

Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

Disability Insurance Employer's Statement

To Be Completed By Employer

Employee's Full Name		Social Security No.	Birthdate	
Employee's Home Address		State	ZIP	
Employee's Phone	Employee's Email			
Work Location	Address	State	ZIP	
Job Title <i>Please attach a copy of the job description.</i>			1. Date Employed	
2. Is employee insured for Short Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Is employee insured for Long Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Is employee insured for Group Life Insurance through The Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No Was employee given Certificate(s) of Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
3. Is disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined				
4. Has the employee filed for: Workers' Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No State Disability/Paid Family Medical Leave* <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly Amount _____ <i>*If employee had a prior state disability or PFML claim in the past year, or is not yet qualified for state disability or PFML, please explain below.</i> IMPORTANT: Prior claims in the last year for state disability insurance (SDI) or paid family medical leave (PFML) may affect the amount of SDI/PFML for which the employee is now eligible. _____ _____ _____				
5. Employee's Earnings \$ _____ <i>Check one</i> <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Commission <input type="checkbox"/> Other <input type="checkbox"/> Shift Differential <input type="checkbox"/> Bonuses Date of last increase _____ Earnings prior to increase \$ _____		6. Last active date at work _____ 7. Job status when disability began: <input type="checkbox"/> Full-time (____ hours/week) <input type="checkbox"/> Part-time (____ hours/week)		
8. Date employee returned to work _____		9. Last date through which sick leave benefits were paid by employer _____		
10. Last date through which any compensation was paid by employer _____		What type(s) of compensation was paid on this date? _____		
11. 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		12. What percentage of the STD premium does the employer pay? _____% What percentage of the LTD premium does the employer pay? _____% Are employer paid premiums included in the employee's salary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Are taxes withheld from employee paid premiums? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A IMPORTANT: Remember to calculate annually the premium contribution percentage information according to the IRS 3 year averaging rule for group coverage.		
13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Employer Name	Location Code (if applicable)	Phone No.	Policy No.	
Mailing Address		City	State	ZIP
Name of employer representative completing this form		Employer representative's Email Address		
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.