**The Standard Benefit Administrators**

800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602

# Florida State University 30-Day Plan (STD/LTD) Disability Insurance Claim Packet Instructions

## Your Disability Benefit Claim

This packet contains the forms necessary to apply for disability benefits. It also addresses common questions about Disability claims. **Please save this material for your future reference.** For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator or call our customer service line at 800.426.4332.

### How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete the Employer's Statement on page 2, and mail or fax it to The Standard Benefit Administrators, before giving the claim packet to you.
2. Complete and sign your part of the claim form on page 4, and then have your treating physician complete their part of the claim form (the Attending Physician's Statement, also on page 4). If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefits administrator. Your physician may return the completed form to you for you to send to us with the other completed forms, or your physician may mail or fax the completed form to us directly, using the contact information at the top of the form.
3. Read the Claim Form Fraud Notice on page 5, then provide it to your treating physician with the Attending Physician's Statement.
4. Sign and date the Authorization, and send it, along with the completed forms, to The Standard Benefit Administrators at the above address. The Standard Benefit Administrators is acting as the claims administrator on behalf of Standard Insurance Company. This authorization allows us to request further information about your claim, if necessary.

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. Your group insurance certificate lists these benefits which may include, but are not limited to, sick leave, Workers' Compensation, State Disability (including Paid Family Medical Leave for your own medical condition), Social Security, and Retirement.

To avoid a possible overpayment on your claim, which would need to be repaid to The Standard Benefit Administrators, please inform The Standard Benefit Administrators if you receive other benefits.

### When You Return To Work

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

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# Florida State University 30-Day Plan (STD/LTD) Disability Insurance Employer's Statement

## To Be Completed By Employer

Reset

| 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 *Please attach a copy of the job description.* | 1. Date Employed |
|---|---|
| | |

2. Date employee's 30-Day Plan (STD/LTD) became effective: _____

Note: Employees covered under this plan option have both STD and LTD coverage.

Is employee insured for Group Life Insurance through Standard Insurance Company? ☐ Yes ☐ No

Was employee given Certificate(s) of Insurance? ☐ Yes ☐ No ☐ Don't Know

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for:
   - Workers' Compensation ☐ Yes ☐ No
   - State Disability/Paid Family Medical Leave* ☐ Yes ☐ No
   - Other ☐ Yes ☐ No

   Weekly Amount _____

*__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.*

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 $ _____
   *Check one* ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐ Commission ☐ Other
   ☐ Shift Differential ☐ Bonuses
   Date of last increase _____ Earnings prior to increase $ _____

6. Last active date at work

7. Job status when disability began: ☐ Full-time ( ___ hours/week) ☐ 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? ☐ Yes ☐ No
    Medicare taxes? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ N/A
    Are taxes withheld from employee paid premiums? ☐ Yes ☐ No ☐ N/A

13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? ☐ Yes ☐ No

***IMPORTANT: Remember to calculate annually the premium contribution percentage information according to the IRS 3 year averaging rule for group coverage.***

| Employer Name | Location Code (if applicable) | Phone No. | Policy No. |
|---|---|---|---|
| **Florida State University** | | | **648965** |

| 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 3 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.

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# Florida State University 30-Day Plan (STD/LTD) 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 **Florida State University** | | Group Policy No. **648965** | |
|---|---|---|---|---|
| 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 5 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 Benefit Administrators. Please complete this form and mail or fax it to The Standard Benefit Administrators 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 5 of this form.

**Signature** _____ **Date** _____

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## Authorization to Obtain and Release Information

Employer/Policyholder Name **Florida State University** Group Policy Number **648965**

**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 7. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ 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.

Employer/Policyholder Name **Florida State University** Group Policy Number **648965**

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.

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