Humana Workplace Voluntary Benefits

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For more information

If you have a question about Humana Specialty Benefits disability coverage and can't find the answer in this guide, feel free to contact us. Contact information is on the back of this page and in the Overview section.

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Contact information

Humana Specialty Benefits makes it easy and convenient for you to do business with us

If you have a question, feel free to contact one of our service teams.

Customer Service

- Phone: 1-877-702-5986
  Representatives are available
  Monday through Friday, 7 a.m. to 6 p.m.,
  Central Time
- Fax: 1-803-283-5634

Claims

- Phone: 1-877-378-1505
- Fax: 1-803-283-5545
- Mail: Humana Specialty Benefits
  P.O. Box 2000
  Lancaster, SC 29721-2000

Premiums

- Contact the assigned billing representative for your organization

Enrollment submission:

Fax: 1-866-584-9140

Mail: Humana Specialty Benefits Enrollments
P.O. Box 14330
Lexington, KY 40512

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Workplace Voluntary Benefits

Overview

Administration

Benefits and claims

Other information

Information in this guide is accurate as of November 2011, unless otherwise noted, and is subject to change. All coverage, benefit, and eligibility determinations are made based on the terms, conditions, and provisions of the plan document, not this guide. For administrator use only – not for distribution to the public.

Look for these boxes throughout your handbook for tips or more information on a key topic.

Workplace voluntary benefits basics

About Humana Specialty Benefits

Our workplace voluntary benefits allow you to offer employees added financial security for them and their families, and you can expand your benefit options without increasing your benefits budget.

Workplace voluntary benefits product offerings

Humana's workplace voluntary benefits products include:

Humana Term and Whole Life

- **Humana Term Life/CriticaLife®** provides income protection during employees' working years, with rates that are designed to remain level for the duration of the policy period. Embedded in the policy is the Accelerated Benefit for Terminal Illness. Features include an Accidental Death and Dismemberment (AD&D) benefit and portability. Optional features include Waiver of Premium, Accidental Death & Dismemberment (AD&D), Loss of Work, and Accelerated Benefit for Critical Illness.
- **Humana Whole Life policies** are available with three paid-up age stipulations: premiums payable to age 65, 90, or 99. The employer selects the policy offered. Embedded in the policy is the Accelerated Benefit for Terminal Illness. Features include an Accidental Death and Dismemberment (AD&D) benefit and portability. Optional features include Waiver of Premium, Loss of Work, and Automatic Benefit Increase.

Specified Disease

- **Humana Critical Illness** provides a lump-sum payment when the employee is first diagnosed with vascular and other critical illnesses. Coverage is available from $5,000 to $50,000, and the employee's family can apply for coverage as well. Coverage is modular and employee-selected for base and optional benefits.
- **Humana Critical Illness/Cancer** provides a lump-sum payment when the employee is first diagnosed with cancer, vascular, and other critical illness. Coverage is available from $5,000 to $50,000, and the employee's family can apply for coverage as well. Coverage is modular and employee-selected for base and optional benefits.
- **Humana Group Cancer Expense** provides funds to help offset the expenses associated with cancer treatment, plus ancillary costs. The benefits of this policy are annually restorable.
- **Humana Cancer Lump Sum** is designed to pay a lump-sum cash benefit when the employee is first diagnosed with internal cancer or malignant melanoma. No hospitalization or treatment is required for the employee to receive the cash benefit. Individuals can use the cash payment for any chosen purpose. The plan pays in addition to any other insurance coverage already in force.

- **Humana Cancer Lump Sum 10-50** is designed to pay a one-time lump sum cash benefit for as much as $50,000 when internal cancer or malignant melanoma is first diagnosed.

Supplemental Health

- **Supplemental Health** may benefit your employees by providing additional reimbursements for costs associated with hospitalization. It also provides optional benefits that provide coverage for physician's office, emergency room services, and diagnostic tests, for example. This policy does not coordinate with an existing group health plan.

