Group Life Claim Form

Employer Statement

To be completed by employer

Employment Information

Name of employer _____ Group number _____

Address of employer _____

City _____ State _____ ZIP _____

Name of employee/retiree _____ Date of birth of employee/retiree _____

Address of employee/retiree _____

City _____ State _____ ZIP _____

Job title _____ Original Date of employment _____

Date employee last worked full-time hours _____

Reason employee stopped work (if more than 31 days) _____

Annual base salary $ _____ Hours worked per week _____

Date of last salary payment to employee _____ Amount paid _____

Deceased Information

Deceased is: ☐ Employee ☐ Retiree ☐ Spouse ☐ Child

Name of deceased, if spouse or child _____ Member identification number _____

Other names by which the decedent may have been known (e.g. maiden name, hyphenated name or an alias)

_____

Address of deceased, if spouse or child _____

City _____ State _____ ZIP _____

Date of birth _____ Date of death _____ Effective date of insurance _____

Does the deceased have any other life insurance coverage with Humana, Inc., its subsidiaries or affiliates? ☐ Yes ☐ No

Are Accidental Death Benefits being claimed? ☐ Yes ☐ No

If yes, please submit copies of the police report and the coroner's report (including laboratory findings) if an autopsy was conducted.

Self Administered employer groups – please complete this section

Insurance class: _____

Amount of basic life $ _____ Amount of Accidental Death Benefit $ _____

Amount of optional (voluntary) insurance $ _____ Date of last increase in insurance _____

Signature (all groups)

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

_____ _____

Authorized signature of employer: Date

Humana®

Mail to: Humana
PO Box 13068
Green Bay, WI 54307-3068

Customer Service: 1-866-427-7478
Fax to: 1-920-339-4794
Email to: GBLife_Disability@humana.com

Group Life Claim Form

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 4-5)

Beneficiary Statement

To be completed by beneficiary If the beneficiary is a minor, please provide Letters of Guardianship for the minor's estate. If the beneficiary is the estate, please provide the Letters Testamentary or Letters of Administration appointing the personal representative of the estate. If the beneficiary is deceased, please provide a copy of the deceased beneficiary's official death certificate.

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Will there be a funeral assignment on this claim? ☐Yes ☐No

If no beneficiary assigned or on file with Humana please complete Affidavit on page 3

Beneficiary Information

Name of beneficiary_____ Date of birth_____

Social Security Number/Tax ID number_____ Phone_____

Address of beneficiary _____

City_____ State_____ ZIP_____

Relationship to deceased _____

Signature of beneficiary:_____ Date _____

Name of beneficiary_____ Date of birth_____

Social Security Number/Tax ID number_____ Phone_____

Address of beneficiary _____

City_____ State_____ ZIP_____

Relationship to deceased _____

Signature of beneficiary:_____ Date _____

Please attach enrollment form or most recent beneficiary designation and attach a certified death certificate with the state's raised seal. ** If no beneficiary assigned or on file with Humana please complete Affidavit on page 3 **

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AFFIDAVIT

We will rely upon this Affidavit to determine benefit payment, unless we receive written notice of a valid claim before payment is made. This Affidavit will release us from further liability. Any payment made by us in good faith will fully discharge us to the extent of such payment. Only complete the Affidavit if no beneficiciary is on file with Humana.

Please complete IN FULL. If not applicable, please mark as such. Please include Full Name (s) and Address(es).

Name of Deceased: _____

Policy Number: _____

Is there an estate currently set up? ☐ Yes ☐ No

Living Spouse of Deceased: _____

Living Child(ren) of Deceased, Including Legally Adopted Child(ren) [Also include date(s) of birth]

_____

_____

Living Parents of Deceased:

_____

_____

Living Brother(s) and Sister(s) of Deceased:

_____

_____

Dated at _____, this _____ day of _____ 20_____

Signature _____

Witness _____

Any person who knowingly files a staement of claim containing any false or misleading information is subject to criminal and civil penalties. The Company, in issuing this claim form is in no way admitting liability or waiving any of its rights under the Policy.

Group Life Claim Form

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.

Group Life Claim Form

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.

Discrimination is against the law

Humana Inc. and its subsidiaries comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide: (1) free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate; and (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-866-427-7478 or** if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-866-427-7478** or if you use a **TTY**, call **711**.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-866-427-7478 (TTY: 711)**.... ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-427-7478 (TTY: 711)**.... 注意: 如果您使用繁體中文 , 您可以免費獲得語言援助服務。請致電 **1-866-427-7478 (TTY: 711)**。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-866-427-7478 (TTY: 711)**.... 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-427-7478 (TTY: 711)**번으로 전화해 주십시오.... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-427-7478 (TTY: 711)**.... Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-427-7478 (телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-427-7478 (TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-427-7478 (ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-866-427-7478 (TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-427-7478 (TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-866-427-7478 (TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-866-427-7478 (TTY: 711)**.... 注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。 **1-866-427-7478 (TTY: 711)**まで、お電話にてご連絡ください。... توجه: اگر ب زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. **1-866-427-7478 (TTY: 711)**

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih **1-866-427-7478 (TTY: 711)**....

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لكبالمجان. اتصل برقم **1-866-427-7478 (رقم هاتف الصم والبكم: 711)**.