TheStandard®
Benefit Administrators

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

Disability Insurance Claim Packet Instructions

Your Disability Benefit Claim

This packet contains the forms necessary to apply for disability benefits. It also addresses common questions about Disability claims. **Please save this material for your future reference.** For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator or call our customer service line at (800) 426-4332.

How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete the Employer's Statement (on page 2), and mail or fax it to The Standard Benefit Administrators, 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 physician complete their part of the claim form (the Attending Physician's Statement, also on page 4). If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefits administrator. Your physician may return the completed form to you for you to send to us with the other completed forms, or your physician may mail or fax the completed form to us directly, using the contact information at the top of the form.
3. Read the Claim Form Fraud Notice (on page 5), then provide it to your treating physician with the Attending Physician's Statement.
4. Sign and date the Authorization (on page 6), and send it, along with the completed forms, to The Standard Benefit Administrators at the above address. The Standard Benefit Administrators is acting as the claims administrator on behalf of Standard Insurance Company. 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 claim 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, or may be eligible to receive, may reduce the amount of Disability benefits due you. Your coverage or group insurance certificate list 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 Benefit Administrators, please inform The Standard Benefit Administrators 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 Benefit Administrators immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

Reset

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Disability Insurance Employer's Statement

TO BE COMPLETED BY EMPLOYER

Employee's Full Name:	Social Security No.:	Job Title: *(Please attach a copy of the job description.)*	1. Date Employed:
Employee's Home Address:		State:	Zip Code:
Work Location: Address:		State:	Zip Code:

2. Is employee insured for Short Term Disability? ☐ Yes ☐ No
   Effective date: _____
   Is employee insured for Long Term Disability? ☐ Yes ☐ No
   Effective date: _____
   Is employee insured for Group Life Insurance through Standard Insurance Company? ☐ Yes ☐ No
   Was employee given Certificate(s) of Insurance? ☐ Yes ☐ No ☐ Don't Know

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for: Workers' Compensation: ☐ Yes ☐ No
   State Disability: ☐ Yes ☐ No
   Other: _____ ☐ Yes ☐ No
   Weekly Amount: _____

5. Employee's earnings: $ _____
   (Check one) ☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ other ☐ shift differential ☐ bonuses
   Date of last increase: _____ Earnings prior to increase: $ _____

6. Last active date at work:

7. Job status when disability began: ☐ Full-time (____ hours/week) ☐ Part-time (____ hours/week)

8. Date employee returned to work:

9. Last date through which sick leave benefits were paid by employer:

10. Last date through which any compensation was paid by employer: What type(s) of compensation was paid on this date?

11. Is employee subject to:
    Social Security taxes? ☐ Yes ☐ No
    Medicare taxes? ☐ Yes ☐ No

13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)?
    ☐ Yes ☐ No

12. What percentage of the STD premium does the **employer** pay? _____%
    What percentage of the LTD premium does the **employer** pay? _____%
    Are employer paid premiums included in the employee's salary? ☐ Yes ☐ No ☐ N/A
    IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.

Employer:	Location Code *(if applicable)*:	Phone No.:	Policy No.:	
Mailing Address:		City:	State:	Zip Code:
Name of Employer representative completing this form:				

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 3 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 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.

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Disability Insurance
Employee/Attending Physician's Statement

TO BE COMPLETED BY EMPLOYEE *The patient is responsible for completing this form at their own expense. Please complete this form and mail it to The Standard Benefit Administrators at the address listed above.*

Full Name:	Employer/Company Name:		Group Policy No.:	
Social Security No.:	Phone No.: ( )	Birthdate:	Sex: ☐ M ☐ F	Birthdate of Youngest Child:
Address:		City:	State:	Zip Code:

1. Is your disability work related? ☐ Yes ☐ No If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

2. Last date at work before disability: _____ Date you returned or expect to return to work: _____

3. Cause of disability: ☐ Accident ☐ Illness ☐ Pregnancy If accident or illness, please explain (include date and location, if applicable):

4. Please describe all work activity, including self-employment, since the start of your disability. If none, initial here: _____

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 5 of this form and will provide it to the physician completing the Attending Physician's Statement.

Signature: **Date:**

TO BE COMPLETED BY THE 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 Benefit Administrators. Please complete this form and mail or fax it to The Standard Benefit Administrators using the contact information listed above.

1. Diagnosis	A. Diagnosis:		ICDA Classification:
B. Symptoms:			Height: Weight: B/P:
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	K. Date admitted: Date discharged:	L. Surgery? ☐ Yes ☐ No	M. Date Surgery completed/scheduled:
N. Reason/Surgery Type:		O. 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. Factors delaying recovery (If applicable):

C. How long do you expect these limitations and restrictions to impair your patient?
☐ Date: _____ ☐ Unable to determine, follow up in: _____ weeks ☐ Permanently

D. 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 Code:	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 5 of this form.

Signature: **Date:**

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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 (STANDARD INSURANCE COMPANY INCLUDES THE STANDARD BENEFIT ADMINISTRATORS).

- 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 Standard Insurance Company 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 Standard Insurance Company. 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 Standard Insurance Company, 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 Standard Insurance Company'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, Standard Insurance Company may disclose to other parties information it has about me. Standard Insurance Company may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Standard Insurance Company in connection with my claim.
- I understand that Standard Insurance Company complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to Standard Insurance Company 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 Standard Insurance Company 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.

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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 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 the same address above.

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