Reset

Standard Insurance Company

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

Accelerated Benefit Employer's Statement

Please print clearly and complete all questions. Form may be returned for completion of unanswered questions.

1. Employee

Name of Employee _____

Street Address _____

City _____ State _____ ZIP _____

Job Title _____

Social Security No. _____ Date of Birth _____

2. Work Status Information

Date of employment or association membership *(union or other)* _____ Union Member ☐ Yes ☐ No

Effective date of Employee's insurance _____

Name of Union _____ Contact Person _____

Employee's status on date disability commenced:

Was Employee Actively at Work the day before disability commenced? ☐ Yes ☐ No

Number of hours worked per week _____ Last day of work before disability commenced _____

Is Employee terminated? ☐ Yes Effective Date _____ ☐ No

If yes, please stop premium payment for this Employee.

Reason for termination

3. Other Information

Does Employee have any of the following insurance coverage with a carrier other than The Standard? Has Employee applied for:

	Other Carrier	Applied	Receiving
A. Long Term Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B. Short Term Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C. Life Insurance under more than one policy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide the name, address and contact person for the above.

A. Name _____

Address _____

City State ZIP

Phone ( ) _____

Fax ( ) _____

B. Name _____

Address _____

City State ZIP

Phone ( ) _____

Fax ( ) _____

Social Security Benefits Has Employee applied for benefits? ☐ Yes ☐ No Is Employee receiving benefits? ☐ Yes ☐ No

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Claimant's Name _____

4. 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 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 than date of last earnings increase,

please give effective date of insurance increase _____

5. Amount of Insurance

Does Employee have group Life Insurance with Standard Insurance Company under more than one policy? ☐ Yes ☐ No

If yes, list all of The Standard's policy numbers _____

Does Employee have Long Term Disability with The Standard? ☐ Yes ☐ No Job Classification _____

Amount of Basic Life Insurance with The Standard $ _____

Amount of Optional Life Insurance with The Standard $ _____

Amount of Voluntary Life Insurance with The Standard $ _____

Amount of Additional Life Insurance with The Standard $ _____

Policy Class Number _____

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.

If premiums have already been terminated, give date paid through _____

6. Attachments

Please attach the following:

a. **Original** Enrollment card and any subsequent beneficiary changes
b. Copy of Job Description
c. Copy of Employment Application or Resume

Important Information Please Attach

7. Employer Representative Completing This Form *Please print or type.*

Employer _____ Representative _____

Address _____ ZIP _____

Phone (_____) _____ Fax (_____) _____ Policy Number _____

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 3 of this form.

Signature _____ Title _____ Date _____

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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.

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