TheStandard®
Standard Insurance Company
Life Benefits Department 888.394.6270 Tel
PO Box 2800 Portland OR 97208-2800

Municipal Employees' Retirement System of Michigan
Disability Claim Packet Instructions

Note to Employer: In order to complete this form, you will need your group policy number. If you do not know this number, please call 800.290.1445.

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, 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.** (You may request additional forms from your employer.) 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.

Reset

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Municipal Employees' Retirement System of Michigan Employer's Statement

Please type or print. Form may be returned for unanswered questions.

1. EMPLOYEE

Full Name: _____ Social Security No.: _____

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

Phone No.: (_____) _____ Birthdate: _____

2. INFORMATION

Job Title: _____ Date Employed: _____
(Please attach a copy of position description.)

Work Location: Address: _____ State: _____ Zip Code: _____

Name of Supervisor: _____ Phone No.: _____

Employer Group: **Municipal Employees' Retirement System of Michigan** Policy No.: **642946**

Employee's coverage effective date with Standard Insurance Company: ☐ STD _____ ☐ Life _____
☐ LTD _____

Is employee currently insured with another carrier for disability coverage? ☐ Yes ☐ No Carrier: _____

Did employee receive a certificate of coverage for each appropriate plan? ☐ Yes ☐ No ☐ Don't Know *(Please forward Certificate of Coverage for covered employee when filing disability claim.)*

Last day of work before disability commenced: _____

Hours worked per week before disability commenced: _____

Date employee returned to work after disability ended: _____

Is medical condition due to employment? ☐ Yes ☐ No ☐ Undetermined

Workers' Compensation claim? ☐ Yes ☐ No Carrier Name: _____

Claim No.: _____ Address: _____

Have you considered allowing the employee to work in another occupation, or to modify and/or alter the job duties of the current occupation?

☐ Yes ☐ No Please explain: _____

_____

On FMLA? ☐ Yes ☐ No Effective date: _____ through: _____

Is employee terminated? ☐ Yes ☐ No Effective: _____ Reason: _____

Is employment scheduled for termination? ☐ Yes ☐ No Effective: _____ Reason: _____

Date sick leave benefits paid through: _____ Salary continuation from: _____ through: _____

3. SALARY (Earnings as of last day worked before disability commenced)

Regularly paid _____ hours per week, excluding overtime.

Please check ONE:

☐ Basic Yearly Earnings $ _____

☐ Basic Monthly Earnings $ _____ for _____ months per year

☐ Basic Hourly Earnings $ _____ for _____ months per year **OR** _____ days per year

☐ Basic Contract Earnings $ _____ length of contract: _____

Date of last increase: _____ Earnings prior to increase: $ _____

Yearly employment schedule, indicate: ☐ 12-month period ☐ Other *(i.e. contract days, 9 mos., etc.):* _____

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Employer's Statement

4. DEDUCTIBLE INCOME

Is employee covered by or now receiving benefits from the following?	Covered Yes	Covered No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Social Security	☐	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐	☐				
c. Retirement or Pension (Employer, PERS, CERS, MERS, etc.) Please specify: _____	☐	☐	☐	☐	☐				
d. Leave Pool or Shared Leave	☐	☐	☐	☐	☐				
e. Other: _____ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

5. LIFE INSURANCE

Was employee covered by Group Life Insurance with The Standard on cease work date? ☐ Yes ☐ No

Date life insurance became effective: _____

Please attach original enrollment card.

Amount of Basic Life Insurance $ _____

Dependent's coverage? ☐ Yes ☐ No

IMPORTANT: Please continue payment of premiums until otherwise notified.

