Humana

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.

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 enrollment form or most recent beneficiary designation.
3. A certified copy of the official death certificate.
4. For accidental death benefits, we require the official complete police report, blood toxicology report, and an autopsy report if one 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 P.O. Box 13068
Green Bay, WI 54307-3068

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Part One—Employer Statement

To be completed by employer

Employment Information

Name of employer | Group number 663866

Address of employer | Employer Phone

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 _____

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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 _____

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 _____

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 _____