



# The Standard<sup>®</sup>

Standard Insurance Company  
Individual Disability Benefits 800.628.9797 Tel 971.321.5609 Fax  
PO Box 5203 Portland OR 97208  
CCIDISUPPORT@standard.com

## Individual Disability Benefits Claim Packet Instructions

### Your Disability Benefit Claim

This packet contains the forms necessary to apply for Individual Disability benefits. Every space on these forms should be filled in to avoid delay in processing your application. If a section does not apply, or information is not available, write “NA” in the space so that we know you did not overlook that particular question. **If a form is received incomplete, it may be returned for completion.**

### How To Apply For Benefits

The Individual Disability Benefits application includes claim forms and two Authorizations.

#### 1. The Insured’s Statement

- Answer every question completely. Be sure to use the appropriate section for injury, sickness or pregnancy. If a question does not apply to you write “NA”.
- If your claim is for medical expense benefits, attach hospital bills, doctors’ statements or other documents verifying your dates of hospitalization and the amount of your medical expenses.
- Use an additional page, if necessary, to give full and complete answers.
- Attach copies of any Social Security, Public Employees Retirement System, Workers’ Compensation or other benefit determinations you have received. If you have applied for any other benefits but have not yet received them, please send a copy of the application receipt. This information is needed to accurately calculate your monthly benefits. If you are unable to make copies of these documents please send the originals. We will photocopy and return them to you promptly.
- Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

#### 2. The Authorization to Obtain and Release Information

##### The Authorization to Obtain and Release Psychotherapy Notes

- Please sign and date the Authorization to Obtain and Release Information and attach it to the Insured’s Statement. Your signature lets Standard Insurance Company (The Standard) get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain and Release Information also lets The Standard release this information to specific persons.

If you have seen or been treated by a Psychiatrist, Psychotherapist, Psychologist, Clinical Social Worker (MSW, MCSW, etc.), or any other provider of treatment for a mental condition, please sign and return the Authorization to Obtain and Release Information **and** the Authorization to Obtain and Release Psychotherapy Notes.

**You will receive copies of these Authorizations upon your request.**

#### 3. The Attending Physician’s Statement

- **Part A** should be completed by you.
- **Part B** should be completed by your physician. **If you have seen more than one physician for your disability, a statement should be completed by each physician.** You may request additional forms from The Standard. Your physician(s) should mail the completed form directly to The Standard.

**You are responsible for making sure all required forms are completed and returned to our office.** If you have any questions, please contact us at the phone number listed above.

# Standard Insurance Company

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PO Box 5203 Portland OR 97208  
CCIDISUPPORT@standard.com

## Individual Disability Benefits Insured's Statement

Please type or print. Form may be returned for unanswered questions.

### 1. Insured

|  |   |
|--|---|
| Full Name _____  | Social Security No. _____               |
| Address _____  | City _____ State _____ ZIP _____        |
| Home Phone No. _____   | Policy No. (s) _____                    |
| Birthdate _____  | Gender _____ Height _____ Weight _____  |
| Name of Spouse _____   | Birthdate _____                         |
| No. of Dependent Children _____  | Birthdate of Youngest _____ Email _____ |
| Name of Policyowner (if other than insured) _____  |   |
| Did your employer pay your premiums? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes what percentage was employer-paid? _____ % |   |

### 2. Employment Income and duties when disability began.

|  |   |
|--|---|
| Employed By (when disability began) _____  | <input type="checkbox"/> Self employed? <input type="checkbox"/> Partner?         |
| If you are an owner, what is the legal form of this business entity? <input type="checkbox"/> S-Corp <input type="checkbox"/> C-Corp <input type="checkbox"/> Other _____      |   |
| Please indicate your ownership percentage _____%   | Tax ID No. _____  |
| If you hold a professional license for your occupation, please provide description (MD, CPA, etc.), state of issue, license number and expiration date.<br>_____               |   |
| Your Occupational Title when disability began _____  | Work Phone _____  |
| Business Address _____   | Corporate Month Ending _____  |
| A. Monthly earned income (after expenses, before taxes) at time disability commenced \$ _____  |   |
| B. Describe all important duties and percent of time usually spent on each:  |   |
| Duties _____   | % _____   |
| <b>Current Employment Status</b>   |   |
| A. Are you working now? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, date you returned to work _____  |   |
| Hours you work per day _____   | Days you work per week _____ Monthly earned income, since returning to work _____ |
| Duties you are able to perform _____   |   |
| Duties you are unable to perform _____   |   |
| B. If you are not currently working, when do you expect to be able to return to work? _____  |   |
| Is your disability work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Date of Injury _____  |
| Have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No   | If yes, W.C. claim number _____   |
| Last full day at work _____  |   |
| Date you became unable to work at your occupation as a result of disability _____  |   |
| Are you now working at, or have you worked at, your occupation or any other occupation since the date of your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| If yes, list names of employers, addresses, telephone numbers, and dates of employment.<br>_____   |   |
| Are you self-employed at any activity? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| Date you resumed part-time work _____  | Work Phone _____ Extension _____  |
| Date you resumed full-time work _____  | Work Phone _____ Extension _____  |

