

- Your Disability Benefit Claim1.** Your employer should complete the Employer's Statement before giving the claim packet to you.
2. Complete and sign your part of the claim form (on page 4), and then have your treating part of the claim form (the Attending Physician's Statement, also on page 4). If more than one you for your disabling condition, each should complete a form. Additional forms are available from your benefits administrator. Your physician may return the completed form to you for you to send to us, or your physician may mail or fax the completed form to us directly, using the address at the top of the form.
  3. Read the Claim Form Fraud Notice on page 5, then provide it to your treating physician and the Attending Physician's Statement.
  4. Sign and date the Authorization and send it, along with the completed claim forms, to The Standard at the address. This authorization allows us to request further information about your claim, if necessary.

Once we receive your completed claim application, it will take approximately one week to make a decision. If we have not reached a decision within one week, you will be notified with the details.

### **Other Benefits That May Reduce Your Disability Benefits**

Other benefits you receive may reduce the amount of Disability benefits due you. Your group insurance certificate lists these benefits which may include, but are not limited to, sick leave, Workers' Compensation, State Disability, Social Security, and Retirement.

To avoid a possible overpayment on your claim, which would need to be repaid to The Standard, please inform The Standard if you receive other benefits.

### **When You Return To Work**

Your disability benefits usually stop when you return to work. **Be sure that you notify The Standard immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

# Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax  
PO Box 2800 Portland OR 97208

## Disability Insurance Employer's Statement

### To Be Completed By Employer

Employee's Full Name	Social Security No.	Job Title <i>Please attach a copy of the job description.</i>	1. Date Employed
Employee's Home Address		State ZIP	
Work Location Address		State ZIP	
		4. Has the employee filed for:	Workers' Compensation Yes No
			State Disability Yes No
			Other _____ Yes No
			Weekly Amount

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**

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.

**FLORIDA RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**MARYLAND RESIDENTS**

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

**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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA 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 subjects such person to criminal and civil penalties.

**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.

**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.	Sex      Birthdate of Youngest Child
Address	City	State      ZIP
1. Is your disability work related?		

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## **Authorization to Obtain and Release Information**

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**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:**

## **Authorization to Obtain and Release Information**

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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. The Standard Benefit Administrators performs claims administration services for Standard Insurance Company. 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.