Reset

Standard Insurance Company
Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Washington Council of Police & Sheriffs Long Term Disability Insurance Employer's Statement

1. Employee

Name of Employee _____ Employer's Name _____

Address _____ City _____ State _____ ZIP _____

Job Title _____ Class: ☐ Faculty/Teacher ☐ Technical/Professional ☐ Administration ☐ Maintenance ☐ Secretarial/Clerical ☐ Other _____

Job Classification _____

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

2. Information

Date employee's LTD coverage became effective: ☐ Basic _____ ☐ Buy-up _____

Work Location: Address _____ State _____ ZIP _____

Was employee given a Certificate? ☐ 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 medical insurance _____

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?

Does the employee participate in your formal retirement plan? ☐ Yes ☐ No Is the plan a qualified plan? ☐ Yes ☐ No

Is the employee eligible but not participating in your formal retirement plan? ☐ Yes ☐ No

Is the formal retirement plan carrier TIAA-CREF or another carrier? ***Please provide name, phone number and address of contact person.*** _____

What is the employee's year-to-date retirement plan contribution? $ _____

Are the employee's contributions vested? ☐ Yes ☐ No

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 No. _____ Date of Injury _____

Address _____ City _____ State _____ ZIP _____

Phone No. (_____) _____ Person to contact _____

Is employment now terminated? ☐ Yes ☐ No Is employment scheduled for termination? ☐ Yes ☐ No

Reason _____ Date of termination _____

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 _____

☐ Commissions ***Please attach list of commissions paid for the period specified in your Group Policy.***

☐ Shift Differential ☐ Bonuses

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/Salary Continuation		
Self-insured Short Term Disability		
Wages/salary, ***earned after*** disability		
Commissions, ***earned after*** disability		

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5. Deductible Income/Benefits From Other Sources

Is employee covered by or now receiving benefits from the following?	Covered		Receiving			Date of Application	Amount		Effective Date
	Yes	No	Yes	No	Don't Know		Weekly	Monthly	
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)	☐	☐	☐	☐	☐				

6. Life Insurance

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

If yes, list policy number(s) _____

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

Amount of Basic Life insurance $ _____ Additional/Optional $ _____ Supplemental $ _____ AD&D $ _____

Dependent's Coverage? ☐ Yes ☐ No If yes, ☐ Spouse ☐ Child

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. Tax Information

Employer's Federal Tax I.D. Number _____

Check one: ☐ We are a private-sector employer
☐ We are a public-sector (government entity) employer

Is this employee subject to:
Social Security taxes? ☐ Yes ☐ No
Railroad Tier 1 taxes? ☐ Yes ☐ No
State Disability taxes? ☐ Yes ☐ No
Medicare taxes? ☐ Yes ☐ No
Tier 1 Medicare taxes? ☐ Yes ☐ No
Unemployment Compensation 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, what percentage of the LTD premium does the employer pay _____ %.

*the employee pay _____ % with "pre-tax" funds.

*the employee pay _____ % with funds that have been taxed.

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

IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.

8. Attachments

Please attach copies of the following:

a. Job Description
b. Employment Application or Resume
c. Enrollment or Election Form for Long Term Disability Insurance
d. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS, etc.)

9. Employer Representative Completing This Form

Employer _____ Group Name **Washington Council of Police and Sheriffs (WACOPS)**

Phone No. _____ Policy Number **753380**

Address _____ City _____ State _____ ZIP _____

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. (_____) _____

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

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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

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.