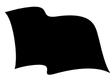

TheStandard®

Standard Insurance Company
Employee Benefits Department 888.641.7193 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

State of California
Long Term Disability Benefits
Employer's Statement

TO BE COMPLETED BY EMPLOYER

1. EMPLOYEE INFORMATION

Name of Employee: ____________________

Address: ____________________ City: ____________ State: ______ Zip Code: ________

Job Title ____________________

Job Classification: ____________________

Phone No.: (______) ____________ Date Employed: ____________ Social Security No.: ____________

2. INFORMATION

Date employee's LTD coverage became effective: ____________ ☐ Conversion Offered Effective Date: ____________

Work Location: Address: ____________________ State: ______ Zip Code: ________

Was employee given a Certificate? ☐ Yes ☐ No ☐ Don't know

Was employee insured under previous LTD Carrier? ☐ Yes ☐ No ☐ Effective Date: ____________

Employee's status on date disability began:
Actively at Work? ☐ Yes ☐ No If no, reason: ____________________ Number of hours worked per week: ______

Last day of work before disability began: ____________

Number of hours worked this day: ____________ Date employee returned to work after disability ended: ____________

Have you considered allowing the claimant to work in another occupation, or modify or alter the job duties of the claimant's occupation, how the job is done (i.e., work schedule), or worksite? ☐ Yes ☐ No If yes, what alternatives were offered to the claimant?

Is disability caused or contributed to by employment? ☐ Yes ☐ No ☐ Undetermined

Has employee filed a Workers' Compensation claim? ☐ Yes ☐ No ☐ Don't know

Workers' Compensation Carrier Name: ____________ Claim #: ____________ Date of Injury: ____________

Address: ____________________ City: ____________ State: ______ Zip Code: ________

Phone No.: (______) ____________ Person to contact: ____________

Is employment now terminated? ☐ Yes ☐ No Is employment scheduled for termination? ☐ Yes ☐ No

Reason: ____________________ Date of termination: ____________

3. SALARY AT TIME OF DISABILITY

☐ Basic Monthly Earnings on last day worked Monthly rate $____________

Please attach the SCO Pay History Print Outs for the 3 full calendar months prior to the employee becoming disabled, and through the last day paid.

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Type	Last date through which paid or payable	Amount / Rate
Sick Pay/Salary Continuation		
Wages/salary, *earned after* disability		

5. DEDUCTIBLE INCOME/BENEFITS FROM OTHER SOURCES

To the best of your knowledge, 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. State Disability Insurance	☐	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Please specify: ______	☐	☐	☐	☐	☐				
e. Other: ______ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

6. PLAN ELECTION INFORMATION

The Employee participates in: *(Check one only)*

☐ 65% Benefit Option ☐ 55% Benefit Option

7. REQUIRED ATTACHMENTS

Please attach copies of the following.

a. Job Description (Duty Statement)

b. Enrollment or Election Form for Long Term Disability Insuranced

c. The SCO Pay History Print Outs (3 full calendar months prior to employee becoming disabled, and through the last day paid)

d. If available, Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS, etc.)

8. EMPLOYER INFORMATION AND REPRESENTATIVE COMPLETING THIS FORM

Employer's Federal Tax I.D. Number: ______

Employer: **State of California** Phone No.: ______ Policy Number: **643146**

Department/Division: ______

Contact Person: ______

Address: ______ City: ______ State: ______ Zip Code: ______

Phone No.: (______) ______ Fax No.: (______) ______

Email: ______

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 3 of this form.

Signature: ______ Date: ______

Prepared by: ______ Title: ______

Phone No.: (______) ______ Fax No.: (______) ______

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State of California Long Term Disability Benefits Claim Form Fraud Notices

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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

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

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.