

1. EMPLOYEE

Name of Employee: _____ Social Security No.: _____ Phone No.: (____) _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Job Title (please attach a copy of job description): _____ Date Employed: _____
 If applicable, please give job classification: _____
 K-12 Member Higher Ed. Academic Retirement Plan Member Other Covered Member
 Employee's work location (agency/institution): _____

2. INFORMATION

Date employee's coverage became effective: Basic _____
 Supplemental _____ Benefit Waiting Period for supplemental: _____
 Is this employee subject to Social Security taxes? Yes No
 Was employee given a Certificate of Insurance/Long Term Disability Plan booklet? Yes No Don't know
 Was employee insured under Previous LTD Carrier? Yes No Effective Date: _____
 Employee's Medical Insurance carrier:
 Phone No.: (____) _____ Effective date for medical insurance: _____
 Employee's status on date disability commenced:
 Actively at Work? Yes No If no, reason: _____ Number of hours worked per week: _____
 Pay status: Yes No If yes, what type of pay? _____
 Last day of work before disability commenced: _____
 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
 Is employment now terminated? Yes No Reason: _____
 Is employment scheduled for termination? Yes No Date of termination: _____
 Reason: _____

3. SALARY AT TIME OF DISABILITY Please check only one box.

Basic Monthly Earnings Monthly rate \$ _____ Basic Weekly Earnings Weekly rate \$ _____
 Basic Yearly Earnings Annual rate \$ _____ Basic Hourly Earnings Hourly rate \$ _____
 Basic Contract Earnings Contract amount \$ _____ Length of contract: _____
 Date of last increase: _____ Earnings prior to increase: \$ _____ per _____ Effective date: _____

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Type	Last date through which paid or payable	Amount/Rate
Sick Pay		
Self-insured Short Term Disability		
Salary Continuation		
Wages / salary, <i>earned after</i> disability		
Vacation Annual Pay		

5. DEDUCTIBLE INCOME

Is employee covered by or now receiving benefits from the following?	Covered		Receiving			Date of Application	Amount Received		Effective Date
	Yes	No	Yes	No	Don't Know		Weekly	Monthly	
a. Social Security _____	<input type="checkbox"/>								
b. Labor & Industries Claim No. _____	<input type="checkbox"/>								
c. Retirement or Pension (PERS, WSTRS) Please specify: _____	<input type="checkbox"/>								
d. Higher Ed. Academic Retirement Plan Account No. _____ <input type="checkbox"/> TIAA/CREF% Employer Contributions ____ % <input type="checkbox"/> Other	<input type="checkbox"/>								
e. Washington Paid Family and Medical Leave	<input type="checkbox"/>								
f. Other _____ (e.g., unemployment or union benefits, etc.)	<input type="checkbox"/>								

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): _____

Date life insurance became effective: _____

Please attach original enrollment card.

Amount of Basic life insurance \$ _____ Additional \$ _____ Supplemental \$ _____ AD&D \$ _____

Dependent's coverage? Yes No

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. ATTACHMENTS

Please attach copies of the following:

a. Job Description	c. Enrollment Form for Long Term Disability Insurance
b. Employment Application or Resume	d. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS, TIAA/CREF, WSTRS, etc.)

8. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: _____ Phone 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 the following page of this form.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

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

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 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.