Accident and Disability

- **Humana Accident** policies can provide employees with off-the-job or 24-hour coverage for accident-related expenses, such as ambulance services, hospital confinement, and medical treatment. The plan also offers coverage for accidental losses such as loss of sight or a limb. Optional benefits and riders further extend coverage and help protect against loss of income or expenses incurred for intensive care hospital stays.
- **Disability Income Advantage** is an individual disability income policy that can help employees when they're unable to work. The plan offers additional benefits for partial disability, terminal illness, survivorship, and catastrophic disability.
- **Disability Income Plus** is workplace voluntary disability income insurance that provides a monthly disability income benefit as a result of a non-occupational "off-the-job" accident or sickness. This plan includes additional benefits for partial disability and waiver of premium, if totally disabled.

Contact information for employers

Customer Service

Phone: 1-877-702-5986

Representatives are available Monday through Friday, 7 a.m. to 6 p.m., Central Time

Fax: 1-803-283-5634

Claims

Phone: 1-877-378-1505

Fax: 1-803-283-5545

Mail: Humana Specialty Benefits
P.O. Box 2000
Lancaster, SC 29721-2000

Premiums

Please contact the assigned billing representative for your organization.

Enrollment submission:

Fax: 1-866-584-9140

Mail: Humana Specialty Benefits Enrollments
P.O. Box 14330
Lexington, KY 40512

Your assigned billing representative processes your premiums and is your single point of contact for any billing-related concerns.

Contact information for employees

Customer Service

Phone:	1-877-378-1505
	Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Claims

Phone:	1-877-378-1505
Fax:	1-803-283-5545
Mail:	Humana P.O. Box 2000 Lancaster, SC 29721-2000

Online resources

Billing

If you prefer to handle benefits administration online, we provide an electronically generated list bill in MS Excel format. The bill is available on our secure website. This method provides every level of detail custom to our standard paper billing, as well as a pre-formatted remittance section that allows you to “drop” in deduction amounts and upload back to your assigned billing representative.

To use our online administration resources, go to www.KMGAmerica.com. Select “Electronic Billing” on the left side of the page.

Downloadable forms

Many of the forms benefits administrators and employees may need are located on the secure employer section of **Humana.com**.

In the Appendix
A list of commonly used forms is in the Other Information section of this guide.

Enrollment and changes

Electronic benefit communication and enrollment

For customers who prefer electronic benefits enrollment, Humana Specialty Benefits offers the ClickEnroll℠ system. With this system, you can present a customized benefits communication and enrollment tool to enroll employees.

With this system, electronic or paperless enrollments can be completed with one or more of the following:

- Laptop – In this situation, the employee and the benefit counselor read through a presentation together, and the employee has the opportunity to interact directly and ask more in-depth questions.
- Call centers – A call center can be inbound or employer-assisted outbound. Typically, presale materials are distributed before enrollment.
- Web-based – In this environment, the Internet can house the presentation and employees can enroll easily via self-service or an agent assisted enrollment.

Adding new employees

New employees may use the web-based, self-service enrollment year-round to elect their benefits.

Adding new dependents

To add a dependent to existing coverage, an application or enrollment form is required. To delete a dependent from an existing policy, the employee must fill out and sign a Policy Service Request Form (Form 6016).

Leave of absence procedures

If one or more of the employees will be on temporary leave of absence and you will not be collecting a premium, please have the employee send premium payments directly to Humana Specialty Benefits. This process allows for continuation of coverage.

