

# Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax  
PO Box 2800 Portland OR 97208

## Long Term Disability Insurance Employer's Statement

### 1. Employee

Name of Employee \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Job Title \_\_\_\_\_ Class:  Faculty/Teacher  Technical/Professional  Administration  
 Maintenance  Secretarial/Clerical  Other \_\_\_\_\_

Job Classification \_\_\_\_\_

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Date Employed \_\_\_\_\_ Social Security No. \_\_\_\_\_

### 2. Information

Date employee's LTD coverage became effective:  Basic \_\_\_\_\_  Buy-up \_\_\_\_\_

Work Location: Address \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Was employee given a Certificate?  Yes  No  Don't Know

Was employee insured under previous LTD carrier?  Yes  No  Effective Date \_\_\_\_\_

Employee's Medical Insurance carrier \_\_\_\_\_

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Effective date for medical insurance \_\_\_\_\_

Employee's status on date disability commenced:  
Actively at Work?  Yes  No If no, reason \_\_\_\_\_ Number of hours worked per week \_\_\_\_\_

Last day of work before disability commenced \_\_\_\_\_  Exempt or  Non-Exempt  Union or  Non-Union

Number of hours worked this day \_\_\_\_\_ Date employee returned to work after disability ended \_\_\_\_\_

Have you considered allowing the claimant to work in another occupation, or modify or alter the job duties of the claimant's occupation, how the job is done (i.e., work schedule), or worksite?  Yes  No If yes, what alternatives were offered to the claimant? \_\_\_\_\_

Does the employee participate in your formal retirement plan?  Yes  No Is the plan a qualified plan?  Yes  No

Is the employee eligible but not participating in your formal retirement plan?  Yes  No

Is the formal retirement plan carrier TIAA-CREF or another carrier? *Please provide name, phone number and address of contact person.* \_\_\_\_\_

What is the employee's year-to-date retirement plan contribution? \$ \_\_\_\_\_

Are the employee's contributions vested?  Yes  No

Is disability caused or contributed to by employment?  Yes  No  Undetermined

Has employee filed a Workers' Compensation claim?  Yes  No  Don't Know

Workers' Compensation Carrier Name \_\_\_\_\_ Claim No. \_\_\_\_\_ Date of Injury \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Person to contact \_\_\_\_\_

Is employment now terminated?  Yes  No Is employment scheduled for termination?  Yes  No

Reason \_\_\_\_\_ Date of termination \_\_\_\_\_

### 3. Salary at Time of Disability *Please check only one box.*

Basic Monthly Earnings Monthly Rate \$ \_\_\_\_\_  Basic Weekly Earnings Weekly Rate \$ \_\_\_\_\_

Basic Yearly Earnings Annual Rate \$ \_\_\_\_\_  Basic Hourly Earnings Hourly Rate \$ \_\_\_\_\_

Basic Contract Earnings Contract Amount \$ \_\_\_\_\_ Length of Contract \_\_\_\_\_

Commissions *Please attach list of commissions paid for the period specified in your Group Policy.*

Shift Differential  Bonuses

Date of last increase \_\_\_\_\_ Earnings prior to increase \$ \_\_\_\_\_ per \_\_\_\_\_ Effective date \_\_\_\_\_

### 4. Compensation for Period After Disability

Type	Last date through which paid or payable	Amount / Rate
Sick Pay/Salary Continuation		
Self-insured Short Term Disability		
Wages/salary, <b>earned after</b> disability		
Commissions, <b>earned after</b> disability		

**5. Deductible Income/Benefits From Other Sources**

Is employee covered by or now receiving benefits from the following?	Covered		Receiving			Date of Application	Amount		Effective Date
	Yes	No	Yes	No	Don't Know		Weekly	Monthly	
a. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
c. State Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) <i>Please specify</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
e. Other _____ (e.g., unemployment or union benefits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**6. Life Insurance**

Was employee covered by Group Life Insurance with The Standard on cease work date?  Yes  No

If yes, list policy number(s) \_\_\_\_\_

Date life insurance became effective \_\_\_\_\_  
*Please attach original enrollment card.*

Amount of Basic Life insurance \$ \_\_\_\_\_ Additional/Optional \$ \_\_\_\_\_ Supplemental \$ \_\_\_\_\_ AD&D \$ \_\_\_\_\_

Dependent's Coverage?  Yes  No If yes,  Spouse  Child

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

**7. Tax Information**

Employer's Federal Tax I.D. Number \_\_\_\_\_

Check one:  We are a private-sector employer  
 We are a public-sector (government entity) employer

Is this employee subject to: Social Security taxes?  Yes  No Medicare taxes?  Yes  No  
Railroad Tier 1 taxes?  Yes  No Tier 1 Medicare taxes?  Yes  No  
State Disability taxes?  Yes  No Unemployment Compensation taxes?  Yes  No

If subject to Social Security taxes what are the employee's year to date Social Security wages? \_\_\_\_\_

Does this employee pay all or a portion of the premium for LTD insurance coverage?  Yes  No

\*If yes, what percentage of the LTD premium does the employer pay \_\_\_\_\_ %.  
\*the employee pay \_\_\_\_\_ % with "pre-tax" funds.  
\*the employee pay \_\_\_\_\_ % with funds that have been taxed.

\* If yes, are employer paid premiums included in the employee's salary?  Yes  No

**\*IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.**

**8. Attachments**

*Please attach copies of the following:*

- a. Job Description
- b. Employment Application or Resume
- c. Enrollment or Election Form for Long Term Disability Insurance
- d. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS, etc.)

**9. Employer Representative Completing This Form**

Employer \_\_\_\_\_ Phone No. \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**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 3 of this form.

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

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

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Fax No. ( \_\_\_\_\_ ) \_\_\_\_\_

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.