



The StandardSM

Plan Administration - 860-272-1135
580 Hazard Avenue
Enfield, CT. 06082,

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

How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete their portion of the claim form on page 2, before giving the packet to you.
2. Complete and sign your part of the claim form. Compare your responses to those of your employer to make sure you agree on all information, including **last day of work** and **sick leave** dates.
3. Your treating physician should complete the Attending Physician's Statement. 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 benefit administrator.
4. Sign and date the Authorization, and send it, along with the claim forms, to Standard Insurance Company (The Standard) at the above 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 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 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 of your claim, 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 or your employer notify The Standard immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

Fax to: 860-272-1137
Or Mail to: Plan Administration, LTD
580 Hazard Avenue
Enfield, CT 06082

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:
2. Is employee insured for Short Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date: _____ Is employee insured for Long Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date: _____ Is employee insured for Group Life Insurance through The Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No		3. Is disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined 4. Has the employee filed for: Workers' Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No State Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly Amount: _____		
5. Employee's earnings: \$ _____ <i>(Check one)</i> <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annual <input type="checkbox"/> commission <input type="checkbox"/> other <input type="checkbox"/> shift differential <input type="checkbox"/> bonuses Date of last increase: _____ Earnings prior to increase: \$ _____			6. Last active day at work:	
8. Date employee returned to work:		9. Last day through which sick leave benefits were paid by employer:		7. Job status when disability began: <input type="checkbox"/> Full-time (____ hours/week) <input type="checkbox"/> Part-time (____ hours/week)
11. Is employee subject to: Social Security taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. What percentage of the STD premium does the employer pay? _____% What percentage of the LTD premium does the employer pay? _____% Has either percentage changed within the last three years? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Last day through which any compensation was paid by employer:		
Employer:	Location Code:	Phone No.: ()	Policy No.:	
Mailing 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 fraud notice on page 4 of this form.				
Signature:			Date:	

TO BE COMPLETED BY EMPLOYEE

Full Name:		Social Security No.:	Phone No.: ()	
Birthdate:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	No. of Dependent Children:	Birthdate of Youngest:	
Address:		City:	State:	Zip Code:
1. Is your disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		2. Have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Do you intend to file? <input type="checkbox"/> Yes <input type="checkbox"/> No		4. Last active day at work:		
5. Date you became unable to work at your occupation because of disability:		6. Date you returned or expect to return to work:		
7. <input type="checkbox"/> Accident. When and where did it happen? <input type="checkbox"/> Illness. When did you first notice and what is the nature of your disability?		8. How does your disability prevent you from working?		
		9. Have you had a previous disability claim with The Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		10. Pregnancy: Expected delivery date: _____ Actual delivery date: _____ Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section		
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 fraud notice on page 4 of this form.				
Signature:			Date:	

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.

- 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 6. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (*please print*)

Social Security No.

Signature of Claimant/Representative

Date

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

This Authorization is a two-page document. Please see page 6 for additional terms and information. Both pages are part of the Authorization.