TheStandard®

Standard Insurance Company
Employee Benefits Department 888.288.1270 Tel 877.282.7713 Fax
PO Box 2800 Portland OR 97208

State of Nevada Public Employees' Benefits Program (PEBP) Long Term Disability Benefits Instructions

PLEASE READ CAREFULLY

Welcome to Standard Insurance Company

We realize that being disabled is difficult. Even though you are unable to work, your financial obligations do not go away. To help you through these difficult times, the State of Nevada PEBP has provided Long Term Disability (LTD) coverage for Members.

Member means a citizen or resident of the United States or Canada who is:

1. An active full time employee of the Employer (or any non-State agency approved by the PEBP Board) regularly working at least 80 hours each month;
2. An active professional full time employee under contract with the University and Community College System of Nevada;
3. An active member of the Nevada Senate or Assembly; or
4. Any other active employee of an Employer which provides benefits under the State of Nevada PEBP who is regularly working at least 80 hours each month.

This packet contains the forms to apply for disability benefits under the State of Nevada PEBP LTD plan. It also addresses common questions about benefit claims. **Please save this information for future reference.**

Your application for benefits consists of four forms. **Every space on these forms 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 that we know you did not overlook that 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 use the appropriate section for injury, sickness or pregnancy. If a question does not apply to you, write "NA".
   - Use an additional page, if necessary, to give full and complete answers.
   - Attach copies of any Social Security, Public Employees Retirement System (PERS), Workers' Compensation, Leave Pool (donated leave), sick leave or other benefit determinations you have received. If you have applied for any other benefits but have not yet received them, please send a copy of the application receipt. This information is needed to accurately calculate your monthly benefits. If you are unable to make copies of these documents, please send the originals. We will photocopy and return them to you promptly.
   - Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**
2. **The Authorization to Obtain Information**
   The Authorization to Obtain Psychotherapy Notes
   - Please sign and date the Authorization to Obtain Information and attach it to the Employee's Statement. Your signature lets The Standard get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain Information also lets The Standard release this information to specific persons.
   - If you have seen or been treated by a Psychiatrist, Psychotherapist, Psychologist, Clinical Social Worker (MSW, MCSW, etc.), or any other provider of treatment for a mental condition, please sign and return the Authorization to Obtain Information **and** the Authorization to Obtain Psychotherapy Notes.

     You will receive copies of these Authorizations upon your request.
3. **The Attending Physician's Statement**
   - **Part A** should be completed by you.
   - **Part B** should be completed by your physician. **If you have seen more than one physician for your disability, a statement should be completed by each physician.** (You may request additional forms from your employer.) Your physician(s) should mail the completed form directly to The Standard.
4. **The Employer's Statement**
   - This first section (1) should be filled out by you. The rest of the form should be completed by your employer, who will mail it to The Standard.

NOTE: You are responsible for making sure the above listed forms are completed and returned to our office. After the completed forms are received and evaluated by The Standard, further information may be necessary to make a decision on your claim. If so, we will notify you with details. Should you have any questions, our office is here to assist you.

Reset

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State of Nevada Public Employees' Benefits Program (PEBP) – Long Term Disability Benefits Employee's Statement

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

1. CLAIMANT

Full Name: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Birthdate: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ Dominant Hand: ☐ Right ☐ Left

Name of Spouse: _____ Birthdate: _____

Birthdate of youngest dependent child: _____ No. of dependent children: _____

Are you enrolled in the PEBP Employer Sponsored Medical Plan? ☐ Yes ☐ No

Category of Active Employee ☐ State ☐ Non-State

Did you receive a Certificate of Insurance for each effective coverage? ☐ Yes ☐ No

Booklet? ☐ Yes ☐ No If no, please contact your employer to obtain a copy.

2. EMPLOYMENT

Agency Name: _____

Name of Agency Representative: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

Supervisor's Name: _____ Supervisor's Phone No.: (_____) _____

Payroll Clerk's Name: _____ Payroll Clerk's Phone No.: (_____) _____

State your job title and describe your duties at work: _____

Is your disability work-related? ☐ Yes ☐ No Date of Injury: _____

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No If Yes, W.C. Claim No.: _____

Last full day at work: _____ * If you are filing your claim more than 180 days after your last day of work please provide a letter of explanation regarding the lateness of filing

Date you became unable to work at your occupation as a result of disability: _____

Are you now working or have you worked at your occupation or any other occupation since the date of your injury? ☐ Yes ☐ No

If yes, list names of employers, addresses, telephone numbers, and dates of employment.

