Accelerated Death Benefit/Living Benefit Claim Form
Employer Statement

The furnishing of forms does not constitute an admission of liability on the part of the Company.

Employer instructions:

1. Check that the employee has completed, dated and signed the *Employee Statement*. Verify that all required information has been provided.
2. Be sure that the employee has retained a copy of this claim form and all required documentation for their records.
3. Complete all sections of this *Employer Statement*.
4. Include a copy of the employee's signed application.
5. Send this claim form and all required documents to the address shown to the right.

The Standard
Life Claims Service Center
P.O. Box 2717
Portland, OR 97208-9830
Phone: 800-552-2137
Fax: 877-305-3901
Email: AL-Claims@standard.com

Section 1: Employer information

Company name		Group policy no.	Class no.	
Company address (no. and street)	City		State	ZIP code

Section 2: Employee information

Employee last name	First name	M.I.	Social Security no.	Date of birth (MMDDYYYY)	
Employee address (no. and street)	City			State	ZIP code
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Rate of pay $_____ per: _____		Amount of insurance $	
Occupation	Date when full-time employment started (MMDDYYYY)	Date last physically at work full-time (MMDDYYYY)			
Reason for leaving work					
Is coverage continuing on a premium paying basis? ☐ Yes ☐ No If no, date of last premium (MMDDYYYY)					

Section 3: Beneficiary information

Beneficiary last name	First name	M.I.	Relationship to employee	Age
Beneficiary address (no. and street)	City		State	ZIP code

Section 4: Employer representative information and signature

Employer representative last name	First name	M.I.	Title
Phone no.	Employer email address		
Employer representative signature **X**			Date (MMDDYYYY)

Reset Form Save and Print

Notice to customers regarding telephone service observance

To ensure our customers receive quality service, we randomly select phone calls for monitoring. These calls, between our customers and employees, are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

‡The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, New York.

This page intentionally left blank.

Accelerated Death Benefit/Living Benefit Claim Form
Employee Statement

Employee instructions:

1. Complete sections 1 and 2 of this *Employee Statement*.
2. Have your doctor complete the *Attending Physician Statement*.
3. If applicable, provide the following documentation:
   - If you are divorced, a copy of the court approved divorce settlement agreement.
   - If you have assigned your rights under the group policy to an assignee or an irrevocable beneficiary, written consent from that assignee or irrevocable beneficiary, for payment of a living benefit claim.
4. Be sure to keep a copy of this claim form and all additional documentation for your records. Give the employer this claim form and all additional documentation.

The Standard
Life Claims Service Center
P.O. Box 2717
Portland, OR 97208-9830 Phone:
800-552-2137
Fax: 877-305-3901
Email: AL-Claims@standard.com

Section 1: Employee information

All questions should be fully answered by the insured or his/her legally appointed guardian or committee.

Last name	First name	M.I.	Social Security no./Tax ID no.	Date of birth (MMDDYYYY)

Address (no. and street)	City	State	ZIP code	Phone no.	Email address

Reason for this claim. What is the qualifying medical condition?	Amount of benefit you are claiming $

Date last physically at work full-time ____ (MMDDYYYY)

Are you now in the process or have you converted your Group Life coverage to an Individual policy? ☐ Yes ☐ No

One or more of the following, herein referred to as 'Insurance Company': Standard Insurance Company, The Standard Life Insurance Company of New York, reserves the right to request an Independent Medical Examination at the Company's expense.

Have divorce proceedings ever been instituted by or against you? ☐ Yes ☐ No If yes, when and where? _____
(If you answer yes to this question, please refer to no. 3 in the Employee instructions at the top of this form.)

Have you assigned your rights under the group policy to an assignee or irrevocable beneficiary? ☐ Yes ☐ No

Section 2: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification instructions: You must cross out item (2) above if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

Claimant address (no. and street)	City	State	ZIP code

Claimant signature	Relationship to insured	Date (MMDDYYYY)
X		

I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital, physician or any other institution or person who has attended or examined me to disclose to Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

For New York residents, the following statement applies: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Employee signature	Date (MMDDYYYY)	Witness signature	Date (MMDDYYYY)
X		**X**	

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

For use by Insurance Company only

Examiner	Claim no.	Total – Benefit and interest	Date approved/denied

Si usted necesita ayuda en Español para entender este documento, puede slicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

‡ The Standard es el nombre comercial de StanCorp Financial Group, Inc. y sus subsidiarias. Los productos del seguro son ofrecidos por Standard Insurance Company de 1100 SW Sixth Avenue of Portland, Oregon, en todos los estados excepto en New York, en donde los productos de seguros son ofrecidos por The Standard Life Insurance Company of New York de 445 Hamilton Avenue, 11th floor, White Plains, New York. Las características y disponibilidad de los productos varían según el estado y la compañía, y son solo responsabilidad de cada subsidiaria. Cada compañía es la única responsable de su propio estado financiero. Standard Insurance Company tiene licencia para ofrecer productos de seguros en todos los estados excepto en New York. The Standard Life Insurance Company of New York tiene licencia para ofrecer productos de seguros únicamente en el estado de New York.

Reset Form Save and Print

Accelerated Death Benefit/Living Benefit Claim Form Disclosure Statement

Any Accelerated Death Benefit/Living Benefit paid to you may be taxable. If so, you may incur a tax obligation. You should seek assistance from a qualified tax advisor prior to your receipt of this benefit.

