Standard Insurance Company
CTA Benefits and Services
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390
CTAService@standard.com

Reset

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: ☐ Certificated ☐ Classified ☐ Other: _____

Phone No.: (_____) _____ Email: _____

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 premiums paid to date: ☐ Yes ☐ No 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

Does the employee participate in your formal retirement plan? ☐ STRS ☐ PERS ☐ Other _____

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

Has employee returned to work? ☐ Full-time _____ Return date ☐ Part-time _____ Return date

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

_____

Workers' Compensation carrier Telephone No.: _____

3. SALARY & CALENDAR AT TIME OF DISABILITY

Salary as of last day worked: 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: _____ Last required day of attendance: _____

Spring vacation starts – and ends: _____ – _____ Winter vacation starts - and ends: _____ – _____

Does employee work a customized calendar work schedule? ☐ Yes ☐ No If yes, attach calendar.

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Total number of Sick Leave days available at the start of disability: _____ From date: _____ To date: _____

Is employee receiving: ☐ Substitute Differential Pay ☐ Half Pay ☐ Other _____ From date: _____ To date: _____

Sub pay rate: _____ Will Sub pay rate change? ☐ Yes ☐ No If yes, date: _____ Sub pay rate change amount: _____

Is employee receiving any other pay (i.e., Catastrophic Leave, maternity leave pay, etc.)? ☐ Yes ☐ No

Type of pay: _____ Full Pay ☐ Yes ☐ No If no, rate of pay _____

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Claimant's Name: _____

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.

Did employee have an Extra Duty Pay contract in place prior to their last day of work? ☐ Yes ☐ No

If yes, will they continue to be paid the Extra Duty Pay while out on Disability? ☐ Yes ☐ No

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): _____

Please attach Enrollment form(s), if applicable.

Dependent's coverage? ☐ Yes ☐ No

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. TAX INFORMATION

Does this employee pay all or a portion of the premium for Disability Benefits insurance coverage? ☐ Yes ☐ No ☐ Pre-tax ☐ Post-tax

*If yes, what percentage of the Disability Benefits premium does the employer pay _____ %.

****IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.***

8. 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
e. Calendar

9. 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 3 of this form.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

Phone No.: (_____) _____ Extension: _____ Employer Email Address: _____

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 HAMPSHIRE RESIDENTS

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO RESIDENTS

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

TEXAS RESIDENTS

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.

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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