_____

Are you self-employed at any activity? ☐ Yes ☐ No Monthly Earnings: _____

Date you resumed part-time work: _____ Work Phone: (_____) _____ Extension: _____

Date you resumed full-time work: _____ Work Phone: (_____) _____ Extension: _____

3. SICKNESS (Please list all illnesses which contribute to your being unable to work at your occupation.)

Illness: _____ Date First Noticed: _____

_____ Date First Noticed: _____

State what you believe caused your illness: _____

_____

Describe your symptoms: _____

Have you ever had the same condition or a related illness before? ☐ Yes ☐ No Date: _____

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4. INJURY

Describe Injuries: _____

Cause of Injuries: _____

Time, Date and Location of Injuries: _____

5. PREGNANCY

Date you expect to cease work: _____ Expected delivery date: _____

Actual delivery date: _____ Expected return to work date: _____

Please indicate any foreseeable complications: _____

6. DISABILITY

Explain how your illness or injury prevents you from working at your occupation: _____

Do you feel a third party is responsible for your disability, or has made your condition worse? ☐ Yes ☐ No

If yes, please explain, giving name of third party. _____

Do you plan to bring a claim or lawsuit against this third party? ☐ Yes ☐ No

7. ATTENDING PHYSICIAN (List all physicians consulted for this injury or illness. Use separate sheet, if needed.)

Physician's Name: _____ Specialty: _____ Phone No.: (____) _____ Fax No.: (____) _____

Address: _____ City: _____ State: ____ Zip: _____

Date First Consulted for this injury or illness: _____ Date Last Consulted: _____

Physician's Name: _____ Specialty: _____ Phone No.: (____) _____ Fax No.: (____) _____

Address: _____ City: _____ State: ____ Zip: _____

Date First Consulted for this injury or illness: _____ Date Last Consulted: _____

Physician's Name: _____ Specialty: _____ Phone No.: (____) _____ Fax No.: (____) _____

Address: _____ City: _____ State: ____ Zip: _____

Date First Consulted for this injury or illness: _____ Date Last Consulted: _____

8. HOSPITAL

Hospital Name: _____ Address: _____

From: _____ through: _____ Reason for hospitalization: _____

From: _____ through: _____ Reason for hospitalization: _____

9. HISTORY List all illnesses or injuries for which you have received treatment over the past five years. Use separate sheet if needed.

Ailment	Date	Medical Professional's Name	Complete Address & Phone No.

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10. DEDUCTIBLE INCOME

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. Retirement or Pension *(Employer, PERS, etc.)* Please specify type _____	☐	☐	☐	☐				
d. Leave Pool or Donated Leave	☐	☐	☐	☐				
e. Third party income: weekly time loss or from judgement, settlement or other award (related to current condition)	☐	☐	☐	☐				
f. Short term or long term disability benefits from another carrier	☐	☐	☐	☐				
g. Other: _____ *(e.g., unemployment or union benefits, etc.)*	☐	☐	☐	☐				

Please send copies of any letters or notices you have now or receive in the future which approve or deny benefits, to allow us to properly calculate disability payments.

11. VOCATIONAL (Complete the following and/or attach a resume.)

Education Level	Yes	No	If no, last grade attended.	
Grade School Graduate	☐	☐		
High School Graduate	☐	☐		
GED	☐	☐		
College Graduate	☐	☐	Degree	Major
Post Graduate	☐	☐	Degree	Major

Have you attended any trade schools or received other special training? ☐ Yes ☐ No

If yes, please describe. _____

Licenses or certificates? ☐ Yes ☐ No

If yes, please describe. _____

Work Experience: (Complete the following starting with your most recent work experience.)

Job Title & Employer	PERS Qualified?	Dates of Employment	Duties	Last Salary
1.		From: To:		
2.		From: To:		
3.		From: To:		
4.		From: To:		
5.		From: To:		

Acknowledgment

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 applicable fraud notice on page 5 of this form.

SIGNATURE _____ DATE _____

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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 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 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) _____ 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.

Authorization to Obtain and Release Psychotherapy Notes

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.
- Any organization or entity administering a benefit or leave program (including statutory benefits)
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record.

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 9. 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.

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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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State of Nevada Public Employees' Benefits Program (PEBP) – Long Term Disability Benefits Attending Physician's Statement

PART A. TO BE COMPLETED BY PATIENT

Full Name: _____ Social Security No.: _____

Other Names Used: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Birthdate: _____ Patient No.: _____

Health Plan: _____

PART B. TO BE COMPLETED BY PHYSICIAN

DEAR DOCTOR: The purpose of this form is to help us determine whether the clinical condition of your patient is disabling. We need documentation of functional impairment. Please include laboratory data and results of special tests *(X-rays, CAT scan, EKG, etc.).* Please attach copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes, and narrative reports.

