TheStandard®

Standard Insurance Company
Life Waiver Of Premium Department
PO Box 2800 Portland OR 97208-2800 800.368.1135 Tel 971.321.5838 Fax

WCIF Washington Counties Insurance Fund

Washington Counties Insurance Fund Accelerated Benefit/ Accelerated Death Benefit Instructions

Your Employer's Group Policy includes an Accelerated Benefit (AB) or Accelerated Death Benefit (ADB) provision. See your Certificate for specific details, including the benefit name and the terms that apply to your Employer's coverage. If you need a Certificate, contact your Employer.

The AB/ADB allows you to receive an early payment of a portion of your group life insurance, once during your lifetime, provided you meet certain requirements.

The following information should be considered in conjunction with the AB/ADB provision in your Certificate.

- You should consult your personal tax advisor and/or legal advisor before you apply for an AB/ADB. The receipt of an AB/ADB may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. If you meet the definition of "terminally ill individual" in the Internal Revenue Code Section 101, your AB/ADB may be non-taxable.
- You must have a Qualifying Medical Condition as defined in the Group Policy.
- If you are eligible for this benefit, you may apply to receive part of your Life Insurance Benefit as an AB/ADB.
- Some group policies require you to have a minimum of amount of life insurance, such as $10,000. The minimum AB/ADB benefit payment may be $5,000 or 10% of your group life insurance, whichever is greater. These amounts are subject to the terms in your Employer's Group Policy. Refer to your Certificate for the amounts that apply to your Employer's coverage.
- If the Group Policy allows an AB/ADB for your insured Spouse or Dependent, benefit claims are filed on form SI 12767 Spouse/Dependent Accelerated Benefit Claim Packet. Please do not use this form for Spouse/Dependent AB/ADB claims.

To apply for the AB/ADB, you must submit a completed claim packet. The four forms in your claim packet are:

1. Employee's Claim/Payment Consent

Please answer each question to the best of your ability. If a question does not apply to you, briefly explain why. If not enough space is given on the form, use an additional sheet. Remember to sign and date the form. An unsigned form may be returned for your signature.

Also, the completed Payment Consent must be notarized if you answer yes to questions 2, 3, or 4 on page 2 of the Employee's Claim.

2. Authorization to Obtain and Release Information

Sign and date this form. This will enable us to obtain the information necessary to determine your eligibility for this benefit. The Authorization also allows us to release this information to other parties for purposes specified on the Authorization. You will receive a copy of this Authorization upon your request.

3. Attending Physician's Statement

- Part A is completed by you.
- Part B is completed by your physician. If more than one physician treats your medical condition, a statement should be completed by each physician.

4. Employer's Statement

This form should be completed entirely by your Employer. Please see that your Employer returns the form to The Standard.

You are responsible for making sure all required forms are completed and returned to our office.

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Reset

Washington Counties Insurance Fund Accelerated Benefit/ Accelerated Death Benefit Employee's Claim

Your complete and accurate answer to each question helps us evaluate your claim. Note, the Employer's Statement and Attending Physician's Statement are forms your Employer and Physician need to complete. It is your responsibility to ensure all forms are submitted to The Standard.

Full Name _____

Birthdate _____ Social Security Number _____

Street Address _____

City _____ State _____ ZIP _____

Phone Number(s) _____ Email Address _____

May we have your authorization to leave confidential medical and/or benefit information by voicemail on your personal cell or telephone?
☐ Yes ☐ No and/or request information from you by email: ☐ Yes ☐ No Please initial: _____ to confirm your election.

Gender _____ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Who may we contact if we cannot reach you? _____
(Name, Relationship, Phone Number)

Name of Employer & Employer Contact **Washington Counties Insurance Fund** Policy Number **645273**

Street Address _____

City _____ State _____ ZIP _____

Phone Number(s) _____ Email Address _____

Are you now working at your occupation or another occupation? ☐ Yes ☐ No If no, last day of work _____

Are you self-employed at any activity? ☐ Yes ☐ No

Have you applied for other claims with The Standard? ☐ Yes ☐ No If yes, list the claim number(s) _____

Describe your present medical condition.

Attach copies of laboratory data, results of special tests (CAT or MRI scans, EKG, etc.), surgical reports, hospital discharge summaries, chart notes, or narrative reports.

Provide the following treating physician information. Attach a separate sheet for additional physicians.

Physician's Name _____ Specialty _____

Street Address _____

City _____ State _____ ZIP _____

Phone Number _____ Fax Number _____ Date first consulted _____ Date last consulted _____

Are you currently hospitalized, in a nursing home, or other care facility? ☐ Yes ☐ No If yes, provide the following:

Hospital or Facility Name _____

Street Address _____

City _____ State _____ ZIP _____

Phone Number _____ Fax Number _____ Admission Date _____ Discharge Date _____

Are you currently receiving in-home care? ☐ Yes ☐ No If yes, care is ☐ Full-time ☐ Part-time

Describe the in-home care you receive and who provides it _____

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Washington Counties Insurance Fund
Accelerated Benefit/ Accelerated Death Benefit
Employee's Claim

Full Name _____

How much life insurance do you have with The Standard? _____

*Generally, you must have at least $10,000 of insurance to be eligible.

