Proof of Disability Extended Benefits or Premium Waiver

Kanawha Insurance Company

HUMANA
Specialty Benefits

Return claim to: Kanawha Insurance Company, P.O. Box 1000, Lancaster, SC 29721-1000

The patient is responsible for the completion of this form without expense to the Company.

Patient Information (to be completed by employee/insured)

First name _____ Middle name _____ Last name _____

Date of birth _____ Full time student: ☐ Yes ☐ No If yes, where? _____

Address (if different from employee's address) _____

Sex: ☐ Male ☐ Female Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Employee/insured's name and address _____

Employee/insured's Social Security Number _____ Policy number _____

Patient's or authorized person's signature — I hereby authorize release of information requested on this form.

Signed _____ Date _____

Physician's Statement (to be completed by attending physician)

1. History
   - (a) When did symptoms first appear or accident happen? Date _____
   - (b) Date patient ceased work because of disability. Date _____
   - (c) Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe

     _____
   - (d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
   - (e) Names and addresses of other treating physicians _____

     _____

2. Diagnosis (including any complications)
   - (a) Diagnosis (ICD-9-CM) (b) Date of last examination _____
   - (c) Subjective symptoms
   - (d) Objective findings (including current X-Rays, EKG's, laboratory data and any clinical findings)

     _____

     _____

     _____

3. Dates of treatment
   - (a) Date of first visit _____ (b) Date of last visit _____
   - (c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

4. Nature of treatment (including surgery and medications prescribed, if any)

   _____

   _____

5. Progress
   - (a) Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
   - (b) Is patient ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined
   - (c) Has patient been hospital confined? ☐ Yes ☐ No If yes, give name and address of hospital _____

     _____

Continued from _____ through _____

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Kanawha Insurance Company

Physician's Statement (to be completed by attending physician), *continued*

6. Cardiac (if applicable)

(a) Functional capacity (American Heart Association) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood pressure (last visit) Systolic _____ Diastolic _____

7. Physical impairment

☐ Class 1 - No limitation of functional capacity; capable of heavy physical activity. No restrictions (0-10%)
☐ Class 2 - Slight limitation of functional capacity; capable of light manual activity. (15-30%)
☐ Class 3 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35-55%)
☐ Class 4 - Marked limitation. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)
☐ Remarks: _____

8. Mental/nervous impairment (if applicable)

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has significant loss of psychological. physiological, personal and social adjustment (severe limitations)
☐ Remarks: _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

9. Prognosis	Patient's Job		Any Other Work	
(a) Is patient now totally disabled?	☐ Yes	☐ No	☐ Yes	☐ No
(b) Do you expect a fundamental or marked change in the future?	☐ Yes	☐ No	☐ Yes	☐ No
(1) If yes, when will patient recover sufficiently to perform duties?	Date _____		Date _____	
	☐ 1 Mo.	☐ 1-3 Mos.	☐ 1 Mo.	☐ 1-3 Mos.
	☐ 3-6 Mos.	☐ Never	☐ 3-6 Mos.	☐ Never

(2) If no, please explain _____

10. Rehabilitation	Patient's Job		Any Other Work	
(a) Is patient a suitable candidate for trial employment?	☐ Yes	☐ No	☐ Yes	☐ No
(1) If yes, when could trial employment commence?	Date _____		Date _____	
	☐ Full-time	☐ Part-time	☐ Full-time	☐ Part-time

(2) If yes, what training will patient require? _____

(3) If yes, what type of employment would you suggest? _____

(4) If no, please explain _____

11. Remarks

_____

_____

Print name (attending physician) _____ Degree _____ Telephone _____

Street address _____ City _____ State _____ ZIP code _____

Signature _____ Date _____

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