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Individual Disability Benefits  
Insured's Statement

Insured's Name \_\_\_\_\_

**3. Sickness** Please list all illnesses which contribute to your being unable to work at your occupation.

|   |                          |
|---|--------------------------|
| Illness _____   | Date First Noticed _____ |
| Illness _____   | Date First Noticed _____ |
| State what you believe caused your illness.   |                          |
| Describe your symptoms _____  |                          |
| Have you ever had the same condition or a related illness before? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ |                          |

**4. Accident** If disability is due to an automobile accident, please include a complete copy of the motor vehicle report.

|   |
|---|
| Describe Injuries _____                   |
| Cause of injuries _____                   |
| Time, Date and Location of Accident _____ |
| _____                                     |

**5. Disability** Explain how your illness or injury prevents you from working at your occupation.

|   |
|---|
| _____   |
| _____   |
| _____   |
| Has your treating physician indicated when you may be able to resume work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If so, when? _____ With what restrictions? _____  |

**6. Attending Physician** List all physicians consulted for this injury or illness. Use separate sheet, if needed.

|   |                           |                 |
|---|---------------------------|-----------------|
| Physician's Name _____                                | Specialty _____           | Phone No. _____ |
| Street Address _____                                  | Fax No. _____             |                 |
| City _____  | State _____               | ZIP _____       |
| Date first consulted for this injury or illness _____ | Date last consulted _____ |                 |
| Physician's Name _____                                | Specialty _____           | Phone No. _____ |
| Street Address _____                                  | Fax No. _____             |                 |
| City _____  | State _____               | ZIP _____       |
| Date first consulted for this injury or illness _____ | Date last consulted _____ |                 |
| Physician's Name _____                                | Specialty _____           | Phone No. _____ |
| Street Address _____                                  | Fax No. _____             |                 |
| City _____  | State _____               | ZIP _____       |
| Date first consulted for this injury or illness _____ | Date last consulted _____ |                 |

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## Individual Disability Benefits Insured's Statement

Insured's Name \_\_\_\_\_

### 7. Pharmacy *List all pharmacies you use to fill prescriptions for this injury or illness. Use separate sheet, if needed.*

|                                    |                       |
|------------------------------------|-----------------------|
| Pharmacy Name _____                | Phone No. _____       |
| Street Address _____               |                       |
| City _____                         | State _____ ZIP _____ |
| Medications (list) _____           |                       |
| Dosage _____                       |                       |
| Number of refills prescribed _____ |                       |

### 8. Medical Insurance Coverage

|                                  |                               |
|----------------------------------|-------------------------------|
| Health Insurance Provider _____  | Phone No. _____               |
| Address _____                    |                               |
| Effective Date of Coverage _____ |                               |
| Policy/Group No. _____           | Member ID/Record Number _____ |

### 9. Hospital *If you were hospitalized for this condition, please complete. Please attach copy of hospital bill if available.*

|                          |                                  |
|--------------------------|----------------------------------|
| Hospital Name _____      | Address _____                    |
| From _____ Through _____ | Reason for Hospitalization _____ |
| From _____ Through _____ | Reason for Hospitalization _____ |

### 10. History *List all illnesses or injuries for which you have received treatment over the past five years. Use separate sheet if needed.*

| Ailment | Date | Physician's Name | Complete Address |
|---------|------|------------------|------------------|
|         |      |                  |                  |
|         |      |                  |                  |
|         |      |                  |                  |
|         |      |                  |                  |
|         |      |                  |                  |

### 11. Other Insurance *List all disability and life insurance coverage currently in force.*

| Type of Insurance | Insurance Company Name and Address | Policy Number |
|-------------------|------------------------------------|---------------|
|                   |                                    |               |
|                   |                                    |               |
|                   |                                    |               |
|                   |                                    |               |
|                   |                                    |               |