Reinstatement

In the event an employee lets the policy lapse and wants to apply for reinstatement, use the following guidelines, according to the type of coverage:

- **Health coverage** – Coverage may be reinstated for up to one year from the lapse date. The employee should submit a Request for Reinstatement Form (Form 6032) and a payroll deduction authorization to be added back to the group billing statement after reinstatement. Any policy not in force for more than one year requires a new application.
- **Term life** – Coverage may be reinstated within one year from the lapse date. The employee should submit two months' premium along with a Request for Reinstatement Form (Form 6032) and a payroll deduction authorization to be added back to the group billing statement after reinstatement.
- **Whole life** – Coverage may be reinstated within three years from the lapse date. All back premiums must be submitted with the Request for Reinstatement Form (Form 6032) and a payroll deduction authorization to be added back to the group billing statement after reinstatement.
- **Group trust** – These products are ineligible for reinstatement.

If the coverage is under a Section 125 plan, please be aware of the limitations concerning the addition or deletion of dependents. If you have any questions, please contact your Section 125 Administrator.

Employee information changes

To make a change in the employee's name or address, a Policy Service Request Form (Form 6016) is required. To make a change in the beneficiary designation on a life policy, a Standard Change of Beneficiary Form is required. Please have the employee contact our Customer Care team for additional information.

Other information changes

If you need to change the employer address, phone number, or contact person, contact Customer Care. To request a change of Agent or Broker of Record, please send a written request citing the reason for this request.

Canceling coverage

Employees who want to cancel their coverage should fill out and sign our Workplace Voluntary Benefits Cancellation Request Form (Form 1618). A copy goes to the employer and the original goes to Humana Specialty Benefits. Humana Specialty Benefits must receive written notice to cancel coverage.

Termination of employment

We offer many insurance policies that are portable. When employees terminate employment, please advise them that they may have the right to continue their coverage. You should also notify us as soon as possible so we can contact the employee to assist with the continuation of their coverage. The above is applicable per plan provisions.

Billing and premiums

Billing methods

We support two billing methods for workplace voluntary benefits:

- **Paper Bill** – About 15 days before the premium due date, we mail an Invoice for Insurance Premiums. You note any changes on the invoice and return it to Humana Specialty Benefits for processing.
- **Electronic Billing** – We provide an electronically generated list bill in on our secure website. This method provides all details on our standard paper billing, as well as a pre-formatted remittance section.

Your prompt remittance of premiums is very important to your employees, especially when they file a claim. Premium must be current in order for the claims examiner to review your employees' claims. Claim payment will be delayed until the premium is received.

Billing modes

For paper/electronic modes, we support the following cycles:

- **Monthly** – Premium is usually due the first day of each month
- **Thirteenthly** – Premium is due every 28 days
- **Other** – Ninthly and 10thly billing modes can be supported

For all modes, we generate billing statements 15 days before the payment due date.

If payment is outstanding when the next bill is generated, past-due amounts are printed on the bill.

Reconciliation

For every bill generated, an electronic bill is generated into the Payment Reconciliation Program. Payments for list bills are received daily and any amount received is applied to the group suspense.

As part of the billing, you may receive:

- An arrears statement listing individual policies that may have an outstanding "no-pay" record.
- The Pending Policies List Bill Notice, which lists individual policies that are still in new business, are pending issue, or are pending a signed endorsement. If the amount remitted isn't equal to the amount billed, the bill is forwarded to the customer's assigned payment representative.

For individual policies that are billed, when no payment is received, we generate a letter of notice and mail it to the employee. If we don't receive a payment within 15 days, the policy will lapse.

For individual policies billed whereby the employee is marked and annotated as terminated, the program will suspend the policy and we will generate a letter of notice, which is mailed to the employee. If we don't receive payment within 15 days, the policy will lapse.

For Workplace Voluntary Benefits policies, we send a notice of lapse to the employer, but not to the employees. The agent of record is notified two days before the pending letter is mailed to the employer.

Termination for non-payment

If we don't receive payment for three billing cycles, the group will be terminated. We will send pending letters to all policyholders advising them that the premiums will no longer be paid through payroll deductions. This notice gives them the opportunity to continue the coverage on a direct-payment or EFT-payment method. If payment is not received within 15 days, the policy will lapse.