6. TAX INFORMATION

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

Railroad Tier 1 taxes? ☐ Yes ☐ No Tier 1 Medicare taxes? ☐ Yes ☐ No

If subject to Social Security taxes what are the employee's year to date Social Security wages? _____

Does this employee pay all or a portion of the premium for LTD insurance coverage? ☐ Yes ☐ No

*If yes, are employer paid premiums included in the employee's salary? ☐ Yes ☐ No

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, Workers' Compensation, MERS or other Retirement)

8. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer Group: _____ Policy No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone 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 below.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

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

CLAIM FORM FRAUD NOTICE

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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Municipal Employees' Retirement System of Michigan Employee Statement

PART B. TO BE COMPLETED BY INSURED EMPLOYEE

Full Name _____ Phone No. (_____) _____

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security number _____ Sex _____ Male _____ Female

Name of Spouse _____ No. of dependent children under age 25 _____ Birthdate of youngest _____

Employer Group: **Municipal Employees' Retirement System of Michigan** Policy No.: **642946**

State your job title and your duties at work _____

Is your disability work related? ☐ Yes ☐ No Have you filed a Workers' Comp. claim? ☐ Yes ☐ No Do you intend to file? ☐ Yes ☐ No

If you have filed a Workers' Comp. claim, please list claim number _____

Last day of work _____ Date you became unable to work at your occupation _____

Are you now working for any employer or self-employed? ☐ Yes ☐ No If yes, please list the name, address and phone number of the employer on a separate piece of paper and attach to this form or provide details of your self-employment.

Date you resumed full-time work _____ or part time work _____

Did you receive a certificate of insurance or brochure? ☐ Yes ☐ No If no, please contact your employer to obtain a copy.

Nature of illness/accident _____

Date first noticed _____ What do you believe caused your disability? (include the time, date and location of accident) _____

Explain how your illness/injury prevents you from working _____

Have you ever had the same condition or a related illness before? ☐ Yes ☐ No

Do you feel a third party is responsible for your disability, or has made your condition worse? ☐ Yes ☐ No

If yes, please explain, giving the name of the third party _____

Do you plan to bring a claim or law suit against this third party? ☐ Yes ☐ No

Pregnancy:

Expected delivery date _____ Actual delivery date _____

Type of delivery (if known): ☐ Vaginal ☐ C-Section Expected return to work date _____

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.

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Municipal Employees' Retirement System of Michigan
Employee Statement

Work Experience: Complete the following starting with your most recent work experience.

Job Title & Employer	Dates of Employment	Duties	Last Salary
1.	From: To:		
2.	From: To:		
3.	From: To:		

Physician's Name _____ Date first consulted for this injury or illness _____

Street Address _____ City _____ State _____ Zip Code _____

Phone No. (_____) _____

List all other medical professionals consulted for any injury or illness within the past three years. ***(continue on a separate page if necessary)***

1. _____ (_____) _____ _____
Name Phone No. Date first consulted

2. _____ (_____) _____ _____
Name Phone No. Date first consulted

If you were hospitalized within the past three years, please complete.

Hospital Name and address _____

From _____ Through _____ Reason for hospitalization _____

From _____ Through _____ Reason for hospitalization _____

Have you applied for or have you received benefits from:

	Applied Yes	Applied No	Receiving Yes	Receiving No	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. Any other Group Disability Plans	☐	☐	☐	☐				
If yes, name of carrier								
d. Retirement (PERS, MERS, CERS, etc.)	☐	☐	☐	☐				
e. Leave Pool or Shared Leave	☐	☐	☐	☐				
f. Other _____ (e.g. unemployment or union benefits)	☐	☐	☐	☐				

Please send copies of any letters or notices approving or denying benefits to allow us to calculate your benefits from The Standard.

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 below.

Signature _____ Date _____

CLAIM FORM FRAUD NOTICE

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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Municipal Employees' Retirement System of Michigan
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 company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit 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, Municipal Employees Retirement System, 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 *(for example, Social Security Administration, Municipal Employees Retirement System, 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 for 24 months. 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. 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.

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Municipal Employees' Retirement System of Michigan
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.
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- 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.
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Municipal Employees' Retirement System of Michigan
Attending Physician's Statement

PART A. TO BE COMPLETED BY EMPLOYEE (PATIENT)

Please type or print. The patient is responsible for the completion of this form without expense to Standard Insurance Company.