What percentage of your life insurance are your requesting be paid as an AB/ADB benefit? _____ %

*Generally, the minimum AB/ADB is $5,000 or 10% of your insurance, and the maximum AB/ADB is $500,000 or 75% of your insurance.

**These amounts are subject to the terms in your Employer's Group Policy. Consult the AB/ADB provision in your Certificate for the amounts that apply to your Employer's coverage.*

1. Do you have a court-approved divorce decree, separate maintenance agreement, or property settlement agreement which requires all or part of your life insurance be paid to your former spouse, spouse, or children? ☐Yes ☐No

2. Are you married and living in a community-property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin)? ☐Yes ☐No
   If yes, your spouse must complete the attached written consent for payment of an AB/ADB.

3. An assignment is a transfer of your rights under this policy; it does not refer to your beneficiary designation. Have you made an assignment of all or part of your insurance? ☐Yes ☐No
   If yes, the assignee must complete the attached written consent for payment of an AB/ADB.

4. Have you filed for bankruptcy? ☐Yes ☐No
   (If you are covered under a policy issued in CT, IL, or TX, you are not required to respond.)
   If yes, the trustee in bankruptcy or other official of the Bankruptcy Court must complete the attached written consent for payment of an AB/ADB.

5. Are you required by a government agency to use the AB/ADB to apply for, receive, or continue a government benefit or entitlement? ☐Yes ☐No
   (If you are covered under a policy issued in CT, you are not required to respond.)

6. Have you applied to convert or have you converted any amount of your life insurance to an individual policy? ☐Yes ☐No

I certify the above answers are true and complete and to the best of my knowledge and belief form the basis of my claim for an AB/ADB. I do understand that the receipt of an AB/ADB may be taxable and affect my eligibility for Medicaid or other government benefits or entitlements. I also understand that if I meet the definition of "terminally ill individual" of the Internal Revenue Code Section 101, my AB/ADB may be non-taxable and these matters should be discussed with my tax and/or legal advisor before applying for an AB/ADB. I further understand that this benefit provides for an accelerated payment of life insurance and is not intended nor designed to provide health, nursing home or long term care benefits.

Does the claimant have a legal representative? ☐Yes ☐No If "Yes," indicate the type of legal representative, provide information below and attach a copy of the appropriate documentation granting authority.

☐ Power of Attorney (Medical or Financial) ☐ Legal Guardian ☐ Conservator

Name _____ Relationship/Title _____

Street Address _____

City _____ State _____ Zip _____ Phone Number _____

Signature

I certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice on page 4 of this form.

Signature _____ Date _____

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.

Standard Insurance Company
Life Waiver Of Premium Department
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Washington Counties Insurance Fund
Accelerated Benefit/
Accelerated Death Benefit
Payment Consent

Complete this form only if you answered yes to questions 2, 3, or 4 on page 2 of the Employee's Claim.

Full Name _____
(name of AB/ADB claimant)

STATE OF _____)
) ss.
County of _____)

The undersigned, on oath being first duly sworn, depose and say:

My relationship to _____ is:
(name of AB/ADB claimant)

- ☐ Spouse living in a community property state
- ☐ Assignee under an assignment
- ☐ Trustee in bankruptcy or other official of the Bankruptcy Court

I understand that payment of an AB/ADB reduces the amount of insurance payable on the death of the AB/ADB claimant by the amount of the AB/ADB paid.

_____
Signature

Subscribed and sworn to before me this _____ day of _____

_____
Notary Public for the

State of _____

My commission expires _____

Authorization to Obtain and Release Information

Employer/Policyholder Name **Washington Counties Insurance Fund** Group Policy Number **645273**

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 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 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 7. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Claim Number _____

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.

Employer/Policyholder Name **Washington Counties Insurance Fund** Group Policy Number **645273**

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.

Standard Insurance Company

Life Waiver Of Premium Department
PO Box 2800 Portland OR 97208-2800 800.368.1135 Tel 971.321.5838 Fax

Washington Counties Insurance Fund
Accelerated Benefit/ Accelerated Death Benefit
Attending Physician's Statement

The patient is responsible for the completion of this form at their own expense. We require comprehensive medical information in order to evaluate the insured's claim for AB/ADB.

Part A. To Be Completed By Patient

Full Name _____

Birthdate _____ Social Security Number _____

Street Address _____

City _____ State _____ Zip _____

Phone Number(s) _____ Email Address _____

May we have your authorization to leave confidential medical and/or benefit information by voicemail on your personal cell or telephone? ☐ Yes ☐ No

and/or request information from you by email: ☐ Yes ☐ No Please initial: _____ to confirm your election.

Gender _____ Policy Number **645273** Claim Number _____

Part B. To Be Completed By Physician

The purpose of this form is to help us determine whether your patient is eligible for accelerated payment of life insurance proceeds. We need to evaluate the clinical condition of your patient.

