The STANDARD INSURANCE

Long Term Disability Benefits Instructions

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

PLEASE READ CAREFULLY

Your application for benefits consists of four forms. **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, **"NA"** should be written 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.**

The four forms are:

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 Information**

   - Please sign and date this form and attach it to the Employee's Statement. Your signature lets The Standard or its agent, The Standard Benefit Administrators, get the information about you that we need to determine your eligibility for benefits. The authorization also lets The Standard or its agent, The Standard Benefit Administrators, release this information to specific persons. **You will receive a copy of this 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 Benefit Administrators.

4. **The Employer's Statement**

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

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.

The STANDARD INSURANCE

Long Term Disability Benefits Employee's Statement

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

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

1. CLAIMANT

Full Name: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Patient No.: _____

Birthdate: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Name of Spouse: _____ Birthdate: _____

No. of dependent children: _____ Birthdate of youngest: _____

Did you receive a Certificate of Insurance? ☐ Yes ☐ No

Brochure? ☐ Yes ☐ No **If no, please contact your employer to obtain a copy.**

2. EMPLOYMENT

Name of Employer: _____ Group Policy No.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

State your job title and describe your duties at work.

Is your disability work-related? ☐ Yes ☐ No Date of injury: _____

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No If Yes, W.C. claim # _____

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

If yes, list names of employers, addresses, telephone numbers, and dates of employment.

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

Date you resumed part-time work: _____ Work Phone: (_____) _____ Extension: _____

Date you resumed full-time work: _____ Work Phone: (_____) _____ Extension: _____

3. SICKNESS *Please list all illnesses which contribute to your being unable to work at your occupation.*

Illness: _____ Date First Noticed _____

_____ Date First Noticed _____

State what you believe caused your illness.

Describe your symptoms: _____

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

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Employee's Statement

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4. INJURY

Describe Injuries: _____

Cause of Injuries: _____

Time, Date and Location of Injuries.

5. PREGNANCY

Date you expect to cease work: _____ Expected delivery date: _____

Actual delivery date: _____ Expected return to work date: _____

Please indicate any foreseeable complications.

6. ATTENDING PHYSICIAN *List all physicians consulted for this injury or illness. Use separate sheet, if needed.*

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

Street Address: _____ Fax No.: (____) _____

City: _____ State: _____ Zip Code: _____

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

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

Street Address: _____ Fax No.: (____) _____

City: _____ State: _____ Zip Code: _____

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

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

Street Address: _____ Fax No.: (____) _____

City: _____ State: _____ Zip Code: _____

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

7. 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: _____

From: _____ through: _____ Reason for hospitalization: _____

8. 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

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9. DEDUCTIBLE INCOME

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.

10. VOCATIONAL *Complete the following and/or attach a resume.*

Education level	Yes	No	If no, last grade attended.	
Grade School Graduate	☐	☐		
High School Graduate	☐	☐		
GED	☐	☐		
College Graduate	☐	☐	Degree	Major
Post Graduate	☐	☐	Degree	Major

Have you attended any trade schools or received other special training? ☐ Yes ☐ No
If yes, please describe.

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:		
4.	From: To:		
5.	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 the following page of this form.

SIGNATURE _____ DATE _____

The Standard Benefit Administrators
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Some states require us to provide the following information to you:

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

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FLORIDA RESIDENTS

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NEW JERSEY RESIDENTS

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PENNSYLVANIA RESIDENTS

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ALL OTHER APPLICANTS AND CLAIMANTS

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.

The STANDARD INSURANCE

Long Term Disability Benefits Authorization to Obtain Information

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

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.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitational 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, 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.
  - 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, or eligibility for other benefits *(for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.)*.

TO STANDARD INSURANCE COMPANY (STANDARD INSURANCE COMPANY INCLUDES THE STANDARD BENEFIT ADMINISTRATORS).

- I understand that The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. I understand that I have the right to revoke this authorization at any time by sending a written statement to The Standard, and that a revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim. Revocation of the authorization may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I acknowledge that I have read the authorization and the state variations *(if applicable)* on the following page. 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/Guardian/Representative _____ Date _____

This Authorization is a two page document. Please see reverse page for additional terms and information. Both pages are part of the Authorization.

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at that scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

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. For additional information about the treatment of confidential abuse information, see accompanying Notice of Confidential Abuse Information Practices. With respect to confidential abuse information, I may revoke this authorization in writing, effective ten days after receipt by The Standard, and I understand that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The STANDARD℠ INSURANCE

Long Term Disability Benefits
Attending Physician's Statement

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

The patient is responsible for the completion of this form without expense to The Standard Benefit Administrators.

PART A. TO BE COMPLETED BY PATIENT

Full Name: _____ Social Security No.: _____

Other Names Used: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Birthdate: _____ Patient No.: _____

Occupation: _____ Employer: _____ Group Policy No.: _____

I returned to work: Date _____ I expect to return to work: Date _____

PART B. TO BE COMPLETED BY PHYSICIAN

DEAR DOCTOR: The purpose of this form is to help us determine whether the clinical condition of your patient is disabling. We need documentation of functional impairment. Please include laboratory data and results of special tests (X-rays, CAT scan, EKG, etc.) Please attach copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes, and narrative reports.

The patient is responsible for the completion of this form without expense to The Standard Benefit Administrators. Forms may be returned for unanswered questions.

1. INFORMATION

Primary Diagnosis: ICD Code (_____) _____

Secondary Diagnosis: ICD Code (_____) _____

Other diagnoses and ICD Codes related to this claim.

Symptoms.

