TheStandard®

Standard Insurance Company – CTA Benefits and Services
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390

Select Form and Print Options

Disability Benefits Claim Packet Instructions

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, State Teachers 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.** 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.

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Disability Insurance Employee's Statement

Please print clearly. Form may be returned for unanswered questions.

1. CLAIMANT

Last Name: _____ First Name: _____

Middle Name: _____ Suffix: _____ Social Security No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: _____ Patient No.: _____

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

Spouse/Domestic Partner Information

Last Name: _____ First Name: _____

Middle Name: _____ Suffix: _____ Date of Birth: _____

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

Did you receive a Certificate of Insurance? ☐ Yes ☐ No Did you receive a Brochure? ☐ Yes ☐ No **If no, please contact The Standard.**

2. EMPLOYMENT

School District Name: _____ Group Policy No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: _____

Job title: _____

Describe your Job Duties:

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

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

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, provide name of employer and dates of employment:

Employer Name: _____ Phone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employment Start Date: _____ Employment End Date: _____

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: _____

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Disability Insurance Employee's Statement

Claimant's Name: _____

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

Illness: _____ Date First Noticed: _____

Illness: _____ 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: _____

4. INJURY

Describe Injuries: _____

Cause of Injuries: _____

Date injury occurred: _____ Time injury occurred: _____

Location where injury occured:

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 Last Name: _____ First Name: _____

Specialty: _____ Phone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Physician's Last Name: _____ First Name: _____

Specialty: _____ Phone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Physician's Last Name: _____ First Name: _____

Specialty: _____ Phone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

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Claimant's Name: ______________________________

7. HOSPITAL *If you were hospitalized for this condition, please complete. Please attach copy of hospital bill if available.*

Hospital Name: ______________________________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

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 of treatment: ______________________________

Physician's Last Name: ______________________________ First Name: ______________________________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

Ailment: ______________________________ Date of treatment: ______________________________

Physician's Last Name: ______________________________ First Name: ______________________________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

Ailment: ______________________________ Date of treatment: ______________________________

Physician's Last Name: ______________________________ First Name: ______________________________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

Ailment: ______________________________ Date of treatment: ______________________________

Physician's Last Name: ______________________________ First Name: ______________________________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

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Disability Insurance Employee's Statement

Claimant's Name: _____

DEDUCTIBLE INCOME/INCOME FROM OTHER SOURCES

Your Group Disability plan is designed so that the income you receive from The Standard and other sources (Social Security, Workers' Compensation and other benefits as described in your Group Policy) will equal the percentage described in your Group Policy. You should check your Group Policy to determine how other benefits may impact your disability benefits. You must send The Standard copies of all of your benefit determinations and related determinations. The policy under which you are insured may require that The Standard benefit payment be reduced by actual or estimated benefits payable from additional sources.

9. DEDUCTIBLE INCOME

Have you applied for or are you receiving benefits from:	**Applied** Yes	No	**Receiving** Yes	No	Date Applied For	Amount Received Weekly	Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐				
d. Retirement or Pension *(Employer, PERS, STRS, 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. INCOME FROM OTHER SOURCES

Are you receiving income from:	Effective Date	Daily Amount Received	Limit Date
a. Substitute Differential Pay			
b. Fully Paid Sick Leave			

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 6 of this form.

SIGNATURE _____ DATE _____

Return to Page 1 for Print Options

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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

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.

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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 (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 8. 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 8 for additional terms and information. Both pages are part of the Authorization.

Return to Page 1 for Print Options

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

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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.

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 10. 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.

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Disability Insurance
Attending Physician's Statement

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: _____ School District Name: _____ 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. 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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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.)

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 (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 13 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.

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Tel 800.522.0406 Fax 888.414.0390

Disability Insurance Employer's Statement

Policy No.: _____ ☐ Voluntary Insurance Coverage ☐ District Paid Insurance Coverage

Please print clearly, and complete all questions. Form may be returned for completion of unanswered questions.

