TheStandard®

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

State of Nevada
Public Employees' Benefits Program (PEBP)
Short Term 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) 368-2859.

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.

Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

State of Nevada
Public Employees' Benefits Program (PEBP)
Short Term Disability Insurance
Employer Statement

Reset

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:		Category of Active Employee: ☐ State ☐ Non-State
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 The Standard? ☐ Yes ☐ No
   Effective date: _____
   Amount of Group Life Insurance: _____
   Amount of Dependents Life Insurance: _____
   PEBP Employer Sponsored Medical Plan
   Effective date: _____

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

4. Has the employee filed for:
   Workers' Compensation ☐ Yes ☐ No
   Weekly Amount: _____
   Workers' Compensation Carrier Name: _____
   Phone No.: _____
   Other: _____ ☐ Yes ☐ No

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 day at work:

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

8. Date employee returned to work:

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

10. Last day through which any compensation was paid by employer:

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

12. What percentage of the STD premium does the **employer** pay? **0** %
    What percentage of the LTD premium does the **employer** pay? **100** %
    Has either percentage changed within the last three years? ☐ Yes ☐ No
    Are employer paid premiums included in the employee's salary?
    ☐ Yes ☐ No ☐ N/A

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

Agency Name:	PEBP Paycenter Code:	Phone No.: ( )	Policy No.: **642682**	
Mailing Address:		City:	State:	Zip Code:
Email Address:			Fax No.: ( )	

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 3 of this form.

Signature: Date:

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

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.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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.

MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

State of Nevada
Public Employees' Benefits Program (PEBP)
Short Term Disability Insurance
Employee Statement

TO BE COMPLETED BY EMPLOYEE

Full Name:	Social Security No.:	Phone No.: ( )	
Birthdate:	Sex: ☐ M ☐ F	No. of Dependent Children:	Birthdate of Youngest:
Address:		City:	State: Zip Code:

1. Is your disability work related? ☐ Yes ☐ No

2. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

3. Do you intend to file for Workers' Compensation? ☐ Yes ☐ 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. ☐ Accident. When and where did it happen?

☐ 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? ☐ Yes ☐ No

10. Pregnancy: Expected delivery date: _____

Actual delivery date: _____

Type of delivery: ☐ Vaginal ☐ C-section

11. Do you currently have another disability plan? ☐ Yes ☐ No

12. Attending Physician *(List all physicians consulted for this injury or illness. Use separate sheet, if needed.):*

Physician's Name: _____ Specialty: _____ Phone No.: (_____) _____ Fax No.: (_____) _____

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

Date First Consulted for this injury or illness: _____ Date Last Consulted: _____

Physician's Name: _____ Specialty: _____ Phone No.: (_____) _____ Fax No.: (_____) _____

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

Date First Consulted for this injury or illness: _____ Date Last Consulted: _____

Physician's Name: _____ Specialty: _____ Phone No.: (_____) _____ Fax No.: (_____) _____

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

Date First Consulted for this injury or illness: _____ Date Last Consulted: _____

13. Hospital:

Hospital Name: _____ Address: _____

From: _____ through: _____ Reason for hospitalization: _____

From: _____ through: _____ Reason for hospitalization: _____

Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

State of Nevada
Public Employees' Benefits Program (PEBP)
Short Term Disability Insurance
Employee Statement

14. Vocational *(Complete the following and/or attach a resume.):*

Education Level	Yes	No	If no, last grade attended.	
Grade School Graduate	☐	☐		
High School Graduate	☐	☐		
GED	☐	☐		
College Graduate	☐	☐	Degree	Major
Post Graduate	☐	☐	Degree	Major

Have you attended any trade schools or received other special training? ☐ Yes ☐ No

If yes, please describe. _____

_____

Licenses or certificates? ☐ Yes ☐ No

If yes, please describe. _____

_____

Work Experience *(Complete the following starting with your most recent work experience.)*

Job Title & Employer	PERS Qualified?	Dates of Employment	Duties	Last Salary
a.		From: To:		
b.		From: To:		
c.		From: To:		
d.		From: To:		
e.		From: To:		

15. Deductible Income:

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. Retirement or Pension *(Employer, PERS, etc.)* Please specify type _____	☐	☐	☐	☐				
d. Leave Pool or Donated Leave	☐	☐	☐	☐				
e. Third party income: weekly time loss or from judgement, settlement or other award (related to current condition)	☐	☐	☐	☐				
f. Short term or long term disability benefits from another carrier	☐	☐	☐	☐				
g. Other: _____ *(e.g., unemployment or union benefits, etc.)*	☐	☐	☐	☐				

Please send copies of any letters or notices you have now or receive in the future which approve or deny benefits, to allow us to properly calculate disability payments.

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 6 of this form.

Signature: Date:

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

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.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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.

MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

State of Nevada
Public Employees' Benefits Program (PEBP)
Short Term Disability Insurance
Attending Physician's Statement

TO BE COMPLETED BY EMPLOYEE

Full Name:	Agency Name:	Group Policy No.: **642682**

The following information is needed to document the patient's inability to work. The patient is responsible for completing this form without expense to The Standard. Please complete this form and mail it to The Standard at the address listed above.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Diagnosis

A. Diagnosis:	ICDA Classification:
B. Symptoms:	C. Objective Findings: Height: Weight: B/P:

2. Pregnancy *(if applicable)*

A. Expected date of delivery:	B. Actual date of delivery:	C. Type of delivery: ☐ Vaginal ☐ C-section

D. Significant complications, if any:

3. History

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

4. Treatment

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)*:

5. Level of Functional Impairment

A. Describe the patient's mental and cognitive limitations, if any.

B. In a work day given two breaks and a meal break, your patient can:

Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total Hours								With positional change
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: ☐ Never ☐ Occasionally ☐ Frequently

C. 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

6. Hospitalization *(if applicable)*

A. Date admitted:	B. Date discharged:	C. Reason:

D. Name of hospital:

7. Prognosis

A. Since onset of symptoms, the patient's condition has: ☐ Improved ☐ Not changed ☐ Retrogressed

B. When do you anticipate the patient can return to work? ☐ Date: ☐ Unable to determine, follow up in: weeks ☐ Never

8. Physician Information *(Please type or print.)*

Name of physician completing this form:			Phone No.: ( )
Specialty:	Tax ID. No.:		Fax No.: ( )
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 5 of this form.

Signature: Date:

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

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.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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.

MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Authorization to Obtain and Release 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.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, 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, Workers' Compensation 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, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- 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 each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- 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 Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice 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 _____

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

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

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

The Authorization form 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 Standard Insurance Company.

Print