



### 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 The Authorization to Obtain Psychotherapy Notes

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

If you have seen or been treated by a Psychiatrist, Psychotherapist, Psychologist, Clinical Social Worker (MSW, MCSW, etc.), or any other provider of treatment for a mental condition, please sign and return the Authorization to Obtain Information *and* the Authorization to Obtain Psychotherapy Notes.

**You will receive copies of these Authorizations 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.

# Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax  
PO Box 2800 Portland OR 97208

## 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 Code: _____
Phone No.: ( _____ ) _____	
Birthdate: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Height: _____ Weight: _____
Name of Spouse: _____	Birthdate: _____
No. of dependent children: _____	Birthdate of youngest: _____
Did you receive a Certificate of Insurance? Brochure? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, please contact your employer to obtain a copy.</b>

### 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of injury: _____
Have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list names of employers, addresses, telephone numbers, and dates of employment.	
Are you self-employed at any activity? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____

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Long Term Disability Insurance  
Employee's Statement

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:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_ **Phone No.:** (\_\_\_\_) \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Fax No.:** (\_\_\_\_) \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Date first consulted for this injury or illness:** \_\_\_\_\_ **Date last consulted:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_ **Phone No.:** (\_\_\_\_) \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Fax No.:** (\_\_\_\_) \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Date first consulted for this injury or illness:** \_\_\_\_\_ **Date last consulted:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_ **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

**9. DEDUCTIBLE INCOME/BENEFITS FROM OTHER SOURCES**

Your Group Disability plan is designed so that the income you receive from Standard Insurance Company and other sources (e.g., Social Security, Worker's Compensation, retirement system, and other income or benefits as described in your Group Policy as deductible income or benefits) combined will provide you with a percentage of predisability earnings, as defined in your Group Policy. Please review your Group Policy to determine how receipt of or eligibility for deductible income or benefits may impact your disability benefits. Please review your obligation to keep Standard Insurance Company informed of your application for and receipt of deductible income or benefits. Additionally, your Group Policy may allow Standard Insurance Company to reduce your disability benefit by estimated deductible income or benefits you are eligible to receive even if you have not applied for them. If your Group Policy states that Social Security benefits will be "deemed payable" even if not received, we will deduct from your disability benefit an estimated Social Security benefit for you and your dependents, based on your Social Security wage record. Please also understand that when deductible income or benefits are awarded you may receive a retroactive award (earlier date) and payment. This retroactive payment may result in an overpayment of your disability benefits because you would receive deductible income or benefits for a period during which you already have received disability benefits from Standard Insurance Company.

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

**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	<input type="checkbox"/>	<input type="checkbox"/>		
High School Graduate	<input type="checkbox"/>	<input type="checkbox"/>		
GED	<input type="checkbox"/>	<input type="checkbox"/>		
College Graduate	<input type="checkbox"/>	<input type="checkbox"/>	Degree	Major
Post Graduate	<input type="checkbox"/>	<input type="checkbox"/>	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 page 5 of this form.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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.

**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**

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.

Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax  
PO Box 2800 Portland OR 97208

Long Term Disability Insurance  
Authorization to Obtain 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.
- Any insurance or annuity company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program or an annuity 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, 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, or eligibility for other benefits including retirement benefits and retirement plan contributions (for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).

TO STANDARD INSURANCE COMPANY (THE STANDARD).

- 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 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 refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim and 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 understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act [HIPAA] and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations (if applicable) on page 7. 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.

*This Authorization is a two-page document. Please see page 7 for additional terms and information. Both pages are part of the Authorization.*

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 the 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**

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

The accompanying Authorization to Obtain Information 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 The Standard, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The Standard 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 The Standard. Within 30 business days of receiving the request, The Standard 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. The Standard 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 The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.

Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax  
PO Box 2800 Portland OR 97208

**Long Term Disability Insurance  
Authorization to Obtain Psychotherapy Notes**

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

- Any physician, medical practitioner or health care provider; and
- Any hospital, clinic, or other medical or medically related facility or association.

**TO GIVE THIS INFORMATION:**

Notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record.

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- 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 refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard’s ability to evaluate or process my claim and 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 understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act [HIPAA] and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations (*if applicable*) on page 9. 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

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The Standard 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 The Standard. Within 30 business days of receiving the request, The Standard 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. The Standard 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 The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.

**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. 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 Dominant Hand  Left  Right  
 b. Mental Disorder  Yes  No  
 c. Alcohol or Drug Condition  Yes  No  
 d. Pregnancy  Yes  No 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: \_\_\_\_\_

Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Long Term Disability Insurance
Attending Physician's Statement

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 manage insurance benefits? [ ] Yes [ ] No
If no, is the patient competent to appoint someone to help manage the insurance benefits? [ ] Yes [ ] No

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.)
Table with columns: NAME, ADDRESS, 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 (Check 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 page 12 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 Standard Insurance Company at the address above.

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

**CALIFORNIA RESIDENTS**

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**COLORADO RESIDENTS**

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**NEW JERSEY RESIDENTS**

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**NEW YORK RESIDENTS**

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**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.

Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax  
 PO Box 2800 Portland OR 97208

Long Term Disability Insurance  
 Employer's Statement

1. EMPLOYEE

Name of Employee: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Class:  Faculty/Teacher  Technical/Professional  Administration  
 Maintenance  Secretarial/Clerical  Other: \_\_\_\_\_  
 Job Classification: \_\_\_\_\_  
 Phone No.: (\_\_\_\_\_) \_\_\_\_\_ Date Employed: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

2. INFORMATION

Date employee's LTD coverage became effective:  Basic \_\_\_\_\_  Buy-up \_\_\_\_\_  
 Work Location: Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Was employee given a Certificate?  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?  
 \_\_\_\_\_  
 Does the employee participate in your formal retirement plan?  Yes  No Is the plan a qualified plan?  Yes  No  
 Is the employee eligible but not participating in your formal retirement plan?  Yes  No  
 Is the formal retirement plan carrier TIAA-CREF or another carrier? Please provide name, phone number and address of contact person: \_\_\_\_\_  
 \_\_\_\_\_  
 What is the employee's year-to-date retirement plan contribution? \$ \_\_\_\_\_  
 Are the employee's contributions vested? \_\_\_\_\_  
 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 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 Contract Earnings Contract amount \$ \_\_\_\_\_ Length of contract \_\_\_\_\_  
 Commissions (Please attach list of commissions paid for the period specified in your Group Policy.)  
 Shift Differential  Bonuses  
 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/Salary Continuation		
Self-insured Short Term Disability		
Wages/salary, <i>earned after</i> disability		
Commissions, <i>earned after</i> disability		

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5. DEDUCTIBLE INCOME/BENEFITS FROM OTHER SOURCES

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

6. LIFE INSURANCE

Was employee covered by Group Life Insurance with The Standard 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/Optional \$ \_\_\_\_\_ Supplemental \$ \_\_\_\_\_ AD&D \$ \_\_\_\_\_

Dependent's coverage?  Yes  No If yes,  Spouse  Child

**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.

\* 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.**

8. ATTACHMENTS

**Please attach copies of the following.**

a. Job Description	c. Enrollment or Election Form for Long Term Disability Insurance
b. Employment Application or Resume	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 page 15 of this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prepared by: \_\_\_\_\_ Title: \_\_\_\_\_

Phone No.: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax No.: ( \_\_\_\_\_ ) \_\_\_\_\_

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