TheStandard®

Standard Insurance Company
Employee Benefits Department 855.757.4717 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Your Choice/Educator Options Long Term Disability Benefits Claim Packet Instructions

Your Disability Benefit Claim

This packet contains the forms necessary to apply for Long Term Disability benefits. Every space on these forms should be filled in to avoid delay in processing your application. If a section does not apply, or information is not available, write **"NA"** in the space so that we know you did not overlook that particular question. **If a form is received incomplete, it may be returned for completion.**

How To Apply For Benefits

The Long Term Disability Benefits application includes claim forms and an Authorization.

1. The Employee's Statement

- Answer every question completely. Be sure to use the appropriate section for injury, sickness or pregnancy. If a question does not apply to you write "NA".
- Use an additional page, if necessary, to give full and complete answers.
- Attach copies of any Social Security, Public Employees Retirement System, Workers' Compensation or other benefit determinations you have received. If you have applied for any other benefits but have not yet received them, please send a copy of the application receipt. This information is needed to accurately calculate your monthly benefits. If you are unable to make copies of these documents please send the originals. We will photocopy and return them to you promptly.
- Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

2. The Authorization to Obtain and Release Information

- Please sign and date the Authorization to Obtain and Release Information and attach it to the Employee's Statement. Your signature lets Standard Insurance Company get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain and Release Information also lets The Standard release this information to specific persons.

  You will receive copies of the Authorization upon your request.

3. The Attending Physician's Statement

- **Part A** should be completed by you.
- **Part B** should be completed by your physician.
- **If you have seen more than one physician for your disability, a statement should be completed by each physician.** (You may request additional forms from your employer.) Your physician(s) should mail the completed form directly to The Standard.

4. The Employer's Statement

- This form should be completed by your employer, who will mail it to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. If you have any questions, our office is here to help you.

Reset

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Your Choice/Educator Options Long Term Disability Insurance Employee's Statement

Please type or print. Form may be returned for unanswered questions.

1. Claimant

Full Name _____ Social Security No. _____

Address _____ City _____ State _____ ZIP _____

Phone No. (_____) _____

Birthdate _____ Sex ☐ Male ☐ Female Height _____ Weight _____

Name of Spouse _____ Birthdate _____

No. of Dependent Children _____ Birthdate of Youngest _____

Do you need a translator? ☐ Yes ☐ No I speak: _____

2. Employment

Name of Employer _____ Group Policy No. _____

State your job title and describe your duties at work.

Last full day at work _____ Date you became unable to work at your occupation as a result of disability _____

Are you now or have you worked at your occupation or any other occupation since the date of your injury? ☐ Yes ☐ No

Are you self-employed at any activity? ☐ Yes ☐ No

Have you returned to work? ☐ Yes ☐ No

If yes, date returned part time _____ Date returned full time _____

If no, date expected to return part time _____ Date expected to return full time _____

Cause of disability: ☐ Motor Vehicle Accident ☐ Other Accident ☐ Illness ☐ Work Related Injury/Illness ☐ Pregnancy

If your disability is work related, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

Contact Name _____ Telephone No. _____

3. Sickness/Injury

Describe illness or injury _____ Date first noticed _____

Cause of illness or injury _____

Have you ever had the same condition or a related illness before? ☐ Yes ☐ No

4. Pregnancy

Date you expect to cease work _____ Expected delivery date _____

Actual delivery date _____

Please indicate any foreseeable complications.

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5. Attending Physician *List all physicians consulted for this injury or illness. Use separate sheet, if needed.*

Physician's Name _____ Specialty _____ Phone No. (____) _____

Street Address _____ Fax No. (____) _____

City _____ State _____ ZIP _____

Date first consulted for this injury or illness _____ Date last consulted _____

Physician's Name _____ Specialty _____ Phone No. (____) _____

Street Address _____ Fax No. (____) _____

City _____ State _____ ZIP _____

Date first consulted for this injury or illness _____ Date last consulted _____

6. Hospital *If you were hospitalized for this condition, please complete. Please attach copy of hospital bill if available.*

Hospital Name _____ Address _____

From _____ Through _____ Reason for Hospitalization _____

7. History *List all illnesses or injuries for which you have received treatment over the past five years. Use separate sheet if needed.*

Ailment	Date	Physician's Name	Complete Address

8. Benefits From Other Sources

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) *Please specify type* _____	☐	☐	☐	☐				
e. Other _____ (e.g., unemployment or union benefits, etc.)	☐	☐	☐	☐				

Please send copies of any letters or notices approving or denying benefits.

9. Vocational *Complete the following and/or attach a resume.*

Highest grade completed _____ Degree earned _____

Work Experience: Complete the following starting with your most recent work experience.

Job Title & Employer	Dates of Employment	Duties	Last Salary
1.	From To		
2.	From To		
3.	From To		

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the applicable fraud notice on page 4 of this form.

SIGNATURE _____ DATE _____

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CALIFORNIA RESIDENTS

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COLORADO RESIDENTS

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DISTRICT OF COLUMBIA RESIDENTS

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FLORIDA RESIDENTS

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NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other 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 insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Authorization to Obtain and Release Information

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations, and eligibility for other benefits or leave periods including, but not limited to, claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 6. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Social Security No. _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

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Your Choice/Educator Options
Long Term Disability Insurance
Attending Physician's Statement

Part A. To Be Completed By Employee

For a prompt review of your claim, ALL of this form must be thoroughly completed by the appropriate persons.

Full Name	Employer/Company Name	Group Policy No.	
Social Security No.	Phone No. ( )	Birthdate	
Address	City	State	ZIP
Date returned to work	Date expected to return to work		

Part B. To Be Completed By Attending Physician

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to The Standard. Please complete this form and mail or fax it to The Standard using the contact information listed above.

