

Your Disability Benefit Claim

This packet contains the forms necessary to apply for Long Term Disability benefits. 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, write "NA" 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.**

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".
- Use an additional page, if necessary, to give full and complete answers.
- Attach copies of any Social Security, Public Employees Retirement System, Workers' Compensation 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 and Release Information

The Authorization to Obtain and Release Psychotherapy Notes

- Please sign and date the Authorization to Obtain and Release Information and attach it to the Employee's Statement. Your signature lets Standard Insurance Company or its agent, The Standard Benefit Administrators, get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain and Release Information also lets Standard Insurance Company or its agent, The Standard Benefit Administrators, 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.

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 Benefit Administrators.

4. The Employer's Statement

- This form should be completed by your employer, who will mail it to The Standard Benefit Administrators.

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 800.426.4332.

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

1. Claimant

Full Name _____ Social Security No. _____

Address _____ City _____ State _____ ZIP _____

Phone No. (____) _____ Email _____

Birthdate _____ Gender _____ Height _____ Weight _____

Name of Spouse _____ Birthdate _____

No. of Dependent Children _____ Birthdate of Youngest _____ Preferred language _____

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

Name of Employer **Florida State University** Group Policy No. **648965**

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 _____

Have you filed a Workers' Compensation claim? Yes No If yes, W.C. claim number _____

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 _____

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 _____
Type of delivery _____ Expected return to work date _____
Please indicate any foreseeable complications.

6. Attending Physician *List all physicians consulted for this injury or illness. Use separate sheet, if needed.*

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 attach copy of hospital bill if available.*

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. Use separate sheet if needed.*

Ailment	Date	Physician's Name	Complete Address

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 pre-disability 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		Receiving		Date Applied For	Amount Received		Effective Date
	Yes	No	Yes	No		Weekly	Monthly	
a. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
c. State Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) <i>Please specify _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
e. Other _____ (e.g., unemployment or union benefits, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Please send copies of any letters or notices approving or denying benefits.

10. Vocational Complete the following and/or attach a resume.

Education level	Yes	No	If no, last grade attended.	
Grade School Graduate	<input type="checkbox"/>	<input type="checkbox"/>		
High School Graduate	<input type="checkbox"/>	<input type="checkbox"/>		
GED	<input type="checkbox"/>	<input type="checkbox"/>		
College Graduate	<input type="checkbox"/>	<input type="checkbox"/>	Degree	Major
Post Graduate	<input type="checkbox"/>	<input type="checkbox"/>	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:		

11. 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 5 of this form.

Signature _____ Date _____

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 HAMPSHIRE RESIDENTS

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 RESIDENTS

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

NEW MEXICO RESIDENTS

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 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.

TEXAS RESIDENTS

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.

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

Employer/Policyholder Name Florida State University Group Policy Number 648965

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) _____ Claim Number _____

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.

Authorization to Obtain and Release Information

Employer/Policyholder Name **Florida State University** Group Policy Number **648965**

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

Employer/Policyholder Name Florida State University Group Policy Number 648965

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. _____

Claim Number _____

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.

Authorization to Obtain and Release Psychotherapy Notes

Employer/Policyholder Name **Florida State University** Group Policy Number **648965**

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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.

Part A. To Be Completed By Patient

Full Name _____		Social Security No. _____	
Other Names Used _____			
Address _____		City _____	State _____ ZIP _____
Phone No. (____) _____		Birthdate _____	Patient No. _____
Occupation _____		Employer _____	Group Policy No. _____
I returned to work: Date _____		I expect to return to work: Date _____	

Part B. To Be Completed By Physician

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 Benefit Administrators. Forms may be returned for unanswered questions.

1. Information

Primary Diagnosis: ICD Code (____) _____	
Secondary Diagnosis: ICD Code (____) _____	
Other diagnoses and ICD Codes related to this claim. _____	
Symptoms _____	
Patient's Height _____	Weight _____ BP _____
	Right Arm BP Left Arm Pulse Radial
Is condition primarily related to:	
a. Patient's Employment <input type="checkbox"/> Yes <input type="checkbox"/> No	Dominant Hand <input type="checkbox"/> Left <input type="checkbox"/> Right
b. Mental Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Alcohol or Drug Condition <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Delivery Date _____
d. Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No	Actual Delivery Date _____
Para _____ Gravida _____	<input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean Section
Complications _____	

2. History

If patient was referred to you, indicate by whom _____	
Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, indicate when _____ Describe _____	
Do, or have, other conditions contributed to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain _____	
Date patient first consulted you for this condition _____ For any condition _____	
Dates of subsequent treatment _____	
Date of most recent visit _____	
Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date Admitted _____ Date Discharged _____	
Admitting Diagnosis _____ Discharge Diagnosis _____	
Name of Hospital _____	
Address _____ City _____ State _____ ZIP _____	

Claimant's Name _____

3. Assessment

Date you recommended patient should stop working _____ Why? _____

Describe the patient's physical, mental and cognitive limitations and work activity limitations _____

How long from today's date will the described limitations impair the patient? _____

Is the 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

4. Treatment

Planned course of treatment. *Please include expected duration, surgeries, therapy, etc.* _____

Medications prescribed: dosage, frequency and date of prescription(s). _____

List other treating or referring physicians. *Continue on separate page, if necessary.*

Name	Address		
1.			
Phone No. ()	City	State	ZIP
2.			
Phone No. ()	City	State	ZIP

What reasonable work or job site modifications could the employer make to assist the individual to return to work? *Please specify.*

Assessment and treatment are complicated by:

Malingering

Significant emotional or behavioral disorder such as: Depression Anxiety *Check pertinent areas.*

Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.

Dependence on drugs/medication. *Please specify.* _____

Other *Please describe.* _____

5. Prognosis

Describe patient's condition since onset of symptoms: Recovered Improved Unchanged Regressed

When do you expect a fundamental or marked change in patient's condition? Never Condition expected to regress Condition expected to improve

State anticipated date _____ or, Unable to determine, follow up in _____ months

When do you anticipate the patient can return to work? State anticipated date _____ or, Unable to determine, because of _____ follow up in _____ months

Remarks _____

6. 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 12 of this form.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

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

Return to The Standard Benefit Administrators at the address above.

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

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

NEW MEXICO RESIDENTS

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 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.

TEXAS RESIDENTS

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.

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.

1. Employee

Name of Employee _____
 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 90-Day Plan (LTD) coverage became effective: _____
 Work Location: Address _____ State _____ ZIP _____
 Was employee given a Certificate? Yes No Don't Know
 Was employee insured under previous 90-Day Plan (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		

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
c. State Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) <i>Please specify</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
e. Other _____ (e.g., unemployment or union benefits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

6. Life Insurance

Was employee covered by Group Life Insurance with Standard Insurance Company 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 Medicare taxes? Yes No
Railroad Tier 1 taxes? Yes No Tier 1 Medicare taxes? Yes No
State Disability 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 90-Day Plan (LTD) insurance coverage? Yes No

*If yes, what percentage of the 90-Day Plan (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
* If yes, are taxes withheld from employer paid premiums? Yes No

***IMPORTANT: Remember to calculate annually the premium contribution percentage information according to the IRS 3 year averaging rule for group coverage.**

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 Florida State University Phone No. (____) _____ Policy Number 648965

Address _____ City _____ State _____ ZIP _____

Email _____

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. (____) _____

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 HAMPSHIRE RESIDENTS

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 RESIDENTS

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