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## Individual Disability Benefits Insured's Statement

Insured's Name \_\_\_\_\_

### 12. Deductible Income/Benefits From Other Sources

| Have you applied for or are you receiving benefits from:                            | Applied                  |                          | Receiving                |                          | Date Applied For | Amount Received |         | Effective Date |
|---|--------------------------|--------------------------|--------------------------|--------------------------|------------------|-----------------|---------|----------------|
|   | Yes                      | No                       | Yes                      | No                       |                  | Weekly          | Monthly |                |
| a. Social Security  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |
| b. Workers' Compensation  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |
| c. State Disability Insurance   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |
| d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.)<br>Please specify _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |
| e. Other _____<br>(e.g., unemployment or union benefits, etc.)                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |

Please send copies of any letters or notices approving or denying benefits.

### 13. Vocational Complete the following and/or attach a resume.

| Education level       | Yes                      | No                       | If no, last grade attended. |       |
|-----------------------|--------------------------|--------------------------|-----------------------------|-------|
| Grade School Graduate | <input type="checkbox"/> | <input type="checkbox"/> |                             |       |
| High School Graduate  | <input type="checkbox"/> | <input type="checkbox"/> |                             |       |
| GED                   | <input type="checkbox"/> | <input type="checkbox"/> |                             |       |
| College Graduate      | <input type="checkbox"/> | <input type="checkbox"/> | Degree                      | Major |
| Post Graduate         | <input type="checkbox"/> | <input type="checkbox"/> | Degree                      | Major |

Have you attended any trade schools or received other special training?  Yes  No If yes, please describe.

#### Work Experience: Complete the following starting with your most recent work experience.

| Job Title & Employer | Dates of Employment | Duties | Last Salary |
|----------------------|---------------------|--------|-------------|
| 1.                   | From:<br>To:        |        |             |
| 2.                   | From:<br>To:        |        |             |
| 3.                   | From:<br>To:        |        |             |
| 4.                   | From:<br>To:        |        |             |
| 5.                   | From:<br>To:        |        |             |

### 14. 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 6 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.

## Authorization to Obtain and Release Information

Employer/Policyholder Name \_\_\_\_\_ Group Policy Number \_\_\_\_\_

**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 8. 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

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Employer/Policyholder Name \_\_\_\_\_ Group Policy Number \_\_\_\_\_

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.

## Authorization to Obtain and Release Psychotherapy Notes

Employer/Policyholder Name \_\_\_\_\_ Group Policy Number \_\_\_\_\_

**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.
- Any organization or entity administering a benefit or leave program (including statutory benefits)
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.*).

**TO GIVE THIS INFORMATION:**

- Notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record.

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- 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 10. 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. \_\_\_\_\_

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.

## Authorization to Obtain and Release Psychotherapy Notes

Employer/Policyholder Name \_\_\_\_\_ Group Policy Number \_\_\_\_\_

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.

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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

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## Individual Disability Benefits Attending Physician's Statement

### Part A. To Be Completed By Patient

|                                |  |
|--------------------------------|--|
| Full Name _____                | Social Security No. _____              |
| Other Names Used _____         |  |
| Address _____                  | City _____ State _____ ZIP _____       |
| Phone No. _____                | Birthdate _____                        |
| Occupation _____               | Employer _____                         |
| I returned to work: Date _____ | I expect to return to work: Date _____ |

### Part B. To Be Completed By Physician

*The purpose of this form is to help us determine whether the clinical condition of your patient is disabling. We need documentation of functional impairment. Please include laboratory data and results of special tests (X-rays, CAT scan, EKG, etc.). Please attach copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes, and narrative reports.*

*The patient is responsible for the completion of this form without expense to The Standard. Forms may be returned for unanswered questions.*

#### 1. Information

|   |
|---|
| Primary Diagnosis: ICD Code ( _____ ) _____   |
| Secondary Diagnosis: ICD Code ( _____ ) _____   |
| Other diagnoses and ICD Codes related to this claim. _____  |
| Symptoms _____  |
| Patient's Height _____ Weight _____ BP _____ Right Arm _____ BP _____ Left Arm _____ Pulse _____ Radial _____   |
| Is condition primarily related to:<br>a. Patient's Employment <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b. Mental Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>c. Alcohol or Drug Condition <input type="checkbox"/> Yes <input type="checkbox"/> No<br>d. Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Para _____ Gravida _____  |
| Complications _____   |
| Dominant Hand <input type="checkbox"/> Left <input type="checkbox"/> Right<br>Is Condition Caused By <input type="checkbox"/> Accident <input type="checkbox"/> Sickness<br>Expected Delivery Date _____<br>Actual Delivery Date _____<br><input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean Section   |

