Standard Insurance Company

Employee Benefits – Waiver of Premium
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Waiver of Premium Employer's Statement

Employee

Name of Employee ______

Street Address ______ City ______ State ______ ZIP ______

Job Title ______

Social Security No. ______ Date of Birth ______

Work Status Information

Employee's employment status on date disability commenced ______ Employee's insurance effective date ______

Was employee actively at work the day before disability commenced? ☐ Yes ☐ No If yes, please list the number of hours worked per week ______ and the last day of work before disability commenced. ______

Has job been modified or hours reduced due to illness or injury prior to last day of work? ☐ Yes ☐ No

Is employee terminated? ☐ Yes ☐ No If yes, please list the effective date of termination ______
Note: If yes, please stop premium payments for this employee.

Reason for Termination ______

If premiums have already been terminated, please provide date premiums have been paid through ______

Date of employment or association membership *(union or other)* ______ Name of union if applicable ______

Contact Person ______

Other Information

A. Carrier

Does employee have any of the following insurance with Standard Insurance Company or with another carrier?

	The Standard	Other Carrier	Applied	Receiving
Long Term Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If The Standard is the carrier, please list the group number ______ If the policy or your employer's statement of coverage has class numbers, please provide the employee's class number ______

If there is a carrier other than The Standard, please complete the following.

Name ______ Address ______

City ______ State ______ ZIP ______ Phone (____) ______ FAX (____) ______

	The Standard	Other Carrier	Applied	Receiving
Short Term Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If The Standard is the carrier, please list the group number ______ If the policy or your employer's statement of coverage has class numbers, please provide the employee's class number ______

If there is a carrier other than The Standard, please complete the following.

Name ______ Address ______

City ______ State ______ ZIP ______ Phone (____) ______ FAX (____) ______

	The Standard	Other Carrier	Applied	Receiving
Life Insurance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If The Standard is the carrier, please list the group number ______ If the policy or your employer's statement of coverage has class numbers, please provide the employee's class number ______

If there is a carrier other than The Standard, please complete the following.

Name ______ Address ______

City ______ State ______ ZIP ______ Phone (____) ______ FAX (____) ______

B. Workers' Compensation Carrier: Has employee applied? ☐ Yes ☐ No Is employee receiving? ☐ Yes ☐ No If yes, please complete the following.

Name ______ Address ______

City ______ State ______ ZIP ______ Phone (____) ______ FAX (____) ______

Contact person ______

C. Social Security Benefits: Has employee applied for benefits? ☐ Yes ☐ No Is employee receiving benefits? ☐ Yes ☐ No

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Amount of Basic Life Insurance with The Standard $ ____________

Amount of Voluntary Life Insurance with The Standard $ ____________

Amount of Additional Life Insurance with The Standard $ ____________

Does employee have Life Insurance with The Standard under more than one policy? ☐ Yes ☐ No

If yes, policy name and number ____________

Amount of Basic Life $ ____________ Amount of Additional Life $ ____________

Does employee have life insurance for dependents under your group policy? ☐ Yes ☐ No

If yes, amount of Spouse Life Insurance $ ____________ Dependents Life Insurance $ ____________

Please continue payment of premiums until otherwise notified unless employee has been terminated.

Earnings

Please check appropriate box and fill in the amount of salary as of employee's last day of work.

☐ Basic Monthly Earnings Monthly Rate $ ____________

☐ Basic Yearly Earnings Annual Rate $ ____________

☐ Basic Contract Earnings Contract Amount $ ____________ Length of Contract ____________

☐ Basic Weekly Earnings Weekly Rate $ ____________

☐ Basic Hourly Earnings Hourly Rate $ ____________

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

Date of last increase ____________

Earnings prior to increase ____________ per ____________

If effective date of increase in insurance is different from date of last increase, please give effective date of increase ____________

Important Notice

Attachments
Please attach the following:

a. **Original** Enrollment card and all subsequent coverage selections or changes
b. **Original** Beneficiary designations and subsequent changes
c. Copy of Job Description
d. Copy of Employment Application or Resume
e. Family status change events

Employer Representative Completing This Form (Please Print or Type)

Employer ____________ Representative ____________

Address ____________ City ____________ State ________ ZIP ____________

Policy No. ____________ Phone No. (_____) ____________ Fax 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 fraud notice on page 3 of this form.

Signature ____________ Date ____________

Title ____________

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 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.