



### Welcome to Standard Insurance Company.

We realize that being disabled is difficult. Even though you are unable to work, your financial obligations don't go away. We at The Standard have prepared this claim packet to assist you with your application for Disability benefits.

This packet contains the forms to apply for Disability benefits under the State of Oregon group policy. It also addresses common questions about benefit claims. **Please save this information for future reference.**

You may qualify for Short Term Disability (STD) and/or Long Term Disability (LTD) benefits if you meet the terms of the group policy, have enrolled for the coverages, and premiums have been deducted from your pay. For specific information about your STD or LTD insurance coverage, refer to your Certificate of Insurance. The group policy is the ultimate authority for all claims decisions. If you do not have a Certificate of Insurance, you should contact your agency benefits representative.

Your application for benefits consists of five 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, "NONE" should be written in the space so that we know you did not overlook the particular question. **If a form is received incomplete, it may be returned for completion. Each form must be completed and submitted to The Standard.** It is recommended that all these forms be submitted at the same time.

The five forms are:

#### 1. Agency Statement

- Completed by your agency benefits representative before the entire packet is given to you. **Be sure the Employer part is completed, and copies of the enrollment form are attached.**

#### 2. Employee Statement

- You complete this form. Compare your responses to the Employer's and contact them if you disagree with any of the information including the **last day of work** and end of **sick leave** dates.

#### 3. Authorization to Obtain Information

##### Authorization to Obtain Psychotherapy Notes

- Sign and date the Authorization to Obtain Information and send it to The Standard with the Agency/Employee Statement.
- Your signature on the Authorization to Obtain Information enables The Standard to obtain the necessary information about you to determine your eligibility for and entitlement to benefits.

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.

#### 4. Attending Physician's Statement

- **Part A:** Complete this part and give the form to your physician.
- **Part B:** Your physician completes this part and sends the form directly to The Standard.

**If more than one physician is treating your disabling condition, each should complete a form. Your employer or agency representative can give you extra forms.**

#### 5. Repayment Agreement

- Your receipt of Workers' Compensation benefits will affect the amount of STD and LTD you can receive. For more information, please refer to "How Other Benefits Affect Your Disability Benefits" on page 2 and to your Certificate of Insurance.
- Please read carefully and sign this form. By doing so, you are stating that you understand how Workers' Compensation benefits affect your Disability benefits and that an overpayment can result if Workers' Compensation benefits are awarded after The Standard begins paying benefits.

**You are responsible** for making sure all required forms are completed and sent to our office. If you have questions about completing these forms, please contact your agency representative or The Standard.



# The Standard<sup>®</sup>

Standard Insurance Company  
Employee Benefits Department  
800.842.1707 Tel 800.378.6053 Fax  
PO Box 2800 Portland OR 97208



## State of Oregon Disability Claim Instructions

You will be contacted by us no later than five working days from the date all completed forms are received in our office. In some cases, additional information may be needed to make a decision on your claim. If so, The Standard will provide details regarding the information needed.

### **Preexisting Conditions**

If you have not been insured under the State of Oregon STD or LTD policy for at least 12 months before becoming disabled, your claim may be subject to a "Preexisting Condition" clause. If you enrolled for disability coverage within the last 12 months, please list all physicians you have seen over the last three years on your claim form or another sheet of paper. Also, please include your Kaiser number, if applicable, under the "Health Plan No." on the Attending Physician's Statement.

A Preexisting Condition is one for which you consulted a physician, received medical treatment or services or took prescribed medication during the 90-day period preceding the effective date of your insurance. The Standard will inform you if this provision applies to you.

For STD, benefits are limited to four weeks for a Disability caused or contributed to by a Preexisting Condition. For LTD, benefits are not payable for Disability caused or contributed to by a Preexisting Condition. Please refer to your Certificate of Insurance for more information.

### **STD Benefits – Work-Related Disability**

The State of Oregon STD policy does not cover work-related disabilities. No benefits are payable if you qualify for Workers' Compensation. Please refer to your Certificate of Insurance.

If you have a pending Workers' Compensation claim, The Standard may pay STD benefits. Please read and complete the Repayment Agreement that is included in this packet. According to the Agreement, if you are later awarded Workers' Compensation benefits or otherwise settle your Workers' Compensation claim, you will be required to repay The Standard for any STD benefits paid to you for a work-related disability. You must notify The Standard immediately when you receive notice of a decision about Workers' Compensation.