The patient is responsible for the completion of this form without expense to The Standard. Forms may be returned for unanswered questions.

The following information is needed to document the Patient's inability to work:

1. DIAGNOSIS

A. Primary Diagnosis: _____ ICDA Classification: _____

B. Secondary Diagnosis *(related to patient's disability):* _____

C. Current Symptoms: _____

_____

D. Objective findings *(Clinical Exam, Imaging Studies, Lab Results):* _____

_____

E. Patient's Height: _____ Weight: _____ Most recent blood pressure: _____ Pulse: _____

2. PREGNANCY (If applicable.)

Expected date of delivery: _____ Anticipated to be normal? ☐ Yes ☐ No

Actual date of delivery: _____ Type of delivery: ☐ Vaginal ☐ Caesarean Section

3. HISTORY

A. When did symptoms appear or accident happen? _____

B. Did you recommend to the patient to stop work? ☐ Yes ☐ No

If yes, as of what date: _____

Why? _____

If no, who recommended that the patient stop work? _____

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

Describe: _____

D. Is the condition related to the patient's employment? ☐ Yes ☐ No ☐ Undetermined

E. Did you complete a Workers' Compensation Report for this condition? ☐ Yes ☐ No

F. Who was the patient referred to you by: _____

4. TREATMENT

A. Date patient first consulted you for this condition: _____, for any condition: _____

B. Dates of subsequent visits: _____

C. Date of most recent visit: _____

D. Treatment Plan *(include surgery, physical therapy, psychiatric counseling):* _____

_____

E. Medications: _____

_____

F. Response to Treatment Plan: _____

_____

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State of Nevada Public Employees' Benefits Program (PEBP) – Long Term Disability Benefits Attending Physician's Statement

5. PHYSICAL CAPACITIES

A. Based on the patient's physical limitations and restrictions, he/she can *(circle the appropriate level of ability):*

Frequently lift *(in pounds):*	50+	50	20	10	0				
Maximum lift:	50+	50	20	10	0				
Walk/Stand at one time (in hours):	8	7	6	5	4	3	2	1	0
Walk/Stand in an 8-hour work day:	8	7	6	5	4	3	2	1	0
Sit at one time (in hours):	8	7	6	5	4	3	2	1	0
Sit in an 8-hour work day:	8	7	6	5	4	3	2	1	0

Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently Fine Manipulation: Right: ☐ Yes ☐ No
Grasp: ☐ Never ☐ Occasionally ☐ Frequently Left: ☐ Yes ☐ No
Reach: ☐ Never ☐ Occasionally ☐ Frequently

6. LEVEL OF FUNCTIONAL IMPAIRMENT

A. The patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

B. Describe the patient's mental and cognitive limitations and restrictions:

C. Is this patient competent to manage insurance benefits? ☐ Yes ☐ No
If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

D. Other impairments *(please be specific)*: _____

_____

E. Dominant hand: ☐ Right ☐ Left

7. HOSPITALIZATION

A. Date admitted: _____ Date discharged: _____ Date surgical procedure performed: _____

B. Reason for admittance to hospital: _____

_____

C. Describe nature of any surgical procedure performed: _____

D. Outcome: _____

Name of hospital: _____

Address: _____ City: _____ State: _____ Zip Code: _____

8. OTHER TREATING MEDICAL PROFESSIONALS (if known)

A. Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

B. Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

9. PROGNOSIS

A. Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed

B. When do you expect a fundamental or marked change in patient's condition? _____

☐ Unable to determine, follow up in _____ weeks _____ months ☐ Never

C. When do you anticipate the patient can return to work?

Full-time: _____ Part-time: _____ (_____ hrs/day, _____ number days/weeks)

☐ Unable to determine, follow up in _____ weeks _____ months ☐ Never

D. What reasonable work or job site modifications could the employer make to assist the individual to return to work? _____

_____

E. Assessment and Treatment are complicated by: ☐ Malingering ☐ Significant exaggeration, inconsistent findings ☐ Dependence on drugs/medications

**** Please send copies of chart notes, diagnostic, laboratory, and electrodiagnostic findings, as well as operative reports and hospital discharge summaries for the past year.**

Acknowledgment

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 applicable fraud notice on page 12 of this form.

Physician's Signature: _____ Date: _____

Physician's Name (Please print): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Physician's Taxpayer ID No.: _____ Phone No.: (_____) _____ Fax No.: (_____) _____

Return to Standard Insurance Company at the address above.

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 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.

