

Humana group life claim form

Instructions

Please submit the following documentation:

1. Group life claim form.
 - Part one—completed by the employer
 - Part two—completed by the beneficiary
2. The original enrollment form or photocopy and any beneficiary changes.
3. A certified copy of the official death certificate.
4. For accidental death benefits, we require the official complete police report and any coroner's report including laboratory findings if an autopsy was conducted.
5. If the beneficiary is:
 - A minor—we require copies of the guardianship papers naming the legal guardian of the minor's estate.
 - An estate—we require the Letters Testamentary or Letters of Administration appointing the personal representative of the estate.
 - Deceased—we require a copy of the deceased beneficiary's official death certificate.

We may require additional information or documents to process the claim.

Please mail all documentation to:

Humana Insurance Company
Group Life Claims
P.O. Box 10708
Green Bay, WI 54307-0708



Part one—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 insurance \$	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 _____

Part two—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.

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.

Beneficiary information

Name of beneficiary	Date of birth	
Social Security Number/Tax ID number	Phone number	
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 number	
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 number	
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 number	
Address of beneficiary		
City	State	Zip
Relationship to deceased		

Signature of beneficiary: _____ Date _____

Group life claim fraud statements

Please refer to the statements that apply based upon the state where you live:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas or Louisiana: 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.

California: For your protection, California law requires the following to appear on this form: any person who knowingly presents a 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 a policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Department 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 or claim or an application containing any false, incomplete, or misleading information is guilty of a felony.

Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: Any person who knowingly and with intent to defraud an insurer company, files a statement or claim containing any false, incomplete, or misleading information, commits a felony.

Kentucky: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files an application or claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Maine, Tennessee or Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in Section 638.20.

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 Mexico: 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 civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud insurance company or another 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 act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application of false claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Texas: Any person who knowingly presents a 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.

If you live in any state not listed above, the following applies to you: any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.