### **How Other Benefits Affect Your Disability Benefits**

Other benefits you receive because of your disability may reduce the amount of STD or LTD benefits due you. Your Certificate of Insurance lists the other benefits, called Deductible Income, that will be subtracted from your maximum STD or LTD Benefit. These include but are not limited to: sick leave or other salary continuation paid by your employer (**including donated sick leave**), not including vacation and comp time, Workers' Compensation (LTD only), Social Security Disability (Primary and Dependents'), Social Security Retirement, any other group disability plans, and work earnings (either from an employer or from self-employment).

Disability or retirement benefits you are eligible to receive from PERS are also deductible from your LTD benefit. The deductible amount will be the Option 1 amount, even if you select a different option.

You must inform The Standard of any other benefits you are receiving or are eligible to receive. There may be an overpayment on your claim if you are awarded other benefits on a retroactive basis or you do not promptly notify us that you are receiving Deductible Income. Any overpayment must be repaid to The Standard.

### **STD Benefits for a Partial Week**

Following your Benefit Waiting Period, if you are Disabled for less than a full week you will receive 1/7 of your weekly STD Benefit for each day of disability. For example, if you are disabled for five days, you will receive 5/7 of your weekly STD Benefit.

### **Payment of Benefits**

STD benefits are paid weekly. STD checks are issued each Wednesday for the previous Monday through Sunday. LTD benefits are paid monthly at the end of the monthly benefit period. The due date of your check is determined by your date of disability.



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## State of Oregon Agency Representative Statement

### PART A. TO BE COMPLETED BY THE AGENCY REPRESENTATIVE

Employee Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Job Title (please attach a copy of the job description) \_\_\_\_\_ Date Hired \_\_\_\_\_

Name of Supervisor \_\_\_\_\_ Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_

Date employee's STD insurance became effective \_\_\_\_\_ Date employee's LTD insurance became effective \_\_\_\_\_

Last day of work before disability began \_\_\_\_\_ Number of hours worked that day \_\_\_\_\_

Date returned to work Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ ( \_\_\_\_\_ hours/week)

Employee's status on date disability began:  Full-time ( \_\_\_\_\_ hours/week)  Part-time ( \_\_\_\_\_ hours/week)  Job Share ( \_\_\_\_\_%)  
 Seasonal  Contract Employee  Summer Contract  Academic Year

If employee was not at work when disability began, was he/she: terminated laid off on leave of absence on sick leave

Through what date are sick leave benefits payable \_\_\_\_\_ No. of hours paid that day \_\_\_\_\_

Last date through which any compensation was paid by employer \_\_\_\_\_ Type \_\_\_\_\_

Is the employee's disability work related?  Yes  No  Undetermined

Has employee filed a Workers' Compensation claim?  Yes  No  Unknown

Amount of earnings \_\_\_\_\_  Hourly  Weekly  Bi-monthly  Monthly  Contract  Annual

Date of last increase \_\_\_\_\_ Earnings prior to increase \_\_\_\_\_

Was employee covered by Group Life insurance with The Standard on last day worked?  Yes  No

If yes, please list policy number \_\_\_\_\_ Amount of coverage \_\_\_\_\_

**IMPORTANT: Please continue payment of life premiums until otherwise notified.**

**Please attach copies of the following: a. Job Description # b. Employment Application or Resume c. Last five life and disability Enrollment Forms d. Deductible Income Documents (Social Security, Workers' Compensation, PERS, etc.)**

**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 4 of this form.

Agency's Full Name \_\_\_\_\_ Agency No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Prepared by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_



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## State of Oregon Disability Claim Form Fraud Notices

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

### **CALIFORNIA RESIDENTS**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### **COLORADO RESIDENTS**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

### **DISTRICT OF COLUMBIA RESIDENTS**

**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

### **FLORIDA RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

### **MARYLAND AND RHODE ISLAND RESIDENTS**

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

### **NEW JERSEY RESIDENTS**

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

### **NEW YORK RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

### **PENNSYLVANIA RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### **ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.