Standard Insurance Company

Employee Benefits Department 888.288.1270 Tel 877.282.7713 Fax
PO Box 2800 Portland OR 97208

State of Nevada Public Employees' Benefits Program (PEBP) – Long Term Disability Benefits Employer's Statement

1. EMPLOYEE

Name of Employee: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Agency Name: _____ PEBP Paycenter Code: _____

Job Title (please attach a copy of job description): _____

Category of Active Employee: ☐ State ☐ Non-State

Phone No.: (_____) _____ Date Employed: _____ Social Security No.: _____

2. INFORMATION

Date employee's coverage became effective: _____

Work Location: Address: _____ State: _____ Zip Code: _____

Was employee given a Certificate of Insurance? ☐ Yes ☐ No ☐ Don't know

Was employee insured under previous LTD Carrier? ☐ Yes ☐ No ☐ Effective Date: _____

Employee's Medical Insurance carrier: _____

Phone No.: (_____) _____ Effective date for PEBP Employer Sponsored Medical Plan: _____

Employee's status on date disability commenced:
Actively at Work? ☐ Yes ☐ No If no, reason: _____ Number of hours worked per week: _____

Last day of work before disability commenced: _____ ☐ Exempt or ☐ Non-Exempt ☐ Union or ☐ Non-Union

Number of hours worked this day: _____ Date employee returned to work after disability ended _____

Have you considered allowing the claimant to work in another occupation, or modify or alter the job duties of the claimant's occupation, how the job is done (i.e., work schedule), or worksite? ☐ Yes ☐ No If yes, what alternatives were offered to the claimant?

Is disability caused or contributed to by employment? ☐ Yes ☐ No ☐ Undetermined

Has employee filed a Workers' Compensation claim? ☐ Yes ☐ No ☐ Don't know

Workers' Compensation Carrier Name: _____ Claim #: _____ Date of Injury: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Person to contact: _____

Is employment now terminated? ☐ Yes ☐ No Reason _____

Is employment scheduled for termination? ☐ Yes ☐ No Date of termination _____

Reason: _____

3. SALARY AT TIME OF DISABILITY Please check only one box.

☐ Basic Monthly Earnings Monthly rate $ _____ ☐ Basic Weekly Earnings Weekly rate $ _____

☐ Basic Yearly Earnings Annual rate $ _____ ☐ Basic Hourly Earnings Hourly rate $ _____

☐ Basic Contract Earnings Contract amount $ _____ Length of contract _____

Employee works: ☐ 12 months per year ☐ _____ months/days per year

Date of last increase: _____ Earnings prior to increase: $ _____ per _____ Effective date: _____

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Type	Last date through which paid or payable	Amount / Rate
Sick Pay		
Voluntary Short Term Disability		
Salary Continuation		
Wages/salary, *earned after* disability		
Vacation Pay		

Standard Insurance Company

Employee Benefits Department 888.288.1270 Tel 877.282.7713 Fax
PO Box 2800 Portland OR 97208

State of Nevada Public Employees' Benefits Program (PEBP) – Long Term Disability Benefits Employer's Statement

5. DEDUCTIBLE INCOME

Is employee covered by or now receiving benefits from the following?	Covered Yes	Covered No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Social Security	☐	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐	☐				
c. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Please specify: _____	☐	☐	☐	☐	☐				
d. Other: _____ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

6. LIFE INSURANCE

Was employee covered by Group Life Insurance with The Standard on cease work date? ☐ Yes ☐ No

Date life insurance became effective: _____
Please attach original enrollment card.

Amount of Basic Life Insurance $ _____ Total Voluntary Life Insurance $ _____

Dependent's coverage? ☐ Yes ☐ No

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. TAX INFORMATION

Is this employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

Railroad Tier 1 taxes? ☐ Yes ☐ No Tier 1 Medicare taxes? ☐ Yes ☐ No

If subject to Social Security taxes what are the employee's year to date Social Security wages? _____

Does this employee pay all or a portion of the premium for LTD insurance coverage? ☐ Yes ☐ No

* If yes, are employer paid premiums included in the employee's salary? ☐ Yes ☐ No

8. ATTACHMENTS

Please attach copies of the following.

a. Job Description
b. Employment Application or Resume
c. Enrollment Form for PEBP Employer Sponsored Medical Plan
d. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS Voluntary Short-Term Disability, etc.)

9. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: _____ Phone No.: _____ Policy Number: **642682**

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Fax No.: _____

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 applicable fraud notice on page 15 of this form.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

Phone No.: (_____) _____ Fax No.: (_____) _____

Standard Insurance Company
Employee Benefits Department 888.288.1270 Tel 877.282.7713 Fax
PO Box 2800 Portland OR 97208

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