TheStandard®

Standard Insurance Company
Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Dade County Fire Fighters Insurance Trust Fund
Accidental Dismemberment
Benefits Instructions

Your application for an Accidental Dismemberment Benefit consists of four forms. Every space should be filled in to avoid delay in processing your application. If a section does not apply, or information is not available, "NA" should be written in the space so we know you did not overlook a particular question. **If a form is received incomplete, it may be returned for completion.**

The four forms are:

1. **The Employee's Statement**

   - Answer every question completely. Be sure to completely describe your injury/loss and how your accident occurred.
   - Use an additional page, if necessary, to complete all questions.
   - Enclose photocopies of all medical records pertaining to your loss.
   - Enclose Accident Report if available.
   - Remember to sign and date your statement. **An unsigned or undated statement may be returned to you.**

2. **The Employer's Statement**

   - This form should be completed by your employer who will mail it to Standard Insurance Company (The Standard).

3. **The Authorization to Obtain Information**

   - Please sign and date this form and attach it to the Employee's Statement. Your signature on this form enables us to obtain the necessary information about you to determine your eligibility for the Accidental Dismemberment benefit. The authorization also allows us to release information to a specific person. **You will receive a copy of the Authorization upon your request.**

4. **The Attending Physician's Statement**

   - **Part 1** should be completed by you.
   - **Parts 2 & 3** should be completed by your physician. If you have seen more than one physician for your loss, a statement should be completed by each one (this form may be photocopied). 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. Processing of your claim will begin when all completed forms are received. Should you have any questions, our office is available to assist you.

Reset

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Employee's Statement

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

EMPLOYEE DATA

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

Birthdate: _____ Social Security No. : _____

Date of Accident: _____

What injuries/losses were sustained?

Describe how accident occurred.

MEDICAL

Describe your present medical condition and indicate any changes.

Please list all physicians who have treated you for this injury/loss.

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Have you had any hospitalizations or surgeries? If so, please indicate.

Hospital name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

From: _____ To: _____

From: _____ To: _____

Please enclose photocopies of pertinent medical records.

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 fraud notice on page 4 of this form.

Signature: _____ Date: _____

(Next page to be completed by employer.)

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Employer's Statement

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

EMPLOYEE INFORMATION

Full Name: _____

Date of employment or association membership (union or other): _____

Date employee's insurance effective: _____

Employee's status: Actively at Work? ☐ Yes ☐ No

Number of Hours Worked per Week: _____ Last day of work: _____

Is employee now terminated? ☐ Yes ☐ No Date of Termination: _____

Reason: _____

AMOUNT OF INSURANCE

Does employee have group life insurance under more than one policy number? ☐ Yes ☐ No

If yes, list all policy numbers: _____

Amount of Basic Life Insurance $ _____

Amount of Additional Life Insurance $ _____

Amount of Accidental Death & Dismemberment Insurance $ _____

If life insurance is based on earnings, please check appropriate box and fill in the amount of salary.

- ☐ Basic Monthly Earnings — Monthly rate $ _____
- ☐ Basic Yearly Earnings — Annual rate $ _____
- ☐ Basic Contract Earnings — Contract amount $ _____ Length of contract: _____
- ☐ Basic Weekly Earnings — Weekly rate $ _____
- ☐ Basic Hourly Earnings — Hourly rate $ _____
- ☐ Commissions (Please attach list of commissions paid for each of last 12 months.)

Insurance Class (Refer to policy schedule of benefits): _____

Amount of benefit being claimed $ _____

Date of last increase in earnings or benefit? _____

Earnings Prior to Increase $ _____ per _____

PREMIUMS

Please advise last month premiums paid: _____

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: **Dade County Fire Fighters Insurance Trust Fund**

Address: **8000 NW 21st Street, Suite 222**

City: **Miami** State: **FL** Zip Code: **33122**

Phone No.: (_____) _____ Policy No.: **645783**

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 fraud notice on page 4 of this form.

Signature: _____ Title: _____ Date: _____

(Please attach copies of all enrollment cards.)

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: 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.

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.

MARYLAND AND RHODE ISLAND RESIDENTS

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

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 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 a 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.

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

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 6. 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.

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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Attending Physician's Statement

PART 1. TO BE COMPLETED BY PATIENT

Full Name: _____ Policy No.: **645783**

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____)_____

To Physicians and Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Standard Insurance Company, Portland, Oregon, any information you have regarding my medical history and physical condition.

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 fraud notice on page 9 of this form.

Signature: _____ Date: _____

PART 2. TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

History (please describe how accident occurred, please attach physician notes, operative reports if available):

Please describe amputation: _____

On what date did amputation take place? _____

Condition: ☐ Regressed ☐ Unimproved ☐ Improved ☐ Recovered

If loss of sight, please complete the following:

Is insured totally blind? _____ Was eye enucleated? _____

If not, please describe the extent of visual field loss: _____

If not totally blind, what was vision at last observation?

With glasses: left: _____ right: _____ date: _____

Without glasses: left: _____ right: _____ date: _____

Can vision be improved by treatment, operation or lenses? ☐ Yes ☐ No

If so, please explain: _____

Hospital confinement

Hospital name: _____

Admitted: _____ Discharged: _____

Other Physicians:

Name & Addresses of other treating or referring physicians:

PART 3. PHYSICIAN COMPLETING THIS FORM

Name of Physician: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

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