Reset

Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

Disability Insurance
Employee/Attending Physician's Statement

To Be Completed By Employee *For a prompt review of your claim, ALL of this form must be thoroughly completed by the appropriate persons.*

Full Name	Employer/Company Name	Group Policy No.	
Social Security No. / Phone No.	Birthdate	Gender	Birthdate of Youngest Child
Address	City	State	ZIP
Email Address			

1. Is your disability work related? ☐ Yes ☐ No If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

2. Last date at work before disability _____ Date you returned or expect to return to work _____

3. Cause of Disability: ☐ Accident ☐ Illness Please explain (include date and location if applicable) _____

3a. Cause of Disabililty: ☐ Pregnancy Expected Date of Delivery _____ Actual Date of Delivery _____ Type of Delivery _____

4. Please describe all work activity, including self-employment, since the start of your disability. If none, initial here _____

5. Have you currently, or in the past year, filed for State Disability/Paid Family Medical Leave benefits? ☐ Yes* ☐ No
*If currently receiving benefits please send in a copy of award notice.

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 2 of this form and will provide it to the physician completing the Attending Physician's Statement.

Signature _____ **Date** _____

To Be Completed By The Attending Physician

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to The Standard. Please complete this form and mail or fax it to The Standard using the contact information listed above.

1. Diagnosis	A. Diagnosis	ICDA Classification
B. Symptoms	Height Weight B/P	
2. Pregnancy (if applicable)	A. Expected date of delivery / B. Actual date of delivery	☐ Vaginal ☐ C-section
3. History and Treatment	A. Date you recommended the patient stop work	B. When did symptoms appear or accident happen?

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?

D. Is this condition related to the patient's employment? ☐ Yes ☐ No E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

F. Date of first visit for this condition	G. Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other _____	H. Date of most recent visit

I. Describe planned course and duration of treatment

J. Hospitalization? ☐ Yes ☐ No	K. Date Admitted / Date Discharged	L. Surgery? ☐ Yes ☐ No	M. Date Surgery Completed/Scheduled
N. Reason/Surgery Type		O. Surgery/Post-Surgery Complications? ☐ Yes ☐ No If yes, please describe	

4. Level of Functional Impairment *Please attach recent chart notes/pertinent records.*

A. Describe patient's physical and/or mental limitations and restrictions (functional capacity).

B. Factors Delaying Recovery (if applicable)

C. How long do you expect these limitations and restrictions to impair your patient?
☐ Date _____ ☐ Unable to determine, follow up in _____ weeks ☐ Permanently

5. Physician Information *Please type or print.*

Name of physician completing this form	Specialty			Phone No.
Address	City	State	ZIP	Fax No.

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 2 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.