Diagnosis

Primary _____

Secondary _____

Course of treatment, including medications _____

Prognosis _____

Based on the diagnosis and prognosis above, does the patient have a terminal condition? _____

In your opinion, what is the patient's life expectancy?

- ☐ Less than 6 months
- ☐ 6 to 12 months
- ☐ 12 to 24 months
- ☐ Greater than 24 months
- ☐ Other

Important Information
Please Attach

copies of laboratory data, results of special tests (CAT or MRI scans, EKG, etc.), surgical reports, hospital discharge summaries, chart notes, or narrative reports.

Weight _____ Height _____

Objective Findings – Objective documentation must be included to support life expectancy _____

Symptoms _____

When did symptoms first appear? _____

Date you recommended patient should stop working _____ Why? _____

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Washington Counties Insurance Fund Accelerated Benefit/ Accelerated Death Benefit Attending Physician's Statement

Claimant's Name _____

Dates and Nature of Treatment

(a) Date of first visit _____ Date of last visit _____

(b) Frequency ☐ Weekly ☐ Monthly ☐ Other *Specify* _____

(c) Will treatment substantially improve function and life expectancy? ☐ Yes ☐ No *If yes, specify* _____

Progress

What is this individual's functional status? Please check the most appropriate level.

The Karnofsky Performance Status Scale

CONDITION	PERCENTAGE	COMMENTS
Able to carry on normal activity and to work. No special care is needed.	☐ 100	Normal, no complaints, no evidence of disease.
	☐ 90	Able to carry on normal activity, minor signs or symptoms of disease.
	☐ 80	Normal activity with effort, some signs or symptoms of disease.
Unable to work. Able to live at home, care for most personal needs. A varying degree of assistance is needed.	☐ 70	Cares for self. Unable to carry on normal activity or to do active work.
	☐ 60	Requires occasional assistance but is able to care for most personal needs.
	☐ 50	Requires considerable assistance and frequent medical care.
Unable to care for self. Requires equivalent of institutional or hospital care. Disease may be progressing rapidly.	☐ 40	Disabled, requires special care and assistance.
	☐ 30	Severely disabled, hospitalization is indicated, although death not imminent.
	☐ 20	Hospitalization necessary, very sick, active supportive treatment necessary.
	☐ 10	Moribund, fatal processes progressing rapidly.

If patient has been hospitalized, please provide the name, address, and phone number of the hospital.

_____

Admitted _____ Discharged _____ Phone _____ Fax _____

Do you believe the patient is competent to manage insurance benefits? ☐ Yes ☐ No

If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

List Other Treating or Referring Physicians

NAME ADDRESS

1. _____ _____
Address and City State ZIP

Phone _____ Fax _____

2. _____ _____
Address and City State ZIP

Phone _____ Fax _____

Physician Completing This Form *Please print or type.*

Name of Physician _____ Specialty _____

Address _____ City _____ State ____ ZIP _____

Phone _____ Fax _____

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 10 of this form.

Signature _____ Date _____

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

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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

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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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Washington Counties Insurance Fund Accelerated Benefit/ Accelerated Death Benefit Employer's Statement

Please print clearly and complete all questions. Form may be returned for completion of unanswered questions.

1. Employee

Name of Employee _____

Street Address _____

City _____ State _____ ZIP _____

Job Title _____ Phone Number(s) _____

Social Security No. _____ Date of Birth _____ Gender _____

2. Work Status Information

Date of hire _____ Effective date of Employee's insurance _____

Union Member ☐ Yes ☐ No If yes, Union name and contact _____

Employee's status on date disability commenced:

Was Employee Actively at Work the day before disability commenced? ☐ Yes ☐ No

Number of hours worked per week _____ Last day of work before disability commenced _____

Is Employee terminated? ☐ Yes Termination Date _____ ☐ No

Reason for termination _____

_____

_____

3. Earnings

At the time the claimant ceased work, what were their earnings?

☐ 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 _____

☐ Commissions. ***Please attach list of commissions paid for the period specified in your group policy.***

☐ Shift Differential ☐ Bonuses

Date of last increase _____ Earnings prior to increase _____ per _____ Effective Date _____

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Washington Counties Insurance Fund
Accelerated Benefit/
Accelerated Death Benefit
Employer's Statement

Claimant's Name _____

4. Amount of Insurance

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

Important Information
Please Attach
original Enrollment form and any subsequent forms changing benefit and/or beneficiary.

Amount of Basic Life Insurance $ _____ Additional/Optional $ _____ Supplemental/Voluntary $ _____

Dependent's Coverage? ☐ Yes ☐ No If yes, ☐ Spouse $ _____ ☐ Child $ _____

IMPORTANT: ***Please continue payment of premiums until otherwise notified.***

If premiums have already been terminated, give date paid through _____

5. Employer Representative Completing This Form *Please print or type.*

Employer **Washington Counties Insurance Fund** Representative _____

Address _____ ZIP _____

Phone _____ Fax _____ Policy Number **645273**

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 fraud notice on page 13 of this form.

Signature _____ Title _____ Date _____

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

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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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.