#### 2. History

|   |
|---|
| If patient was referred to you, indicate by whom _____  |
| Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| If yes, indicate when _____ Describe _____  |
| Do, or have, other conditions contributed to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain _____  |
| Date patient first consulted you for <b>this</b> condition _____ For <b>any</b> condition _____                       |
| Dates of subsequent treatment _____   |
| Date of most recent visit _____   |
| If patient was hospitalized, please provide dates. Admitted _____ Discharged _____                                    |
| Admitting Diagnosis _____ Discharge Diagnosis _____   |
| Name of Hospital _____  |
| Address _____ City _____ State _____ ZIP _____  |

# Standard Insurance Company

Individual Disability Benefits 800.628.9797 Tel 971.321.5609 Fax  
PO Box 5203 Portland OR 97208  
CCIDISUPPORT@standard.com

## Individual Disability Benefits Attending Physician's Statement

Insured's Name \_\_\_\_\_

### 3. Assessment

The date you recommended patient should stop working \_\_\_\_\_ Why? \_\_\_\_\_

Describe the patient's physical, mental and cognitive limitations and work activity limitations \_\_\_\_\_

Physical Limitations (Please check if applicable and describe the extent of the limitation(s))

- Standing/Sitting/Walking (number of hours/day)
- Bending/Stooping (number of hours/day)
- Lifting/Carrying (specific pounds)
- Use of Hands (gross/fine manipulations)
- Other (explain)

Physical Impairment

- Class 1 - No limitations of functional capacity; capable of heavy work; no restrictions. (0-10%)
- Class 2 - Medium manual activity. (15-30%)
- Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
- Class 4 - Moderate limitation of functional capacity; capable of clerical/administration (sedentary) activity. (60-70%)
- Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)

Mental Limitations/Impairment

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- Class 5 - Patient has significant loss of psychological, personal and social adjustment (severe limitations)

HAVE YOU RECOMMENDED ANY TREATMENT FOR THESE PSYCHOLOGICAL SYMPTOMS?  Yes  No

IF YES, DESCRIBE RECOMMENDED TREATMENT AND/OR NAME AND ADDRESS OF SOURCE PATIENT WAS REFERRED TO.

How long from today's date will the described limitations impair the patient? \_\_\_\_\_

### 4. Treatment

Planned course of treatment. *Please include expected duration, surgeries, therapy, etc.* \_\_\_\_\_

Medications prescribed: dosage, frequency and date of prescription(s). \_\_\_\_\_

List other treating or referring physicians. *Continue on separate page, if necessary.*

| Name      |  | Address |       |     |
|-----------|--|---------|-------|-----|
| 1.        |  |         |       |     |
| Phone No. |  | City    | State | ZIP |
| 2.        |  |         |       |     |
| Phone No. |  | City    | State | ZIP |

What reasonable work or job site modifications could the employer make to assist the individual to return to work? *Please specify.*

Assessment and treatment are complicated by:

- Malingering
- Significant emotional or behavioral disorder such as:  Depression  Anxiety *Check pertinent areas.*
- Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.
- Dependence on drugs/medication. *Please specify.* \_\_\_\_\_
- Other *Please describe.* \_\_\_\_\_

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## Individual Disability Benefits Attending Physician's Statement

Insured's Name \_\_\_\_\_

### 5. Prognosis

Describe patient's condition since onset of symptoms:  Recovered  Improved  Unchanged  Regressed  
When do you expect a fundamental or marked change in patient's condition?  Never  Condition expected to regress  Condition expected to improve  
State anticipated date \_\_\_\_\_ or, Unable to determine, follow up in \_\_\_\_\_ months.  
When do you anticipate the patient can return to work? State anticipated date \_\_\_\_\_ or, Unable to determine, because of \_\_\_\_\_  
\_\_\_\_\_, follow up in \_\_\_\_\_ months.  
Remarks \_\_\_\_\_

### 6. 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 14 of this form.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Physician's Name (Please Print) \_\_\_\_\_ Specialty \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Physician's Taxpayer ID No. \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

*Return to Standard Insurance Company at the address above.*

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.