Full Name _____ Social Security No. _____

Employer Group **Municipal Employees' Retirement System of Michigan** Policy No. **642946**

Phone No. (_____) _____ Medical Plan _____ Patient No. _____

PART B. TO BE COMPLETED BY PHYSICIAN

The following information is needed to document the Patient's inability to work:

1. Diagnosis

A. Primary Diagnosis _____ ICDA Classification _____

B. Secondary Diagnosis (related to patient's disability) _____

C. Symptoms _____

D. Objective findings _____

E. Patient's height _____ Weight _____ Most recent blood pressure _____

2. Pregnancy (If Applicable)

Expected date of delivery _____ /_____ /_____ Anticipated to be normal? ☐ Yes ☐ No

Para _____ Gravida _____ Abortion _____

Actual date of delivery _____ /_____ /_____ Type of delivery: ☐ Vaginal ☐ Caesarean Section

3. History

A. When did symptoms appear or accident happen? _____ /_____ /_____

B. Did you recommend the patient stop work? ☐ Yes ☐ No

If yes, as of what date? _____ /_____ /_____

Why? _____

If no, who recommended that the patient stop work? _____

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when? _____ /_____ /_____

Describe _____

D. Is the condition related to

a. Patient's Employment? ☐ Yes ☐ No ☐ Undetermined

b. Mental Disorder? ☐ Yes ☐ No ☐ Undetermined

c. Alcohol or Drug Condition? ☐ Yes ☐ No ☐ Undetermined

E. Did you complete a Workers' Compensation Report for this condition? ☐ Yes ☐ No

4. Treatment

A. Date of first visit _____ /_____ /_____

B. Date of subsequent visits _____

C. Date of most recent visit _____ /_____ /_____

D. Planned course of treatment (Include surgery, physical therapy, psychiatric counseling.) _____

Medications: _____

5. Cardiac classification (If Applicable)

A. Functional classification (American Heart Association) ☐ Class I ☐ Class II ☐ Class III ☐ Class IV

B. Therapeutic classification ☐ Class A ☐ Class B ☐ Class C ☐ Class D ☐ Class E

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Attending Physician's Statement

6. Physical Capacities

A. Based on the patient's physical limitations and restrictions, he/she can: (Circle the appropriate level of ability.)

Frequently lift (in pounds)	50+	50	20	10	0				
Maximum lift:	50+	50	20	10	0				
Walk/Stand at one time (in hours):	8	7	6	5	4	3	2	1	0
Walk/Stand in an 8-hour work day:	8	7	6	5	4	3	2	1	0
Sit at one time (in hours):	8	7	6	5	4	3	2	1	0
Sit in an 8-hour work day:	8	7	6	5	4	3	2	1	0
Bend/Stoop:	Never		Occasionally			Frequently			

7. Level of Functional Impairment

A. The patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

B. Describe the patient's mental and cognitive limitations and restrictions _____

C. Is this 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

D. Other impairments (please be specific) _____

E. How long will the above limitations impair the patient? _____

F. Dominant hand: ☐ Left ☐ Right

8. Hospitalization

A. Date admitted ____ / ____ / ____ Date discharged ____ / ____ / ____ Date surgical procedure performed ____ / ____ / ____

B. Reason for admittance to hospital _____

C. Describe nature of any surgical procedure performed _____

Name of hospital _____

Address _____ City _____ State _____ Zip _____

9. Other treating medical professionals (if known)

A. Name _____ Specialty _____ Phone No. (____) _____
Address _____ City _____ State _____ Zip _____

B. Name _____ Specialty _____ Phone No. (____) _____
Address _____ City _____ State _____ Zip _____

10. Prognosis

A. Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed

B. When do you expect a fundamental or marked change in the patient's condition? ____ / ____ / ____

☐ Unable to determine, follow up in ____ weeks ____ months. ☐ Never

C. When do you anticipate the patient can return to work?

____ / ____ / ____ Full-time ____ / ____ / ____ Part-time (____ hrs/day, ____ days/weeks)

☐ Unable to determine, follow up in ____ weeks ____ months. ☐ Never

Name of Physician completing this form (Please type or print.) _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone No (____) _____ Taxpayer Identification 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 below.

Signature _____ Fax No. _____ Date ____ / ____ / ____

Please send copies of chart notes, diagnostic, laboratory, and electrodiagnostic findings, as well as operative reports and hospital discharge summaries for the past year.

Return to: Standard Insurance Company
Special Accounts Benefits
P.O. Box 2800
Portland, OR 97208–2800

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