



The Standard[®]

The Standard Life Insurance Company of New York
Individual Disability Benefits 800.378.6057 Tel 971.321.5609 Fax
900 SW Fifth Avenue Portland OR 97204
CCIDISUPPORT@standard.com

Individual Disability Benefits Claim Packet Instructions

Your Disability Benefit Claim

This packet contains the forms necessary to apply for Individual 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 Individual Disability Benefits application includes claim forms and two Authorizations.

1. The Insured’s Statement

- Answer every question completely. Be sure to use the appropriate section for injury, sickness or pregnancy. If a question does not apply to you write “NA”.
- If your claim is for medical expense benefits, attach hospital bills, doctors’ statements or other documents verifying your dates of hospitalization and the amount of your medical expenses.
- 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 Insured’s Statement. Your signature lets The Standard Life Insurance Company of New York (The Standard) get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain and Release Information also lets The Standard release this information to specific persons.

If you have seen or been treated by a Psychiatrist, Psychotherapist, Psychologist, Clinical Social Worker (MSW, MCSW, etc.), or any other provider of treatment for a mental condition, please sign and return the Authorization to Obtain and Release Information **and** the Authorization to Obtain and Release Psychotherapy Notes.

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 The Standard. Your physician(s) should mail the completed form directly to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. If you have any questions, please contact us at the phone number listed above.

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Individual Disability Benefits
Insured's Statement

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

1. Insured

Form section 1: Insured. Fields include Full Name, Social Security No., Address, City, State, ZIP, Home Phone No., Policy No. (s), Birthdate, Gender, Height, Weight, Name of Spouse, Birthdate, No. of Dependent Children, Birthdate of Youngest, Email, Name of Policyowner (if other than insured), and Did your employer pay your premiums? (Yes/No) with percentage of employer-paid.

2. Employment Income and duties when disability began

Form section 2: Employment Income and duties when disability began. Fields include Employed By (Self employed? Partner?), legal form of business entity (S-Corp, C-Corp, Other), ownership percentage, Tax ID No., professional license description, Occupational Title, Work Phone, Business Address, Corporate Month Ending, Monthly earned income, and a list of duties with percentages.

Current Employment Status

Form section 3: Current Employment Status. Fields include Are you working now? (Yes/No) with return date, hours worked, duties performed, return to work date, disability work-related status, date of injury, Workers' Compensation claim status, last full day at work, date unable to work, current occupation since injury, list of employers, self-employment status, and dates of resumed part-time and full-time work.

Insured's Name _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	

4. Accident *If disability is due to an automobile accident, please include a complete copy of the motor vehicle report.*

Describe Injuries _____ Cause of injuries _____ Time, Date and Location of Accident _____ _____
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5. Disability *Explain how your illness or injury prevents you from working at your occupation.*

_____ _____ _____
Has your treating physician indicated when you may be able to resume work? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, when? _____ With what restrictions? _____

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 _____

Insured's Name _____

7. Pharmacy *List all pharmacies you use to fill prescriptions for this injury or illness. Use separate sheet, if needed.*

Pharmacy Name _____	Phone No. _____
Street Address _____	
City _____	State _____ ZIP _____
Medications (list) _____	
Dosage _____	
Number of refills prescribed _____	

8. Medical Insurance Coverage

Health Insurance Provider _____	Phone No. _____
Address _____	
Effective Date of Coverage _____	
Policy/Group No. _____	Member ID/Record Number _____

9. 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 _____

10. 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

11. Other Insurance *List all disability and life insurance coverage currently in force.*

Type of Insurance	Insurance Company Name and Address	Policy Number

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**Individual Disability Benefits
 Insured's Statement**

Insured's Name _____

12. Deductible Income/Benefits From Other Sources

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.

13. 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:		

14. Acknowledgement

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.

Signature _____ Date _____

Authorization to Obtain and Release Information

Employer/Policyholder Name _____ Group Policy Number _____

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 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 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 _____ Group Policy Number _____

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 _____ Group Policy Number _____

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.

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- 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:
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 - 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 _____ Group Policy Number _____

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Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

Part A. To Be Completed By Patient

Full Name _____ Social Security No. _____
 Other Names Used _____
 Address _____ City _____ State _____ ZIP _____
 Phone No. _____ Birthdate _____
 Occupation _____ Employer _____
 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. 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 Yes No Dominant Hand Left Right
 b. Mental Disorder Yes No
 c. Alcohol or Drug Condition Yes No Is Condition Caused By Accident Sickness
 d. Pregnancy Yes No Expected Delivery Date _____
 Para _____ Gravida _____ Actual Delivery Date _____
 Complications _____ Vaginal Caesarean Section

2. History

If patient was referred to you, indicate by whom _____
 Has patient ever had same or similar condition? Yes No
 If yes, indicate when _____ Describe _____
 Do, or have, other conditions contributed to this condition? Yes 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 _____
 If patient was hospitalized, please provide dates. Admitted _____ Discharged _____
 Admitting Diagnosis _____ Discharge Diagnosis _____
 Name of Hospital _____
 Address _____ City _____ State _____ ZIP _____

Insured's Name _____

3. Assessment

The date you recommended patient should stop working _____ Why? _____

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

Physical Limitations (Please check if applicable and describe the extent of the limitation(s))

- Standing/Sitting/Walking (number of hours/day)
- Bending/Stooping (number of hours/day)
- Lifting/Carrying (specific pounds)
- Use of Hands (gross/fine manipulations)
- Other (explain) _____

Physical Impairment

- Class 1 - No limitations of functional capacity; capable of heavy work; no restrictions. (0-10%)
- Class 2 - Medium manual activity. (15-30%)
- Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
- Class 4 - Moderate limitation of functional capacity; capable of clerical/administration (sedentary) activity. (60-70%)
- Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)

Mental Limitations/Impairment

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- Class 5 - Patient has significant loss of psychological, personal and social adjustment (severe limitations)

HAVE YOU RECOMMENDED ANY TREATMENT FOR THESE PSYCHOLOGICAL SYMPTOMS Yes No

IF YES, DESCRIBE RECOMMENDED TREATMENT AND/OR NAME AND ADDRESS OF SOURCE PATIENT WAS REFERRED TO _____

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.* _____

Insured's Name _____

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

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.

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 at the address above.