

Accident Claim Filing Instructions

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.

Page One – Filing Instructions:

- Complete the appropriate sections of the claim form (page 2)
- Attach an itemized billing from your provider which includes the date of service, charge amount, diagnosis and procedure codes
- A copy of the police report is required for all motor vehicle accidents
- If requesting disability benefits under the disability rider of your accident plan, a disability claim form must be completed
- Submit to the address or fax to the number below.

Page Two and Three – Accident Claim Form - Insured Statement:

- Must be completed each time to file a claim
- Complete all questions in both sections of the claim form
- Sign and date the claim form.

Page Four – Authorization Form:

- The Authorization to allow physicians to release medical records.
- Please make certain the Claimant or Authorized Representative sign and date the form.



- Before mailing your claim form, please be sure you have included all items listed above to prevent delay in processing of your claim.
- Attach an itemized billing from your provider that includes the dates of service, charge amount, diagnosis, and procedure codes.
- Retain a copy of all information submitted for your records.

If you have any questions when completing this form, please call 1-800-845-7519.

Mail the completed form to the following address:

Humana Claims
c/o Bay Bridge Administrators, LLC
PO Box 161690
Austin, TX 78716

Or FAX to: 1-512-275-9350

Accident Claim Form – Insured Statement

Section I – General Information:

Is the claim for the: Policyholder Dependent

Policyholder's Name _____ Policy No. _____

Mailing Address _____ Social Security No. _____

City _____ State _____ ZIP Code _____ Date of Birth ____/____/____

Daytime Telephone No. (____) _____

Email Address: _____

Claimant Name _____ Date of Birth ____/____/____

Section II – Accident Details:

Date of Accident ____/____/____ First date treated for injury ____/____/____

Was this accident caused or contributed to by a medical condition? Yes No

If yes, what is the medical condition _____

Did this accident occur at work? Yes No If yes, did you inform your employer? Yes No

Reported to: Employer Name _____

Address _____ Telephone No. (____) _____

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim? Yes No

Please provide **specific** details of how your accident occurred:

Type of Injury:

Where did the accident occur?

Details on what caused the accident:

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Section III – Travel Expense Rider:

Please check the type of travel benefit you are claiming for:

Meals Use of Personal Vehicle Lodging Expenses for common carriers of transportation

Please check who accompanied you for your accident treatment:

Attended alone Spouse or Friend Multiple adults

Please include travel receipts for reimbursement of benefit.

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 page 4 and 5)

The above statements are true to the best of my knowledge and belief.

Signature of Employee

_____/_____/_____
Date



- All bills must contain the date of service, charge amount, diagnosis and procedure codes
- A copy of the Police report is required for all motor vehicle accidents
- To request disability benefits under the disability rider of your accident plan, a separate disability claim form must be completed.

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Accident Claim Form – Insured Statement

Authorization to release information - For the Use and Disclosure of Protected Health Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related 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. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals, pharmacies and pharmacy benefit managers to disclose my protected health information.
3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
5. I authorize only designated staff of Bay Bridge Administrators, LLC, Third Party Administrator for Kanawha Insurance Company, a Humana Company, to receive in writing, by photocopy, facsimile, or by telephone, my protected health information.
6. 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 re-disclosed and would no longer be protected.
7. 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 Bay Bridge Administrators LLC, PO Box 161690, Austin, TX 78716. This revocation shall become effective on the date it is received by Bay Bridge Administrators. 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.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim. A photocopy or facsimile of this authorization shall be valid as the original.

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 for all records or records for dates of service _____ to _____.

_____/_____/_____
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 Bay Bridge Administrators LLC.

If you have any questions when completing this form, please call 1-800-845-7519.

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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.

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.

Alaska, Delaware, Idaho, Maine, Maryland, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Virginia, 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.

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.

State Specific Fraud Warning Statements

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.

Puerto Rico

Any person who knowingly and with intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (\$5,000) dollars and not more than ten thousand (\$10,000) dollars, or fixed term imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.