



# The Standard<sup>®</sup>

The Standard Life Insurance Company of New York  
877.237.5915 Tel  
85 Allen Street, Suite 210 Rochester NY 14608

## Disability Claim

---

### Your Disability Benefit Claim

This packet contains the forms that will help us to process your claim for Disability Benefits. **Please save a copy of this material for your future reference.** For specific information about your Disability Benefits coverage, please contact your employer's benefits administrator or call The Standard Life Insurance Company of New York's customer service line listed at the top of this form.

### How To Apply For Benefits

- You must complete and sign the section of the form called, PART A – CLAIMANT'S STATEMENT.
- Your treating physician must complete the section of the form called, PART B – HEALTH CARE PROVIDER'S STATEMENT.
- It is necessary for your employer to complete PART C – EMPLOYER'S STATEMENT. This information will assist us in confirming your eligibility for the benefit and in determining the appropriate benefit level to which you may be eligible.
- Please sign and date the AUTHORIZATION TO OBTAIN INFORMATION form. This authorization allows us to request further information about your claim, if necessary.

Please send this information to The Standard Life Insurance Company of New York (The Standard) at the above address. Once we receive your completed claim application, it will take approximately one week to make a claim decision. If we have not reached a decision within one week, you will be notified with the details.

### Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive may reduce the amount of Disability Benefits due you. These benefits may include, but are not limited to, unemployment compensation, Workers' Compensation, and Social Security Disability. To avoid a possible overpayment of your claim, please inform The Standard if you receive other benefits.

### Tax Withholding

Generally, the portion of your benefits subject to federal taxes, state taxes and city taxes (if applicable), is the percentage of premium paid by your employer.

### When You Return To Work

Your disability benefits usually stop when you return to work. **Be sure that you or your employer notify The Standard immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

**NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS**

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A – THE “CLAIMANT’S STATEMENT”, BE ACCURATE AND CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT ON YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE’S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B – THE “HEALTH CARE PROVIDER’S STATEMENT.”**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED TO THE STANDARD **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED**.
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

**PART A – CLAIMANT’S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS**

**Social Security Number**

--	--	--	--	--	--	--	--	--	--

1. My name is .....  
First Middle Last
2. Address .....  
Number Street City or Town State Zip Code Apt. No.
3. Tel. No ..... 4. Date of Birth ..... 5. Married (Check one)  Yes  No
6. My disability is (if injury, also state how, when and where it occurred) .....
7. I became disabled on ..... a. I worked on that day  Yes  No  
Month Day Year  
 b. I have since worked for wages or profit.  Yes  No If “Yes”, give dates .....
8. Give name of employer.

EMPLOYER’S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was .....  
Occupation Name of Union and Local Number, if Member
10. For the period of disability covered by this claim
  - a. Are you receiving wages, salary or separation pay: .....  Yes  No
  - b. Are you receiving or claiming:
    - (1) Workers’ compensation for work-connected disability .....  Yes  No
    - (2) Unemployment Insurance Benefits .....  Yes  No
    - (3) Damages for personal injury .....  Yes  No
    - (4) Benefits under the Federal Social Security Act for long-term disability .....  Yes  No

IF “YES” IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:

I have  received  claimed from ..... for the period ..... to .....

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began.....  Yes  No  
 If “Yes”, fill in the following: I have been paid by ..... From ..... To .....

12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

**ACKNOWLEDGEMENT** – ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD 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 A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Claim signed on .....  
Date Claimant's Signature

If signed by other than claimant, print below: name, address, and relationship of representative.  
 .....

**NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS**

**IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT.**

**PART B – HEALTH CARE PROVIDER’S STATEMENT (Please Print or Type)**

**THE HEALTH CARE PROVIDER’S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE STANDARD WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under “Remarks.”**

1. Claimant's Name ..... 2. Date of Birth ..... 3. Sex  Male  Female

4. Diagnosis/Analysis ..... Diagnosis Code .....

a. Claimant's Symptoms .....

b. Objective Findings .....

5. Claimant Hospitalized?  Yes  No From ..... To .....

6. Operation Indicated?  Yes  No a. Type ..... b. Date .....

7. Enter Dates for the Following:

- a. Date of your first treatment for this disability .....
- b. Date of your most recent treatment for this disability .....
- c. Date claimant was unable to work because of this disability .....
- d. Date claimant will be able to perform usual work .....

Month	Day	Year

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?

Yes  No

Remarks (attach additional sheet, if necessary) .....

(If disability is pregnancy related, please enter estimated delivery.)

I affirm that <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Licensed in the State of	License Number
I am a <input type="checkbox"/> Dentist <input type="checkbox"/> Podiatrist <input type="checkbox"/> Nurse-Midwife		

**ACKNOWLEDGEMENT – 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 A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.**

Health Care Provider's Signature ..... Date .....

Health Care Provider's Name (Please Print) ..... Tel. No .....

Office Address .....

Number Street City or Town State Zip

**Part C – Employer's Statement** *Please print or type*

Employee's Full Name _____		Social Security No. _____	Job Title <i>Please attach a copy of the job description.</i> _____	1. Date Employed _____																																																		
2. Is employee insured for Statutory Disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____  Is employee insured for Short Term Disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____  Is employee insured for Long Term Disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____		3. Is disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined  Work Location _____  Address _____  State _____ ZIP _____																																																				
4. Has the employee filed for: Workers' Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly Amount _____		Name of Workers' Compensation carrier _____ Address _____ State _____ ZIP _____																																																				
5. If employee is no longer in your employ, check reason: <input type="checkbox"/> labor dispute <input type="checkbox"/> lack of work <input type="checkbox"/> fired <input type="checkbox"/> quit <input type="checkbox"/> other <i>please explain</i> _____																																																						
6. Do you expect to rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No		7. Has the employee received Unemployment Insurance Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include dates _____																																																				
8. Employee's earnings 8 weeks prior to disability (including the week in which disability occurred)																																																						
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Month</th> <th>Week Ending Day</th> <th>Year</th> <th>No. Days Worked</th> <th>Amount</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Month	Week Ending Day	Year	No. Days Worked	Amount																																														Check days normally worked <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
Month	Week Ending Day	Year	No. Days Worked	Amount																																																		
9. Last active day at work _____		10. Job status when disability began: <input type="checkbox"/> Full-time (____ hours/week) <input type="checkbox"/> Part-time (____ hours/week)																																																				
11. Date employee returned to work _____		12. Are wages being continued during disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", does the employer request reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																				
13. Through what date are wages being continued? _____ Through what date is the employer requesting reimbursement? _____ Type of wages continued: <input type="checkbox"/> Sick Pay <input type="checkbox"/> Vacation Pay <input type="checkbox"/> Salary Continuation <input type="checkbox"/> Other _____																																																						
14. Is employee subject to: Social security taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. What percentage of the Statutory Disability premium does the employer pay? _____%																																																				
16. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																						
Employer Name _____		Phone No. _____	Policy No. _____																																																			
Mailing Address _____		City _____	State _____	ZIP _____																																																		
<b>Acknowledgement</b> – 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.																																																						
Signature _____			Date _____																																																			

## Authorization to Obtain and Release 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.
- 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, THE STANDARD BENEFIT ADMINISTRATORS 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 The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators 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 6. 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.

## **Authorization to Obtain and Release Information**

---

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. The Standard Benefit Administrators performs claims administration services for Standard Insurance Company. 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.