For Workplace Voluntary Benefits coverage that doesn't include a portability provision, the policy will lapse after the third "no pay" from the group. We will send a notice only to the group and not to the employee.

Claims procedures

Claim filing overview

The employee or certificate holder is responsible for completing his or her own claim forms. Claim forms are available on **Humana.com**, and by calling our Customer Service department. We accept claim forms by mail and by fax.

Mailing address:
Humana
P.O. Box 2000
Lancaster, SC 29721-2000

Fax number:
1-803-283-5545

We strive to process all claims within ten business days after receipt of all required forms. To avoid delays in processing, the claimant should submit the required documentation listed in this guide.

Life claims

The following documentation is required:

- A Death Claim Administration Form (Form 5044 for whole life and Form 5624 for term life) completed and signed by the beneficiary of the policy.
- If benefits have been assigned to someone other than the beneficiary, a copy of the assignment must also be submitted.
- If the beneficiary is deceased, a copy of the death certificate for the beneficiary is needed.
- If the employee has an estate, a copy of the executor or personal representative papers is required.
- A certified death certificate – photocopies aren't accepted.
- If the cause of death is listed as "pending autopsy," a copy of the autopsy report is required.

- If the death was due to an accident, a copy of the police report for the accident is required. A copy of the toxicology report, autopsy, or both may also be required.

Accident claims

Claimants who prefer to fill out a form can use the Accident Claim Form (Form 6554). Those who submit a claim without the claim form should include the policy number or certificate number on each piece of correspondence.

The following is needed when filing a claim:

- If a claim form isn't used, provide details of the accident, including date and time of occurrence.
- If the accident was due to a motorized vehicle accident or assault, a copy of the police report is required.
- Invoices from the providers with the diagnosis, date of service, procedure performed and charge must accompany either the claim form or other documentation.

Additional information is required if the accident claim involves disability. See the next section for details.

Disability claims

The Claim Form for Disability Income Insurance Policy (Form 5169) is required. Following are instructions for completion:

- Page 1 – Employee's Statement of Claim.
  - This section must be completed each time a claim is filed.
  - The employee should be certain to answer every question – especially the last date worked, whether the employee has returned to work, and whether it was on a part-time or full-time basis. If the disability is due to an accident, the employee should include the details requested, including the date and time of the accident.
  - The employee must sign and date the authorization for the doctor to release information to Humana.

- Page 2 – Employer's Statement of Claim.
  - All questions must be completed by the employee's supervisor or an authorized Human Resources department staff member.
  - Benefits will be paid based on the last date worked and expected return-to-work date provided by the employer and doctor on this form.
  - To ensure that taxes are handled properly, the questions about Section 125 and employer/employee contribution need to be answered.
- Pages 3 and 4 – Physician's Statement for Disability Claim.
  - The employee should ask his or her attending doctor to complete this section.
  - This section must indicate the dates of disability, including an expected return-to-work date. If the return-to-work date is unknown, the doctor should indicate the date of the employee's next appointment or recheck for this condition.
  - All sections about limitations and progress should be reviewed and completed carefully based on employee's current condition. This information will assist in determining extent of disability and decrease the need for progress notes.
  - If the employee is able to perform limited duty or part-time activities, this should be indicated on the form.

Critical Illness claims

Claimants are welcome to use our Critical Illness Claim Form (Form 6781). Those who submit a claim without the claim form should include the certificate number on each piece of correspondence.

The following documentation is required:

- **All claims** – The invoices from the providers with the diagnosis, date of service, procedure performed, and charge.
- **Cancer benefit only** – A copy of the pathology report showing a definite diagnosis of cancer for the specific cancer on which the claim is being filed.
- **Vascular benefit only** – A copy of the hospital records are required to confirm the diagnosis of heart attack or stroke.

