



Please Read Carefully

1. The receipt of an Accelerated Benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. If you meet the definition of “terminally ill individual” in the Internal Revenue Code Section 101, your accelerated benefit may be non-taxable. You should consult your personal tax advisor and/or legal advisor before you apply for an Accelerated Benefit.
2. Your Group Policy provides a benefit which allows you to receive an early payment of a portion of your group life insurance once during your lifetime, if you meet certain requirements. Please consult the Accelerated Benefit provision of your certificate for details.
3. To be eligible for this benefit, you must have at least \$10,000 group life insurance and you must have a Qualifying Medical Condition as defined in the group policy. If you have questions regarding the Qualifying Medical Conditions, please contact your Employer or our office.
4. If you are eligible for this benefit, you may apply to receive part of your Life Insurance Benefit as an accelerated benefit.
5. The minimum Accelerated Benefit is \$5,000 or 10% of your group life insurance, whichever is greater.
6. In order to apply for the benefit, you must submit a completed claim packet. Your claim packet consists of three forms. All questions on these forms are important. Please answer them to the best of your ability. If a section does not apply to you, or the information is unavailable, please indicate that in the space provided.

The three forms in your claim packet are:

1. Employee’s Statement/Consent to Payment

You must fill out this Statement completely. If not enough space is given on the form, please use an additional sheet. Remember to sign and date the Statement. An unsigned Statement will be returned for your signature.

2. Authorization to Obtain and Release Information

Please sign and date this form and attach it to the Employee’s Statement. Your signature on this form enables Standard Insurance Company to obtain the information necessary to determine your eligibility for this benefit. The Authorization also allows us to release this information to other parties for purposes specified on the Authorization. You will receive a copy of this Authorization upon your request.

3. 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. 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. Processing of your claim will begin when all completed forms are received. Should you have any questions, our office is available to assist you.

Standard Insurance Company

Life Benefits Department
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

Accelerated Benefit
Employee's Claim

Please make sure that you have answered all questions completely and accurately. If there are unanswered questions, the review of your claim may be delayed. An Employer's Statement and Attending Physician's Statement must also be submitted to The Standard.

Please print clearly.

Full Name _____
 Street Address _____
 City _____ State _____ ZIP _____
 Phone (_____) _____ Birthdate _____ Social Security No. _____
 Marital Status Single Married Widowed Divorced
 Have you received a Certificate of Insurance, brochure or other written description of the Accelerated Benefit? Yes No

Name of Employer _____
 Street Address _____
 City _____ State _____ ZIP _____
 Date Hired _____
 Have you stopped working? Yes No If yes, last day at work _____

Are you self-employed at any activity? Yes No Are you covered under more than one group life insurance policy issued by Standard Insurance Company? Yes No
 Are you now working at your occupation or another occupation? Yes No Have you applied for waiver of premium? Yes No

Describe your present medical condition.

Please provide the following information regarding any physicians who have treated you. Attach a separate sheet for additional physicians.

Physician's Name _____ Speciality _____
 Street Address _____
 City _____ State _____ ZIP _____
 Phone (_____) _____ Date first consulted _____ Date last consulted _____
 Please indicate if you are currently confined to a hospital Yes No Nursing Home Yes No
 If you answered yes, please provide the date confinement began _____ Is confinement permanent? Yes No
 Please provide the name and address of hospital or nursing home.

 Name _____
 Street _____ City _____ State _____ ZIP _____

Claimant's Name _____

Are you currently receiving in-home care? Yes No If yes, care is Full-time Part-time
Please describe type of care and by whom provided.

What amount of accelerated benefit are you claiming? _____ % \$ _____
10% minimum* \$5,000 minimum*
25% minimum* \$250,000 maximum*
50% maximum* \$500,000 maximum*
75% maximum*

* Subject to the terms in your policy, the minimums and maximums indicated here may vary. Please read the Accelerated Benefit provision in your Certificate of Insurance.

Is part or all of your Life Insurance required to be paid to your children, spouse or former spouse as a part of a court-approved divorce decree, separate maintenance agreement or property settlement agreement? Yes No

Are you married and living in a community-property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin)? Yes No
If yes, your spouse must complete the attached written consent for payment of an Accelerated Benefit.

