months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.
Coronary Artery Bypass Surgery	Operative report documenting major surgery requiring median sternotomy (division of breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist; results of angiography testing that diagnosed coronary heart disease.
Invasive Cancer or Malignant Melanoma	Diagnosis based on pathologist's report or, in the event that the cancer was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of cancer.
Carcinoma in Situ	Diagnosis based on pathologist's report or, in the event that the carcinoma in situ was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of carcinoma in situ.
Major Organ Transplant	Medical records that demonstrate Major Organ Failure; and 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 Disease	Documentation of chronic irreversible failure of both kidneys and proof of regular (at least weekly) renal dialysis.
Occupational HIV	Documentation demonstrating all of the following: that the Covered Person initially contracted and was diagnosed with Human Immunodeficiency Virus (HIV) after the Date of Certificate; that the cause of the 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 twelve (12) months preceding diagnosis; results from blood tests performed within five (5) days of the accident and within twelve (12) months of the accident.
Terminal Illness Benefit (Base Insured Only)	Documentation demonstrating that the Insured suffers from a sickness that will, with a reasonable degree of medical certainty, result in death of a Covered Person under the Policy within [twelve] months from the date that the attending Physician signs a Claim form.

Death Claim Form (Level Term Life/CriticalLife) Policy Form 8013

Please submit a certified death certificate for all death and accidental death claims. Please submit an accident report for all accidental deaths or dismemberments.

Name of Insured _____ Policy/Certificate Number _____

Insured's Date of Birth _____ Insured's Social Security Number _____

Name of Claimant _____

Relationship to Insured _____ Claimant's Date of Birth _____

Date of Death _____ Was Death due to any of the following Suicide Homicide Accidental Death

Name of Beneficiary _____

Beneficiary's Social Security Number _____ Date of Birth _____

Beneficiary's Mailing Address _____

Beneficiary's Relationship to Deceased _____ Beneficiary's Phone Number _____

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.

Witness at Hand

Date

Signature of Agent/Notary Public

Date

Signature of Beneficiary

Date

Physician's Statement

To be used when no Death Certificate is Available or when the claim is for Accidental Dismemberment or Loss of Sight.

Name of Covered Person/Deceased _____

Age at Death _____ Date of Death/Dismemberment or Loss of Sight _____

Cause of Death/Dismemberment or Loss of Sight Natural Suicide Homicide Accidental Death

Contributing Causes of Death or any Chronic Ailments _____

Date of First Treatment _____ Date of Last Treatment _____

Physician's Name _____ Telephone Number _____

Physician's Address _____

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Signature

Date