TheStandard®

Standard Insurance Company
Employee Benefits Department 866.756.8115 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Oregon Educators Benefit Board
Long Term Disability Benefits
Claim Packet Instructions

Your Disability Benefit Claim

This document contains the Employee's Statement forms necessary to apply for Long Term Disability benefits. Every space on this form should be filled in to avoid delay in processing your application. If a section does not apply, or information is not available, write **"NA"** in the space so that we know you did not overlook that particular question. **If the form is received incomplete, it may be returned for completion.**

How To Apply For Benefits

The Long Term Disability Benefits application includes claim forms and an Authorization.

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".
- If additional space is needed in order to give full and complete answers, please use the Additional Information section number 11.
- If you are receiving benefits from Social Security, Public Employees Retirement System, Workers' Compensation or any other entity, please send copies of these benefit determinations to the address at the top of this page. 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.

2. The Authorization to Obtain and Release Information
The Authorization to Obtain and Release Psychotherapy Notes

- After your submitted claim has been received, we will mail an Authorization to Obtain and Release Information form to you, along with an Authorization to Obtain and Release Psychotherapy Notes.

  Please sign and date the Authorization to Obtain and Release Information to the address at the top of this page. Your signature lets Standard Insurance Company get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain and Release 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 and Release Information ***and*** the Authorization to Obtain and Release Psychotherapy Notes to the address at the top of this page.

  You will receive copies of these Authorizations upon your request.

3. The Attending Physician's Statement

After we receive your submitted claim intake form, we will send Attending Physician's Statement(s) directly to your physician(s). Your physician(s) should mail the completed form directly to The Standard. A blank copy will be mailed to you for your reference.

Printing the Form
Prior to submitting the form, you may print a copy for your records.

You are responsible for making sure all required forms are completed and returned to our office. If you have any questions, please contact your benefit administrator or call our customer service line at 866.756.8115.

Reset

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Oregon Educators Benefit Board
Long Term Disability Insurance
Employee's Statement

Please type answers directly on to the form. If additional space is needed in order to give full and complete answers, please us the Additional Information section number 11.

1. Claimant

Full Name _____ Social Security No. _____

Address _____ City _____ State _____ ZIP _____

Phone No. (_____) _____

Birthdate _____ Sex ☐ Male ☐ Female Height _____ Weight _____

Name of Spouse _____ Birthdate _____

No. of Dependent Children _____ Birthdate of Youngest _____

Did you receive a Certificate of Insurance? ☐ Yes ☐ No Did you receive a Brochure? ☐ Yes ☐ No
If you did not receive a Certificate of Insurance or Brochure, please contact your employer to obtain a copy.

2. Employment

Educational Entity _____ Group Policy No. **646595**

Address _____ City _____ State _____ ZIP _____

Phone No. (_____) _____

State your job title and describe your duties at work.

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

Last full day at work _____

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

Are you now working at, 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

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 _____

Illness _____ 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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Long Term Disability Insurance
Employee's Statement

Claimant's Name _____

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. Attending Physician *List all physicians consulted for this injury or illness.*

Physician's Name _____ Specialty _____ Phone No. (_____) _____

Street Address _____ Fax No. (_____) _____

City _____ State _____ ZIP _____

Date first consulted for this injury or illness _____ Date last consulted _____

Physician's Name _____ Specialty _____ Phone No. (_____) _____

Street Address _____ Fax No. (_____) _____

City _____ State _____ ZIP _____

Date first consulted for this injury or illness _____ Date last consulted _____

Physician's Name _____ Specialty _____ Phone No. (_____) _____

Street Address _____ Fax No. (_____) _____

City _____ State _____ ZIP _____

Date first consulted for this injury or illness _____ Date last consulted _____

7. Hospital *If you were hospitalized for this condition, please complete. Please mail a copy of the hospital bill, if available, to the address at the top of this page.*

Hospital Name _____ Address _____

From _____ Through _____ Reason for Hospitalization _____

From _____ Through _____ Reason for Hospitalization _____

8. History *List all illnesses or injuries for which you have received treatment over the past five years.*

Ailment	Date	Physician's Name	Complete Address

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Claimant's Name _____

9. Deductible Income/Benefits From Other Sources

Your Group Disability plan is designed so that the income you receive from Standard Insurance Company and other sources (e.g., Social Security, Workers' Compensation, retirement system, and other income or benefits as described in your Group Policy as deductible income or benefits) combined will provide you with a percentage of predisability earnings, as defined in your Group Policy. Please review your Group Policy to determine how receipt of or eligibility for deductible income or benefits may impact your disability benefits. Please review your obligation to keep Standard Insurance Company informed of your application for and receipt of deductible income or benefits. Additionally, your Group Policy may allow Standard Insurance Company to reduce your disability benefit by estimated deductible income or benefits you are eligible to receive even if you have not applied for them. If your Group Policy states that Social Security benefits will be "deemed payable" even if not received, we will deduct from your disability benefit an estimated Social Security benefit for you and your dependents, based on your Social Security wage record. Please also understand that when deductible income or benefits are awarded you may receive a retroactive award (earlier date) and payment. This retroactive payment may result in an overpayment of your disability benefits because you would receive deductible income or benefits for a period during which you already have received disability benefits from Standard Insurance Company.

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. State Disability Insurance	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) *Please specify* _____	☐	☐	☐	☐				
e. Other _____ (e.g., unemployment or union benefits, etc.)	☐	☐	☐	☐				

Please send copies of any letters or notices approving or denying benefits to the address at the top of this page.

10. Vocational

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.

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

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

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11. Additional Information *If additional space is needed in order to give full and complete answers, please use this section.*

12. Acknowledgement and Electronic Signature

Electronic Signature

By clicking the Submit button below, I certify that the answers I have made throughout this online claim submission are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6. In addition, by clicking the Submit button below, I acknowledge that I am signing this online claim electronically. I understand that this electronic signature shall be enforceable under applicable state or federal law and is equivalent to a manual signature.

Submit Reset Print

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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.

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 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.

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