Instructions for completing the claim form:

- Page 1 – Claim Information and Authorization
  - The claimant should complete the policy and employee information, and answer Question 1 through Question 5.
  - The claimant must sign and date the authorization for the doctor to release information to Humana Specialty Benefits.
- Page 2 – The Attending Physician's Report; this report is only required in lieu of a billing with CPT-4 codes
  - The claimant should complete Part A and sign in this section only if he or she wants the benefits assigned to the provider. If the claimant doesn't sign in this section, the benefits will be paid to the employee.
  - The attending doctor should fill out Part B. Question 1 must list the diagnosis code; if not using ICD9 codes, the name of the code must also be given.

Lump Sum Cancer claims

Claimants who want to use a form can use the Cancer Claim – Individual Form (Form 5228). Those who submit a claim without the claim form should include the policy number or certificate number on each piece of correspondence.

The following documentation is required:

- A copy of the pathology report showing a definite diagnosis of cancer for the specific cancer on which the claim is being filed.
- If the diagnosis is based on clinical diagnosis rather than pathology, the attending doctor will need to provide a statement indicating the reasons for the diagnosis. The form includes space for this information.

Instructions for completing the claim form:

- Page 1 – Claim Information and Authorization
  - The claimant should complete the policy and employee information, and answer Question 1 through Question 5.
  - The claimant must sign and date the authorization for the doctor to release information to Humana Specialty Benefits.
- Page 2 – Attending Physician's Report
  - The claimant's attending doctor should complete this section. Question 1 must list the diagnosis code; if not using ICD9 codes; the name of the code also must be given.

Expense Incurred Cancer Expense claims

Claimants who want to use a form can use the Cancer Claim – Individual Form (Form 5057). Those who submit a claim without the claim form should include the policy number or certificate number on each piece of correspondence.

The following documentation is required:

- All claims – Billing statements from providers showing the diagnosis, date of service, procedure performed, and charge.
- A copy of the pathology report showing a definite diagnosis of cancer for the specific cancer on which the claim is being filed.

Instructions for completing the claim form:

- Page 1 – Claim Information and Authorization
  - The claimant should complete the policy and employee information, and answer Question 1 through Question 5.
  - The claimant must sign and date the authorization for the doctor to release information to Humana Specialty Benefits.
- Page 2 – The Attending Physician's Report; this report is only required in lieu of a billing with CPT-4 codes
  - The claimant should complete Part A and sign in this section only if he or she wants the benefits assigned to the provider. If the claimant doesn't sign in this section, the benefits will be paid to the employee.
  - The attending doctor should fill out Part B. Question 1 must list the diagnosis code; if not using ICD9 codes; the name of the code must also be given.

Appendix: forms

List of claim forms

The following claim forms for benefits are available on our website, Humana.com. Employers and employees also can get forms by calling our Customer Care phone number.

Types of Claim	Form Number	Marketing Names of Products Using the Claim Forms
Accident Claims (group)	6554	Humana Accident
Cancer Claims, Expense Incurred Cancer Claims	5057	Humana Cancer Expense
Cancer Claims, Lump Sum Only	5228	Humana Cancer Lump Sum Humana Cancer Lump Sum 10-50
Critical Illness Claims	6781	Humana Critical Illness Humana Critical Illness and Cancer
Term Life	5624	CriticaLife®, Level Term Life
Whole Life	5044	Humana Whole Life 65 Humana Whole Life 90 Humana Whole Life 99
Disability	5169	Disability Income Plus Disability Incom Advantage

List of miscellaneous forms

To get these forms, visit Humana.com or call Customer Care.

Form Name	Form Number
Beneficiary Designation/Change Form	6042
Workplace Voluntary Benefits Cancellation Request Form	1618
Policy Service Request Form	6016
Request for Reinstatement Form	6032
Cancellation Request Form	1618
Reinstatement Form	6032
Service Request Form	6016
Payer Change Request	6020

Many of these forms have a state-specific version for California. If you're in California, be sure to download the correct version of the form.

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