1. EMPLOYEE

Name of employee: _____

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

Job Title: _____

Class: ☐ Faculty/Teacher ☐ Education Support Professional ☐ Administration ☐ Secretarial/Clerical ☐ Other: _____

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

2. INFORMATION

Last day worked: _____ Number of hours worked on last day: _____ First full day of absence for this disability (mo/da/yr): _____

Status on day of disability: ☐ Full-time ☐ Part-time ☐ 11 or 12 month employee

Insured's premium paid to date: _____ Are you required to make Medicare contributions for this employee? ☐ Yes ☐ No

Are you required to make Social Security contributions for this employee? ☐ Yes ☐ No

Has employee retired? ☐ Yes ☐ No

Does the employee participate in your formal retirement plan? ☐ Yes ☐ No

Is the employee eligible but not participating in your formal retirement plan? ☐ Yes ☐ No Is the formal retirement plan carrier ☐ STRS ☐ PERS ☐ Other

If other, provide name and address _____

Is employment terminated? ☐ Yes ☐ No Date of termination: _____

Reason for termination: _____

Is employment scheduled for termination? ☐ Yes ☐ No

Has employee returned to work? ☐ Yes ☐ No If yes, ☐ Full-time _____ (Return date) ☐ Part-time _____ (Return date)

If intermittent absences, please show dates: _____

Was this disability due to occupational cause? ☐ Yes ☐ No If yes, include name and address of Workers' Compensation carrier: _____

_____

Workers' Compensation carrier Telephone No.: _____ Last day of occupational cause leave: _____

3. SALARY AT TIME OF DISABILITY

Salary at start of disability: Hourly: _____ Monthly: _____ Annual Contract: _____

Average number of hours worked: Day: _____ or Week: _____ Total days of required attendance this school year: _____

Daily rate of pay: _____

First required day of attendance: _____ Winter vacation starts – and ends: _____ – _____

Spring vacation starts – and ends: _____ – _____ Last required day of attendance: _____

Is school on 12 month schedule? ☐ Yes ☐ No If yes, please attach track schedule.

If part-time, please attach schedule.

If vacation schedule differs from above, please indicate employee's scheduled vacation. _____

Standard Insurance Company

CTA Benefits and Services
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390

Disability Insurance Employer's Statement

Claimant's Name: _____

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Sick Leave days available at start of this disability: _____ Last day at full pay (mo/da/yr): _____

When accumulated sick leave is exhausted, do you pay the difference between monthly contract salary and the total paid to a substitute for the number of work days in that month? ☐ Yes ☐ No

If no, please describe method used: _____

Number of days at Sub or other pay (if applicable): _____ Date Sub deductions start from employee's pay (mo/da/yr): _____

Sub pay rate: _____ When will Sub rate change? (mo/da/yr) _____ What amount will it change to? _____

Date Salary Continuance or Sub Differential pay ends (mo/da/yr): _____ Any other pay received from the district? _____

Is the employee eligible for any other income replacement plan? ☐ Yes ☐ No Carrier: _____

Address and/or Telephone No.: _____

Is employee eligible to draw from any other benefits? ☐ Yes ☐ No

If yes, please explain _____

Effective date: _____ No. of days: _____

5. EXTRA DUTY PAY

***Extra Duty Pay** includes, but is not limited to, income received from coaching, after-school programs, summer school sessions, advising or mentoring stipends. Extra duty pay must be defined in a special contract or letter of agreement between the insured and the district. It does not include additional compensation such as overtime pay, bonuses or district-funded fringe benefits.

Attach a copy of the agreement and the work schedule.

Begin date: _____ End date: _____

Please indicate dates this pay was NOT PAID due to the employee's disability: _____

Applicable rate of pay NOT PAID due to disability.

Hourly rate: _____ Number of hours per day: _____ Daily rate: _____ Weekly rate: _____ Monthly rate: _____

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 Enrollment form(s), if applicable.***

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

Dependent's coverage? ☐ Yes ☐ No

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. ATTACHMENTS

Please attach copies of the following.

a. Job Description
b. Employment Application or Resume
c. Income From Other Sources (Deductible Benefits) Documents (Social Security, Worker's Compensation, PERS, etc.)
d. Enrollment form(s), if applicable

8. SCHOOL DISTRICT REPRESENTATIVE COMPLETING THIS FORM

Employer/School District Name: _____ 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 16 of this form.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

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

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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

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.

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