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## State of Oregon Employee Statement

### PART B. TO BE COMPLETED BY INSURED EMPLOYEE

Full Name \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security number \_\_\_\_\_ Sex  Male  Female

Name of Spouse \_\_\_\_\_ No. of dependent children \_\_\_\_\_ Birthdate of youngest \_\_\_\_\_

State your job title and your duties at work \_\_\_\_\_

Is your disability work related?  Yes  No Have you filed a Workers' Comp. claim?  Yes  No Do you intend to file?  Yes  No

If you have filed a Workers' Comp. claim, please list claim number \_\_\_\_\_

Last day of work \_\_\_\_\_ Date you became unable to work at your occupation \_\_\_\_\_

Are you now working for any employer or self-employed?  Yes  No If yes, please list the name, address and phone number of the employer on a separate piece of paper and attach to this form or provide details of your self-employment.

Date you resumed full-time work \_\_\_\_\_ or part time work \_\_\_\_\_

Did you receive a certificate of insurance or brochure?  Yes  No

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Nature of illness/accident \_\_\_\_\_

Date first noticed \_\_\_\_\_ What do you believe caused your disability? (include the time, date and location of accident) \_\_\_\_\_

Explain how your illness/injury prevents you from working \_\_\_\_\_

Have you ever had the same condition or a related illness before?  Yes  No

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Pregnancy:

Expected delivery date \_\_\_\_\_ Actual delivery date \_\_\_\_\_

Type of delivery (if known): Vaginal C-Section Expected return to work date \_\_\_\_\_

### 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.



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## State of Oregon Employee Statement

**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:		

Physician's Name \_\_\_\_\_ Date first consulted for this injury or illness \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_

List **all** other medical professionals consulted for any injury or illness within the past three years. (continue on a separate page if necessary)

1. \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
 Name Phone No. Date first consulted  
 \_\_\_\_\_  
 Address City State Zip

2. \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
 Name Phone No. Date first consulted  
 \_\_\_\_\_  
 Address City State Zip

If you were hospitalized within the past three years, please complete.

Hospital Name and address \_\_\_\_\_  
 From \_\_\_\_\_ Through \_\_\_\_\_ Reason for hospitalization \_\_\_\_\_  
 From \_\_\_\_\_ Through \_\_\_\_\_ Reason for hospitalization \_\_\_\_\_

Have you applied for or have you received benefits from:

	Applied		Receiving		Date of Application	Amount		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. Any other Group Disability Plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
	If yes, name of carrier				_____			
d. Retirement (PERS, etc.)	<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"/>	_____	_____	_____	_____

Please send copies of any letters or notices approving or denying benefits to allow us to calculate your benefits from The Standard.

### 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 7 of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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### **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.

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### **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 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.





## **Authorization to Obtain and Release Information**

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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 11. 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.



## Authorization to Obtain and Release Psychotherapy Notes

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.



# The Standard<sup>®</sup>

Standard Insurance Company  
Employee Benefits Department  
800.842.1707 Tel 800.378.6053 Fax  
PO Box 2800 Portland OR 97208



## State of Oregon Repayment Agreement

I, \_\_\_\_\_, understand and agree as follows:

I have filed a claim with Standard Insurance Company for disability benefits under the State of Oregon Short Term Disability Policy 442210 (STD Policy) and/or the State of Oregon Long Term Disability Policy 606717 (LTD Policy). My claim is for an injury or sickness which occurred on or about \_\_\_\_\_.

The STD Policy does not cover my disability if it arose out of or in the course of any employment for wage or profit. I am not entitled to benefits under the STD Policy for any period during which I am entitled to workers' compensation.

If I receive workers' compensation for a period during which benefits are payable under the LTD Policy, my LTD benefit will be reduced by the workers' compensation I receive.

I have an obligation to pursue workers' compensation to which I may be entitled.

*(Please check each statement below that applies to you and attach a copy of the workers' compensation award or denial, if any.)*

- I filed a claim for workers' compensation benefits for the same injury or sickness for which I am claiming STD or LTD benefits. (Date workers' compensation claim filed \_\_\_\_\_ and claim no. \_\_\_\_\_).
- I have not received any workers' compensation for this claim to date.
- I am now receiving workers' compensation.
- I have not filed a claim for workers' compensation benefits for the injury or sickness for which I am claiming STD or LTD benefits.

