

# Claim Statement Life/Accidental Death and Dismemberment Kanawha Insurance Company

**HUMANA.**  
Specialty Benefits

Return form to: Plan Administration, Ltd. 580 Hazard Avenue, Enfield, CT 06082  
(To avoid delay please answer all questions)

## Instructions:

THIS FORM IS TO BE COMPLETED BY THE GROUP POLICYHOLDER/EMPLOYER, NOT THE DESIGNATED BENEFICIARY. Upon the death of an insured employee, or dependent, the following items must be furnished without expense to Kanawha Insurance Company.

1. Completed and signed Claim Statement.
2. A *certified copy* of the deceased person's death certificate. If no death certificate is available, the Physician's Statement on the back of this form may be submitted in its place.
3. The employee's enrollment form, all beneficiary designated forms and any assignment forms, if applicable. If any beneficiary is deceased, a certified copy of his or her death certificate must also be submitted.
4. If death resulted from an accident and AD&D insurance is in force, a police report and a newspaper article giving the details of the accident.
5. If insurance proceeds are payable to the estate of the insured, to a minor, or to a mentally incompetent person, a certified copy of the legal document appointing the executor or administrator of the estate or the guardian or conservator of the beneficiary.
6. If claim is for Day Care Benefit or Education and Training Benefit, please submit copies of bills.

## To Be Completed by Policyholder (Employer)

Name of policyholder \_\_\_\_\_ Policy number \_\_\_\_\_

Insured's last name \_\_\_\_\_ First name \_\_\_\_\_ Middle \_\_\_\_\_

Social Security Number \_\_\_\_\_ Class \_\_\_\_\_ Date of birth \_\_\_\_\_

Occupation \_\_\_\_\_ Date of employment \_\_\_\_\_ Premium paid-to date \_\_\_\_\_

Salary (if insurance is salary based) \_\_\_\_\_ City and state of residence \_\_\_\_\_

Effective date of coverage \_\_\_\_\_ Was evidence of insurability required? \_\_\_\_\_

If deceased is a dependent, last name \_\_\_\_\_ First name \_\_\_\_\_ Middle \_\_\_\_\_

Social Security Number \_\_\_\_\_ Dependent's date of birth \_\_\_\_\_

Relationship of dependent to insured:  Spouse  Son  Daughter  Other: \_\_\_\_\_

City and State of Residence \_\_\_\_\_

Date of death \_\_\_\_\_ Date last worked \_\_\_\_\_

Reason for leaving work prior to death:  Disability  Terminated  Retired  Vacation  Other: \_\_\_\_\_

Was deceased considered an employee on date of death?  Yes  No

Was insurance terminated prior to death?  Yes  No If yes, Termination Date \_\_\_\_\_

Reason for termination \_\_\_\_\_

Amount of insurance claim: Basic Life Insurance \_\_\_\_\_ Supplemental Life \_\_\_\_\_

Basic AD&D Insurance \_\_\_\_\_ Supplemental AD&D \_\_\_\_\_

Claim is for:  Life Insurance  AD&D  Other: \_\_\_\_\_

# Claim Statement Life/Accidental Death and Dismemberment Kanawha Insurance Company

## To Be Completed by Policyholder (Employer), continued

Complete the following information for each living beneficiary entitled to benefits

Beneficiary's last name \_\_\_\_\_ First name \_\_\_\_\_ Middle \_\_\_\_\_

Social Security Number \_\_\_\_\_ Sex  Male  Female

Beneficiary's mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of birth \_\_\_\_\_ Relationship to deceased \_\_\_\_\_ Beneficiary's phone number \_\_\_\_\_

Benefit Payment Preference:  Lump Sum Payment by Check  Checkbook Option (IBA)

Beneficiary's last name \_\_\_\_\_ First name \_\_\_\_\_ Middle \_\_\_\_\_

Social Security Number \_\_\_\_\_ Sex  Male  Female

Beneficiary's mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of birth \_\_\_\_\_ Relationship to deceased \_\_\_\_\_ Beneficiary's phone number \_\_\_\_\_

Benefit Payment Preference:  Lump Sum Payment by Check  Checkbook Option (IBA)

Remarks \_\_\_\_\_

The above statements are true to the best of my knowledge and belief. Signature & title of policyholder's representative:

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date Signed \_\_\_\_\_

## Physician's Statement – To be used only when no Death Certificate is available or when the claim is for accidental dismemberment or loss of sight

Please complete this section and mail to: Kanawha Insurance Company, P.O. Box 1000, Lancaster, SC 29721-1000

Full name of deceased person \_\_\_\_\_ Date of death \_\_\_\_\_

Place of death \_\_\_\_\_ Occupation \_\_\_\_\_

Cause of death/dismemberment or loss of sight:  Natural  Suicide  Accidental  Homicide

Contributing cause(s) of death or any chronic ailments \_\_\_\_\_

Date of first treatment \_\_\_\_\_ Date of last treatment \_\_\_\_\_

If deceased was disabled, give dates he or she was unable to work: From \_\_\_\_\_ To \_\_\_\_\_

Doctor's name (Please Print) \_\_\_\_\_ Telephone number \_\_\_\_\_

Doctor's address \_\_\_\_\_

I hereby certify that the above information is true and complete to the best of my knowledge and belief:

Doctor's signature \_\_\_\_\_ Date signed \_\_\_\_\_

Any person who, with 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 is guilty of insurance fraud.