



## State of Arizona Short Term Disability Claim Packet Instructions

Standard Insurance Company  
PO Box 2800 Portland OR 97208-2800 800.368.2859 Tel

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### Your Disability Benefit Claim

This packet contains the forms necessary to apply for Short Term Disability (STD) benefits. It also addresses common questions about Disability claims. **Please save this material for your future reference.** For specific information about your STD insurance coverage, refer to your group insurance certificate. This certificate is the ultimate authority for STD claim decisions. If you need other information, please contact your Agency Benefit Liaison or call our customer service line at (800) 368-2859.

### How To Apply For Benefits

A STD benefits' application includes a claim form and an Authorization.

To obtain these forms and apply for STD benefits, contact your Agency Benefit Liaison.

Once Standard receives your claim application, it will take approximately three working days to make a claim decision. If we have not reached a decision within that time, you will be notified with the details.

### When STD Benefit Payments Are Paid

STD benefits are paid weekly; checks are typically mailed each Wednesday.

### Benefits For Partial Week

While STD benefits are payable and you are disabled for less than one week, you will receive one-seventh of your weekly STD benefit for each day of disability. For example, if you are disabled for five days, you will receive five-sevenths of your weekly STD benefit.

### When You Return To Work

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





**TO BE COMPLETED BY EMPLOYEE**

Full Name:	Employer: <b>State of Arizona</b>	Group Policy Number: <b>617950</b>
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*The following information is needed to document the patient’s inability to work. The patient is responsible for completing this form without expense to Standard Insurance Co.*

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

<b>1. Diagnosis</b>	
A. Diagnosis:	ICDA Classification:
B. Symptoms:	C. Objective Findings: Height: _____ Weight: _____ B/P: _____ / _____
<b>2. Pregnancy (if applicable)</b>	
A. Expected date of delivery:	B. Actual date of delivery:
C. Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section	
D. Significant complications, if any:	
<b>3. History</b>	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when? _____
D. Is this condition related to the patient’s employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	E. Did you complete a workers’ compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4. Treatment</b>	
A. Date of first visit:	B. Date(s) of subsequent visits:
C. Date of most recent visit:	
D. Planned course and duration of treatment (include surgery and medications, if any):	
<b>5. Level of Functional Impairment</b>	
<b>A. Describe the patient’s physical limitations, if any.</b>	<b>B. In a work day given two breaks and a meal break, your patient can:</b>
C. Describe the patient’s mental and cognitive limitations, if any.	Lift (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+
	Carry (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+
	Total Hours
	Sit 8 7 6 5 4 3 2 1 (hrs) _____
	Stand 8 7 6 5 4 3 2 1 (hrs) _____
	Walk 8 7 6 5 4 3 2 1 (hrs) _____
	Alternately sit/stand 8 7 6 5 4 3 2 1 (hrs) _____
	Bend/stoop: <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently
	D. Is this patient competent to endorse checks and direct the use of proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6. Hospitalization (if applicable)</b>	
A. Date admitted:	B. Date discharged:
C. Reason:	
D. Name of hospital:	
<b>7. Prognosis</b>	
A. Since onset of symptoms, the patient’s condition has: <input type="checkbox"/> Improved <input type="checkbox"/> Not changed <input type="checkbox"/> Retrogressed	
B. When do you anticipate the patient can return to work? <input type="checkbox"/> Date: _____ <input type="checkbox"/> Unable to determine, follow up in _____ weeks <input type="checkbox"/> Never	
<b>8. Physician Information (Please type or print.)</b>	
Name of physician completing this form:	Phone Number: ( )
Specialty:	Tax ID. #: _____ Fax Number: ( )
Mailing Address:	City: _____ State: _____ Zip Code: _____
Some states require this statement on claim forms: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. In Florida fraud is a felony.	
Signature:	Date:



# Authorization to Obtain Information

Standard Insurance Company, Group Benefits  
PO Box 2800 Portland OR 97208-2800 503.248.2845 Tel

**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.
- Any insurance company.
- Any employer or plan administrator.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, etc.*).
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitational organization or program.

**TO GIVE THIS INFORMATION:**

- All medical information on me, including medical history, diagnosis, prognosis and treatment of any physical or mental condition.
- Any non-medical information requested about me, including such things as: education, employment history, or eligibility for other benefits (*for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claim status, benefit amounts and effective dates, etc.*).

**TO STANDARD INSURANCE COMPANY, THE PLAN ADMINISTRATOR, THE POLICYOWNER.**

I understand that Standard will use the information to determine my eligibility or entitlement for insurance benefits.

Standard may release information about me to a reinsurer, a plan administrator, the policyowner, or any person performing business or legal services for Standard in connection with my claim.

I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with Standard Insurance Company. A photocopy of this authorization is as valid as the original.

\_\_\_\_\_  
NAME (*please print*)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION ON REQUEST.**