Have you made an assignment of all or part of your insurance? Yes No
If yes, the assignee must complete the attached written consent for payment of an Accelerated Benefit.
(An assignment is a transfer of your rights under this policy; it does not refer to your beneficiary designation.)

Have you filed for bankruptcy? Yes No
If yes, the trustee in bankruptcy or other official of the Bankruptcy Court must complete the attached written consent for payment of an Accelerated Benefit.
(If you are covered under a policy issued in CT, IL, or TX, you are not required to respond.)

Are you required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement? Yes No
(If you are covered under a policy issued in CT, you are not required to respond.)

Have you previously applied for or received an Accelerated Benefit under the Group Policy? Yes No

Have you made application to convert or have you converted all or part of your coverage under the Group Policy to an individual policy? Yes No

I certify the above answers are true and complete and to the best of my knowledge and belief form the basis of my claim for an Accelerated Benefit. I do understand that the receipt of an Accelerated Benefit may be taxable and affect my eligibility for Medicaid or other government benefits or entitlements. I also understand that if I meet the definition of "terminally ill individual" of the Internal Revenue Code Section 101, my Accelerated Benefit may be non-taxable and these matters should be discussed with my tax and/or legal advisor before applying for an Accelerated Benefit. I further understand that this benefit provides for an accelerated payment of life insurance and is not intended nor designed to provide health, nursing home or long term care benefits.

Acknowledgment

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 4 of this form.

Signature _____

Date _____

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.

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 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.

Standard Insurance Company

Life Benefits Department
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

**Accelerated Benefit
Payment Consent**

STATE OF _____)
) ss.
County of _____)

The undersigned, on oath being first duly sworn, depose and say:

My relationship to _____ is:
(Name of Claimant)

- Spouse living in a community property state
- Assignee under an assignment
- Trustee in bankruptcy or other official of the Bankruptcy Court

I understand that the claimant is making application to Standard Insurance Company (The Standard) for the payment of an Accelerated Benefit in the amount of \$_____ under a group term life insurance policy. I consent to the payment by The Standard to claimant of the Accelerated Benefit should The Standard determine the claimant to be eligible.

Signature

Subscribed and sworn to before me this _____ day of _____

Notary Public for the
State of _____

My commission expires _____

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 a claim(s) under my life, dismemberment and/or disability insurance, or leave of absence claim, 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 life, dismemberment and/or disability insurance claim(s) and leave of absence claim. 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) _____ 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

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. The Standard Benefit Administrators performs claims administration services for Standard Insurance Company. An absence manager may be hired by your employer and maybe 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.

Claimant's Name _____

Dates and Nature of Treatment

(a) Date of first visit _____ Date of last visit _____

(b) Frequency Weekly Monthly Other *Specify* _____

(c) Will treatment substantially improve function and employability? Yes No *If yes, specify* _____

(d) Have you made referrals? Yes No *If yes, specify* _____

Name _____ Specialty _____ Phone (_____) _____

Progress

(a) Has patient: Retrogressed Unchanged Improved Recovered

(b) Is patient: Hospital confined Bed confined House confined Ambulatory

(c) If patient has been hospitalized, please provide the name, address, and phone number of the hospital.

Admitted _____ Discharged _____ Phone (_____) _____

Limitation *If there is a limitation, check and describe below.*

Are the limitations permanent? Yes No

Sitting Climbing Bending Use of left hand/arm Use of right hand/arm Sitting Walking

Stooping Lifting Pushing/Pulling Other clarify _____

Physical Impairment **as defined in Federal Dictionary of Occupational Titles*

Class 1 – No limitation of functional capacity; capable of heavy work*; No restrictions

Class 2 – Medium manual activity*

Class 3 – Slight limitation of functional capacity; capable of light work*

Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity

Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity

Remarks _____

Do you believe the patient is competent to manage insurance benefits? Yes No

If no, is the patient competent to appoint someone to help manage the Insurance benefits? Yes No

List Other Treating or Referring Physicians

	NAME	ADDRESS
1.	_____	_____
		City State ZIP
2.	_____	_____
		City State ZIP

Name of Physician _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone (_____) _____ Taxpayer Identification No. _____

Acknowledgment

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 10 of this form.

Signature _____ Date _____

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