

Standard Insurance Company

Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Accidental Dismemberment
Employer's Statement

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

Employee Information

Full Name _____
Date of employment or association membership (union or other) _____
Date employee's insurance became effective _____
Employee's Status: Actively at Work? Yes No
Number of Hours Worked per Week _____ Last Day of Work _____
Is employee now terminated? Yes No Date of termination _____
Reason _____
Provide Dependent name and Social Security No. below only if Dependent is applying for insurance benefits.
Dependent's Name _____ Dependent's Social Security No. _____

Amount of Insurance

Does employee have group Life Insurance under more than one policy number? Yes No
If yes, list all policy numbers _____
Amount of Member's Basic Life Insurance \$ _____
Amount of Member's Additional Life Insurance \$ _____
Amount of Member's Accidental Death & Dismemberment Insurance \$ _____
Amount of Dependent Life Insurance \$ _____
Amount of Additional Dependent Life Insurance \$ _____
Amount of Dependent Accidental Death and Dismemberment Insurance \$ _____
If life insurance is based on Member's earnings, please check appropriate box and fill in the amount of salary.
 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 each of last 12 months.
Insurance Class. Refer to policy schedule of benefits. _____
Amount of benefit being claimed \$ _____
Date of last increase in earnings or benefit? _____
Earnings Prior to Increase \$ _____ per _____

Premiums

Please advise last month premiums paid _____

Employer Representative Completing this Form

Employer _____
Address _____
City _____ State _____ ZIP _____
Phone No. (_____) _____ Policy 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 2 of this form.
Signature _____ Title _____ Date _____

Please attach copies of all enrollment cards.

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.