Long Term Disability Claim Process

At The Standard, we're committed to keeping the claim process simple for you and your employees to understand and follow. We've outlined the steps we take and the documentation we need to make a decision when you file an LTD claim.

The checklist below includes all the documents that must be completed, signed and dated (at time of receipt) and returned to The Standard before we can process and evaluate the claim. Collectively these forms make up Proof of Loss.

Please note that situations vary depending on claim specifics. If you have questions, regarding a specific claim, please contact The Standard at 800.368.1135. If you have general questions, feel free to contact your local service office.

What is my responsibility as the employer for a Long Term Disability (LTD) claim?

The employer is required to submit the following completed form to The Standard:

Employer Statement Form

Can be accessed online or you can obtain copies from your local servicing office:

- https://www.standard.com/eforms/3379.pdf.
- AdminEASE: http://www.adminease.standard.com

Job description

- Please provide the job description for the job your employee was performing up to the date last worked.

Enrollment form(s)

- LTD enrollment forms are required if LTD is elective (voluntary) coverage
- Life insurance enrollment forms and current beneficiary designation is required if the employee has Life insurance coverage through The Standard where Waiver of Premium may apply

What does an employee need to do to file a Long Term Disability (LTD) claim?

To submit a claim, the employee is required to provide the following completed forms to The Standard:

Employee Statement and Authorization Form: May be found online or may be provided by the employer:

- https://www.standard.com/eforms/3379ee.pdf
- The Standard's website: www.standard.com

Attending Physician Statement (APS) – The employee should provide the APS to their treating physician(s) for completion. The physician or employee can submit their portion of the claim packet independently, or the employee can collect the APS and submit it with their completed statements.

If the employee submits a claim without and Employer's Statement, he or she will be directed to contact you to complete one as soon as possible.

What happens once The Standard receives a claim form?

The Standard's Intake team will set up an LTD claim within three business days of receipt of a completed claim form. When the claim is set up it will be listed in incomplete status until we have received all required claim forms. The Standard's Intake team manages the collection of documents for a claim and pursuit of missing claim forms. While the LTD claim is in incomplete status text alerts will be sent to those who have enrolled to provide status updates and acknowledgement of received claim forms. Once all necessary documents are received, the claim will be sent to the appropriate LTD team for assignment to a Benefits Examiner or Analyst. Once the claim has been assigned to a Benefits Examiner or Analyst it will be listed in pending status until we are able to reach a claim determination. In rare circumstances, if we have not received all required claim forms within 72 days of receipt of the initial claim form, claim may be denied for failure to provide Proof of Loss.

How do I find out information on the status of a claim?

You can monitor claim activity 24/7 via AdminEASE (www.adminease.standard.com). Select "claims" from the menu and then select "reports online." This tool will bring you to a menu of reports (login/password information is available on the login screen).

What happens during an evaluation?

Once an LTD claim is assigned, the Benefits Examiner or Analyst will review the information initially received and make the initial decision within seven business days of the date the claim was assigned to them. This initial review may result in a determination to approve, deny or continue pending the claim for additional information.

During the initial review period, the Benefits Examiner or Analyst may do any combination of the following:

- Consult with a Vocational Case Manager to assess the employee's occupational requirements.
- Conduct a phone interview with the employee to determine sufficient facts and circumstances to make a decision.
- Consult with a Nurse Case Manager to discuss information about the claimant's limitations and restrictions.
- Contact the employer to request additional information such as payroll records or other pertinent information to making the claim decision.

When is a decision not made?

If we are unable to make a decision based on the information initially available, the claim will remain in pending status and the claimant will be advised of the reason the claim remains pending. This communication may occur via letter, phone, or both depending on the claim circumstances. In this communication, we will provide a description of what information is needed, whether it has already been requested, and what the employee can do to assist us in obtaining this information. The claimant will be sent status letters every 15 working days while the claim remains in a pending status.

If we are unable to reach a claim determination within 45 days of the date of assignment, we will send a letter to the employee providing an explanation of what information remains outstanding and/or the current status of our review. This would occur in addition to regular status updates between the Benefits Examiner or Analyst.

How long does it normally take for a claim decision to be made?

Our goal is to make the correct decision at the earliest possible time with an anticipated turnaround time of less than 30 days from the date the claim was assigned to the date a decision is made, to either approve or deny. For claims involving diagnoses such as maternity or fractures the anticipated date from assigned to decision is less than 5 days.

If the LTD claim is approved, what happens?

If the available information supports Disability as defined by the Group Policy and all other policy provisions have been met, the Benefits Examiner or Analyst will approve the claim in our claim payment system and any benefits that were already due to the employee will be issued the following business day. The Examiner or Analyst will

send an approval letter to the employee outlining the details of the benefit calculation and information regarding ongoing LTD benefits. If the claim has been approved without an anticipated closure date, the Examiner or Analyst will also attempt to contact the employee to discuss the information contained in the approval letter. An abbreviated copy of the employee's approval letter is mailed to the Employer.

Ongoing benefits are issued on a monthly basis and sent several days prior to the due date to ensure timely receipt. Claims approved without an anticipated closure date will be issued ongoing benefits based on a preference of either electronic funds transfer (EFT) or check.

If the LTD claim is denied, what happens?

If the available information does not support Disability as defined by the Group Policy and/or all other policy provisions are not met, the Examiner or Analyst will deny the claim in our claim payment system and will send the employee a detailed letter regarding the reason for denial, including any applicable policy provisions. The denial letter will also include information regarding the employee's right to request a review. The employer is provided a brief written explanation of the decision.

What procedures are in place to ensure timely and accurate coordination of supplemental income and offsets?

While the claim review is completed, and at the time of the claim approval, the Benefits Examiner or Analyst will talk to the employee about any Deductible Income they may be entitled to. If the employee confirms they are receiving Deductible Income, we will offset this income to ensure that they receive the correct LTD benefit.

Through written and verbal communication, the Examiner or Analyst ensures that the employee understands how the Group Policy defines Deductible Income and advises them of their responsibility to pursue Deductible Income and notify The Standard when they receive other income. We also ask you to notify The Standard if one of your employees returns to work in any capacity when LTD benefits are payable. The Standard also partners with a Social Security vendors, to screen and assist LTD claimants in their pursuit of Social Security Disability benefits. They also assist in securing repayment of any overpaid benefits as a result of the Social Security award.

What if I need further assistance?

Always remember you may contact your service team with questions. If you have any servicing questions, you can contact your local service office. If you have any claim-specific questions or issues, please contact The Standard Benefits Department at 800.368.1135.