The Standard
Life Claims Service Center
P.O. Box 2717
Portland, OR 97208-9830 Phone:
800-552-2137
Fax: 877-305-3901
Email: AL-Claims@standard.com

Section 1: Effect of payment of personal Accelerated Death Benefit/Living Benefit on your remaining personal life insurance and supplemental life insurance benefits

$ _____ Your (combined amount of personal life insurance and supplemental life insurance) Benefit prior to payment of your Accelerated Death Benefit/Living Benefit

– $ _____ Minus your Accelerated Death Benefit/Living Benefit

$ _____ Your (combined amount of personal life insurance and supplemental life insurance) Benefit remaining after payment of your Accelerated Death Benefit/Living Benefit. This is the remaining death benefits, if any, available to the beneficiary.

This Accelerated Death Benefit/Living Benefit is not a long-term care policy or a nursing home insurance policy. The amount this benefit pays you may not be enough to cover your medical, nursing home, or other bills. You may use your Accelerated Death Benefit/Living Benefit for any purpose.

Section 2: Disclosures and notices

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income.

Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, certificateholders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependent.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, certificateholders should seek assistance from a qualified tax advisor.

For New York residents, the following statements apply:

- No health care facility as defined in Public Health Law section 20 can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.
- The insurer is prohibited from paying accelerated death benefits to the certificateholder for a period of five days from the date on which the information specified in subdivision (f) of Regulation 143 is transmitted in writing to the certificateholder.

Section 3: Applicant information and signature

Applicant last name	First name	M.I.

I acknowledge that I have made application for this benefit voluntarily, and without coercion of a third party.

For New York residents, the following statement applies: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Applicant signature **X**	Date (MMDDYYYY)

Section 4: Spouse information and signature

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

Spouse last name	First name	M.I.

I acknowledge that I have made application for this benefit voluntarily, and without coercion of a third party.

For New York residents, the following statement applies: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Spouse signature **X**	Date (MMDDYYYY)

Si usted necesita ayuda en Español para entender este documento, puede slicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

‡ The Standard es el nombre comercial de StanCorp Financial Group, Inc. y sus subsidiarias. Los productos del seguro son ofrecidos por Standard Insurance Company de 1100 SW Sixth Avenue of Portland, Oregon, en todos los estados excepto en New York, en donde los productos de seguros son ofrecidos por The Standard Life Insurance Company of New York de 445 Hamilton Avenue, 11th floor, White Plains, New York. Las características y disponibilidad de los productos varían según el estado y la compañía, y son solo responsabilidad de cada subsidiaria. Cada compañía es la única responsable de su propio estado financiero. Standard Insurance Company tiene licencia para ofrecer productos de seguros en todos los estados excepto en New York. The Standard Life Insurance Company of New York tiene licencia para ofrecer productos de seguros únicamente en el estado de New York.

Reset Form Save and Print

The laws of some states require us to provide you with the following information

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: 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 fines and confinement in prison.

California: For your protection California law requires the following statement 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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 a 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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: '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: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: 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 fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: 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: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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: For New York residents, the following statement applies: 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 materials thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Rhode Island: 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 fines and confinement in prison.

Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

West Virginia: 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 fines and confinement in prison.

Accelerated Death Benefit/Living Benefit Claim Form
Attending Physician Statement

Attending physician instructions:
Please mail or fax this report directly to the address shown to the right.

The Standard
Life Claims Service Center
P.O. Box 2717
Portland, OR 97208-9830 Phone:
800-552-2137
Fax: 877-305-3901
Email: AL-Claims@standard.com

Section 1: Patient information

Patient last name	First name	M.I.	Social Security no.	Date of birth (MMDDYYYY)

Address (no. and street)	City	State	ZIP code

Employer

Section 2: Attending physician's statement — Space is available on the reverse side if you wish to amplify your answers.

The employee seeking benefits is responsible for getting this information at his/her own expense. If number 4 is not completed in full, claim processing will be delayed.

1	Diagnosis
2	a. Subjective symptoms
	b. Objective findings: Include results of current x-rays, EKGs, or any other special tests relevant to your judgment of prognosis
	c. Is patient: ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined
3	Treatment
	Date of first visit for above condition (MMDDYYYY) — Date of most recent visit (MMDDYYYY)
4	**Prognosis:** "In my best medical judgment, the above patient's life expectancy is _____ months or less, or not more than _____ months."
5	**Mental condition:** Is the patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No

Remarks

Section 3: Attending physician's information and signature

Attending physician last name	First name	M.I.	Degree

Address (no. and street)	City	State	ZIP code

Attending physician signature X	Date (MMDDYYYY)

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

Reset Form Save and Print

Si usted necesita ayuda en Español para entender este documento, puede slicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

‡ The Standard es el nombre comercial de StanCorp Financial Group, Inc. y sus subsidiarias. Los productos del seguro son ofrecidos por Standard Insurance Company de 1100 SW Sixth Avenue of Portland, Oregon, en todos los estados excepto en New York, en donde los productos de seguros son ofrecidos por The Standard Life Insurance Company of New York de 445 Hamilton Avenue, 11th floor, White Plains, New York. Las características y disponibilidad de los productos varían según el estado y la compañía, y son solo responsabilidad de cada subsidiaria. Cada compañía es la única responsable de su propio estado financiero. Standard Insurance Company tiene licencia para ofrecer productos de seguros en todos los estados excepto en New York. The Standard Life Insurance Company of New York tiene licencia para ofrecer productos de seguros únicamente en el estado de New York.

Use this space for any additional information