Standard Insurance Company may pay me STD or LTD benefits while my claim for workers' compensation is pending. My acceptance of benefits under either the STD or LTD policies may result in an overpayment of my claim. Under the STD or LTD policies I am required to immediately repay Standard Insurance Company for any overpayment of my claim.

If my workers' compensation claim is accepted, compromised or settled, I will notify Standard Insurance Company immediately, I will immediately repay Standard Insurance Company the full amount of any STD benefits paid to me and I will also immediately repay Standard Insurance Company for any overpayment of my LTD claim.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness



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## State of Oregon Attending Physician's Statement

### PART A. TO BE COMPLETED BY EMPLOYEE (PATIENT)

Please type or print. The patient is responsible for the completion of this form without expense to Standard Insurance Company.

Full Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Birth Date \_\_\_\_\_ Patient No. \_\_\_\_\_

Medical Plan \_\_\_\_\_ Group Policy No. \_\_\_\_\_

### PART B. TO BE COMPLETED BY PHYSICIAN

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. Symptoms \_\_\_\_\_

D. Objective findings \_\_\_\_\_

E. Patient's height \_\_\_\_\_ Weight \_\_\_\_\_ Most recent blood pressure \_\_\_\_\_

#### 2. Pregnancy (If Applicable)

Expected date of delivery \_\_\_\_\_ Anticipated to be normal?  Yes  No

Para \_\_\_\_\_ Gravida \_\_\_\_\_ Abortion \_\_\_\_\_

Actual date of delivery \_\_\_\_\_ Type of delivery:  Vaginal  Caesarean Section

#### 3. History

A. When did symptoms appear or accident happen? \_\_\_\_\_

B. Did you recommend the patient 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

#### 4. Treatment

A. Date of first visit \_\_\_\_\_

B. Date of subsequent visits \_\_\_\_\_

C. Date of most recent visit \_\_\_\_\_

D. Planned course of treatment (Include surgery, physical therapy, psychiatric counseling.) \_\_\_\_\_

Medications: \_\_\_\_\_



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## State of Oregon Attending Physician's Statement

**5. Cardiac classification (If Applicable)**

A. Functional classification (American Heart Association)  Class I  Class II  Class III  Class IV

B. Therapeutic classification  Class A  Class B  Class C  Class D  Class E

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**6. 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						

---

**7. 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 assign someone to help manage the insurance benefits?  Yes  No

D. Other impairments (please be specific): \_\_\_\_\_

E. How long will the above limitations impair the patient? \_\_\_\_\_

F. Dominant hand:  Left  Right

---

**8. Hospitalization**

A. Date admitted \_\_\_\_\_ Date discharged \_\_\_\_\_ Date surgical procedure performed \_\_\_\_\_

B. Reason for admittance to hospital: \_\_\_\_\_

C. Describe nature of any surgical procedure performed: \_\_\_\_\_

Name of hospital \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

---

**9. Other treating medical professionals (if known)**

A. Name \_\_\_\_\_ Specialty \_\_\_\_\_ Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

B. Name \_\_\_\_\_ Specialty \_\_\_\_\_ Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

---

**10. 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 the 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, \_\_\_\_\_ days/weeks)  
 Unable to determine, follow up in \_\_\_\_\_ weeks \_\_\_\_\_ months.  Never

---

**Name of Physician completing this form** (Please type or print.) \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No ( \_\_\_\_\_ ) \_\_\_\_\_ Taxpayer Identification 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 \_\_\_\_\_ Fax No. \_\_\_\_\_ Date \_\_\_\_\_

*Please send copies of chart notes, diagnostic, laboratory, and electrodiagnostic findings, as well as operative reports and hospital discharge summaries for the past year.*  
Return to Standard Insurance Company, Special Accounts Benefits, PO Box 2800, Portland, OR 97208.



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Employee Benefits Department  
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## State of Oregon Disability Claim Form Fraud Notices

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

### **CALIFORNIA RESIDENTS**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### **COLORADO RESIDENTS**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

### **DISTRICT OF COLUMBIA RESIDENTS**

**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

### **FLORIDA RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

### **MARYLAND AND RHODE ISLAND RESIDENTS**

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

### **NEW JERSEY RESIDENTS**

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

### **NEW YORK RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

### **PENNSYLVANIA RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### **ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.