1. Diagnosis	A. Diagnosis		ICDA Classification
B. Symptoms			Height Weight B/P Dominant Hand ☐ Left ☐ Right
2. Pregnancy (if applicable)	A. Expected date of delivery	B. Actual date of delivery	☐ Vaginal ☐ C-section
3. History and Treatment	A. Date you recommended the patient stop work		B. When did symptoms appear or accident happen?

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?

D. Is this condition related to the patient's employment? ☐ Yes ☐ No

E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

F. Date of first visit for this condition	G. Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other _____	H. Date of most recent visit

I. Describe planned course and duration of treatment

J. Hospitalization? ☐ Yes ☐ No If yes, ☐ Inpatient ☐ Outpatient	K. Name of Hospital

L. Address of Hospital

M. Date admitted Date discharged	N. Surgery? ☐ Yes ☐ No	O. Date Surgery completed/scheduled
P. Reason/Surgery Type		Q. Surgery/Post-Surgery Complications? ☐ Yes ☐ No If yes, please describe

4. Level of Functional Impairment ***Please attach recent chart notes/pertinent records.***

A. Describe patient's physical and/or mental limitations and restrictions (functional capacity).

B. How long from today's date will the described limitations impair the patient?

C. Factors Delaying Recovery (if applicable)

D. When do you anticipate the patient can return to work? State anticipated date _____ or,
unable to determine because of _____, follow up in _____ months.

E. Is the patient competent to manage insurance benefits? ☐ Yes ☐ No
If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

5. Physician Information ***Please type or print.***

Name of physician completing this form	Specialty			Phone No. ( )
Address	City	State	ZIP	Fax No. ( )

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 8 of this form.

Signature _____ **Date** _____

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA RESIDENTS

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 RESIDENTS

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 the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA RESIDENTS

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NEW JERSEY RESIDENTS

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NEW YORK RESIDENTS

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Your Choice/Educator Options Long Term Disability Insurance Employer's Statement

1. Employee

Name of Employee _____

Address _____ City _____ State _____ ZIP _____

Job Title _____ Date Employed _____ Social Security No. _____

2. Information

Date employee's LTD coverage became effective _____ Was employee insured under previous LTD carrier? ☐ Yes ☐ No ☐ Effective Date _____

Work Location: Address _____ State _____ ZIP _____

Employee's status on date disability commenced:
Actively at Work? ☐ Yes ☐ No If no, reason _____ Number of hours worked per week _____

Last day of work before disability commenced _____ ☐ Exempt or ☐ Non-Exempt ☐ Union or ☐ Non-Union

Number of hours worked this day _____ Date employee returned to work after disability ended _____

Have you considered allowing the claimant to work in another occupation, or modify or alter the job duties of the claimant's occupation, how the job is done (i.e., work schedule), or worksite? ☐ Yes ☐ No If yes, what alternatives were offered to the claimant?

Is disability caused or contributed to by employment? ☐ Yes ☐ No ☐ Undetermined

Has employee filed a Workers' Compensation claim? ☐ Yes ☐ No ☐ Don't Know

Workers' Compensation Carrier Name _____ Claim No. _____ Date of Injury _____

Address _____ City _____ State _____ ZIP _____

Phone No. (_____) _____ Person to contact _____

Is employment now terminated? ☐ Yes ☐ No Is employment scheduled for termination? ☐ Yes ☐ No

Reason _____ Date of termination _____

3. Salary at Time of Disability *Please check only one box.*

☐ Basic Monthly Earnings Monthly Rate $_____ ☐ Basic Weekly Earnings Weekly Rate $_____

☐ Basic Yearly Earnings Annual Rate $_____ ☐ Basic Hourly Earnings Hourly Rate $_____

☐ Basic Annual Contract Earnings Contract Amount $_____ Length of Contract: ☐ 9 month ☐ 12 month ☐ Other _____

☐ Shift Differential

Is employee receiving any other contract pay? ☐ Yes ☐ No

Date of last increase _____ Earnings prior to increase $_____ per _____ Effective date _____

4. Deductible Income/Benefits From Other Sources

Is employee covered by or now receiving benefits from the following?	Covered Yes	Covered No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Social Security	☐	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) *Please specify* _____	☐	☐	☐	☐	☐				
e. Other _____ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

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5. Life Insurance

Was employee covered by Group Life Insurance with The Standard on cease work date? ☐ Yes ☐ No

Date life insurance became effective _____
Please attach original enrollment card.

Amount of Basic Life insurance $_____ Additional/Optional $_____ Supplemental $ _____ AD&D $_____

Dependent's Coverage? ☐ Yes ☐ No If yes, ☐ Spouse ☐ Child

IMPORTANT: Please continue payment of premiums until otherwise notified.

6. Tax Information

Is this employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No
State Disability taxes? ☐ Yes ☐ No Unemployment Compensation taxes? ☐ Yes ☐ No

If subject to Social Security taxes what are the employee's year to date Social Security wages? _____

What percentage of the LTD premium does the employee pay _____ % with "pre-tax" funds.*

the employee pay _____ % with funds that have been taxed.*

* If yes, are employer paid premiums included in the employee's salary? ☐ Yes ☐ No

IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.

7. Attachments

Please attach copies of the following:

a. Job Description
b. Enrollment or Election Form for Long Term Disability Insurance
c. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS, etc.)

8. Employer Representative Completing This Form

Employer _____ Phone No. _____ Policy Number _____

Address _____ City _____ State _____ ZIP _____

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the applicable fraud notice on page 11 of this form.

Signature _____ Date _____

Prepared by _____ Title _____

Phone No. (_____) _____ Fax No. (_____) _____

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