Patient's Height: _____ Weight: _____ BP _____ (Right arm) BP _____ (Left arm) Pulse _____ (Radial)

Is condition primarily related to:

a. Patient's Employment ☐ Yes ☐ No
b. Mental Disorder ☐ Yes ☐ No
c. Alcohol or Drug Condition ☐ Yes ☐ No
d. Pregnancy ☐ Yes ☐ No

Dominant Hand ☐ Left ☐ Right

Expected Delivery Date _____

Para _____ Gravida _____ Actual Delivery Date _____

Complications: _____ ☐ Vaginal ☐ Caesarean Section

2. HISTORY

If patient was referred to you, indicate by whom: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No

If yes, indicate when: _____ Describe: _____

Do, or have, other conditions contributed to this condition? ☐ Yes ☐ No

If Yes, please explain: _____

Date patient first consulted you for **this** condition: _____ For **any** condition: _____

Dates of subsequent treatment: _____

Date of most recent visit: _____

If patient was hospitalized, please provide dates. Admitted: _____ Discharged: _____

Admitting Diagnosis: _____ Discharge Diagnosis: _____

Name of Hospital: _____

Address: _____ City: _____ State: _____ Zip Code: _____

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Long Term Disability Benefits
Attending Physician's Statement

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Claimant's Name: _____

3. ASSESSMENT

Date you recommended patient should stop working: _____ Why? _____

Describe the patient's physical, mental and cognitive limitations and work activity limitations: _____

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

Is the patient competent to endorse checks and direct the use of the proceeds? _____

4. TREATMENT

Planned course of treatment (Please include expected duration, surgeries, therapy, etc.) _____

Medications prescribed: dosage, frequency and date of prescription(s). _____

List other treating or referring physicians. (Continue on separate page, if necessary.)

NAME	ADDRESS		
1.			
Phone No. ( )	City	State	Zip Code
2.			
Phone No. ( )	City	State	Zip Code

What reasonable work or job site modifications could the employer make to assist the individual to return to work? Please specify:

Assessment and treatment are complicated by:

- ☐ Malingering
- ☐ Significant emotional or behavioral disorder such as depression, anxiety, hysteria. (Circle pertinent areas.)
- ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.
- ☐ Dependence on drugs/medication. Specify: _____
- ☐ Other (please describe): _____

5. PROGNOSIS

Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

When do you expect a fundamental or marked change in patient's condition? ☐ Never ☐ Condition expected to regress ☐ Condition expected to improve

State anticipated date: _____ or, Unable to determine, follow up in: _____ months

When do you anticipate the patient can return to work? State anticipated date: _____ or, Unable to determine, because of: _____

_____ follow up in: _____ months

Remarks: _____

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 the following page of this form.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____ Specialty _____

Address _____ City _____ State _____ Zip Code _____

Physician's Taxpayer ID No. _____ Phone No. ( ) _____ Fax No. ( ) _____

Return to: The Standard Benefit Administrators at the address above.

The STANDARD INSURANCE

Long Term Disability Benefits
Claim Form Fraud Notices

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

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ALL OTHER APPLICANTS AND CLAIMANTS

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The STANDARD INSURANCE

Long Term Disability Benefits Employer's Statement

The Standard Benefit Administrators
PO Box 5031 White Plains NY 10602-5031 800.426.4332 Tel 800.378.8361 Fax

1. EMPLOYEE

Name of Employee: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Job Title (please attach a copy of job description): _____

If applicable, please give job classification: _____

Phone No. : (_____) _____ Date Employed: _____ Social Security No. : _____

2. INFORMATION

Date employee's coverage became effective:

Was employee given a Certificate of Insurance? ☐ Yes ☐ No ☐ Don't know

Was employee insured under Previous LTD Carrier? ☐ Yes ☐ No ☐ Effective Date: _____

Employee's Medical Insurance carrier: _____

Phone No. : (_____) _____ Effective date for medical insurance: _____

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 #: _____ Date of Injury: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Person to contact: _____

Is employment now terminated? ☐ Yes ☐ No Reason _____

Is employment scheduled for termination? ☐ Yes ☐ No Date of termination _____

Reason: _____

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 Contract Earnings Contract amount $ _____ Length of contract _____

☐ Commissions (Please attach list of commissions paid for the period specified in your Group Policy.)

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

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Type	Last date through which paid or payable	Amount / Rate
Sick Pay		
Self-insured Short Term Disability		
Salary Continuation		
Wages / salary, *earned after* disability		
Commissions, *earned after* disability		
Vacation Pay		

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Long Term Disability Benefits Employer's Statement

The Standard Benefit Administrators
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5. DEDUCTIBLE INCOME

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)	☐	☐	☐	☐	☐				

6. LIFE INSURANCE

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

If yes, list policy number(s): _____

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

Amount of Basic life insurance $ _____ Additional $ _____ Supplemental $ _____ AD&D $ _____

Dependent's coverage? ☐ Yes ☐ No

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. TAX INFORMATION

Employer's Federal Tax I.D. Number: _____

Check one: ☐ We are a private-sector employer
☐ We are a public-sector (government entity) employer

Is this employee subject to:								
	Social Security taxes?	☐ Yes	☐ No	Medicare taxes?	☐ Yes	☐ No
	Railroad Tier 1 taxes?	☐ Yes	☐ No	Tier 1 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? _____

Does this employee pay all or a portion of the premium for LTD insurance coverage? ☐ Yes ☐ No

*If yes, what percentage of the LTD premium does the employer pay _____ %.

*the employee pay _____ % with "pre-tax" funds.

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

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

8. ATTACHMENTS

Please attach copies of the following.

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

9. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: _____ Phone No.: _____ Policy Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

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 the following page of this form.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

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

The STANDARD INSURANCE

Long Term Disability Benefits
Claim Form Fraud Notices

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