TheStandard®

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability Benefits
Claim Packet Instructions

WELCOME TO STANDARD INSURANCE COMPANY

We realize that being disabled is difficult. Even though you are unable to work, your financial obligations don't go away. To help you through these difficult times, your employer has purchased "basic" long term disability (LTD) coverage. If you were eligible, enrolled for and have paid the required premiums, you may also have "supplemental" LTD coverage through Standard Insurance Company.

This packet contains the forms to apply for disability benefits under the State of Washington group policy. It also addresses common questions about benefit claims. **Please save this information for future reference.**

PLEASE READ CAREFULLY

Your application for benefits consists of four forms. **Every space on these forms should be filled in** to avoid delay in processing your application. If a section does not apply, or information is not available, **"NA"** should be written in the space so that we know you did not overlook that particular question. **If a form is received incomplete, it may be returned for completion. Each form must be completed and submitted to Standard Insurance Company.**

The four forms are:

1. **The Employee's Statement**
   - Answer every question completely. Be sure to use the appropriate section for injury, sickness or pregnancy. If a question does not apply to you write "NA".
   - Use an additional page, if necessary, to give full and complete answers.
   - Attach copies of any Social Security, Public Employees Retirement System, Workers' Compensation, TIAA/CREF or Higher Education Academic Retirement Plan, Labor & Industries, Shared Leave, Sick Leave or other benefit determinations you have received. If you have applied for any other benefits but have not yet received them, please send a copy of the application receipt. This information is needed to accurately calculate your monthly benefits. If you are unable to make copies of these documents please send the originals. We will photocopy and return them to you promptly.
   - Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

2. **The Authorization to Obtain Information**
   The Authorization to Obtain Psychotherapy Notes
   - Please sign and date the Authorization to Obtain Information and attach it to the Employee's Statement. Your signature enables The Standard to get the information about you that we need to determine your eligibility and entitlement for benefits. The Authorization to Obtain Information also lets The Standard release this information to specific persons.

     If you have seen or been treated by a Psychiatrist, Psychotherapist, Psychologist, Clinical Social Worker (MSW, MCSW, etc.), or any other provider of treatment for a mental condition, please sign and return the Authorization to Obtain Information ***and*** the Authorization to Obtain Psychotherapy Notes.

     You will receive copies of these Authorizations upon your request.

3. **The 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.** (You may request additional forms from your employer.) Your physician(s) should mail or fax the completed form directly to The Standard. Contact information is listed above.

4. **Employer's Statement**
   - This form should be completed by your employer, who will mail or fax it to The Standard. Contact information is listed above.

You are responsible for making sure all required forms are completed and returned to our office. Note: After the completed forms are received and evaluated by The Standard, further information may be necessary to make a decision on your claim. If so, we will notify you with details. Should you have any questions, our office is here to assist you.

Long Term Disability Benefit Amount

If your LTD claim is approved, and you continue to be disabled as defined by the group policy, benefits under the basic plan are payable after you have served the benefit waiting period of 90 days from the date you became disabled, the end of sick leave, or Washington State Paid Family & Medical Leave, whichever is longer. Under the supplemental plan, benefits are payable after you have served the 90 day benefit waiting period, or the end of sick leave, or Washington State Paid Family & Medical Leave, whichever is longer.

LTD benefits under the basic plan are paid monthly at 60% of your predisability earnings (up to a monthly maximum of $667), reduced by deductible income, including but not limited to PERS, TRS, SERS, sick leave, salary continuation (including shared leave), Social Security, Labor & Industries and a portion of your earnings from work (if working while disabled).

If you are insured under the supplemental plan, supplemental LTD benefits are paid monthly at 60% of your predisability earnings (up to a monthly maximum of $16,667), reduced by deductible income, including but not limited to PERS, TRS, SERS, sick leave, salary continuation (including shared leave), Social Security, Labor & Industries, a portion of your earnings from work (if working while disabled). This plan has a minimum benefit of $100 or 10% of the LTD benefit, whichever is greater.

It is your responsibility to notify The Standard if you receive income from other sources, including deductible income as specified in your group policy (or LTD Plan booket).

There may be an overpayment on your claim if The Standard is not promptly informed that you are receiving income from other sources (deductible income). Any overpayment must be repaid in full to The Standard.

Pre-existing Conditions

Your LTD coverage has a preexisting condition exclusion that may affect your entitlement to benefits if you have not been insured under the State of Washington group policy for at least 12 months. The exclusion may apply if:

1) you consulted a physician, received medical treatment or services, or took prescribed drugs or medications for a condition during the 90 days before the effective date of your LTD insurance; and

2) this condition (called a preexisting condition), or the medical or surgical treatment of this condition, caused or contributed to the condition for which you are filing a claim. Please consult your LTD Plan Booklet for additional information regarding this or other exclusions and limitations that may apply.

Payment of Benefits

If you qualify for LTD benefits, your monthly benefit checks will be mailed directly to the mailing address you provide to us. Your benefit check can also be directly deposited via electronic funds transfer into your bank account. If you are interested in this payment option, please contact the Benefits Analyst assigned to your claim. Benefits are paid monthly at the end of each monthly benefit period.

Tax Information

LTD benefits issued under the basic plan are subject to Federal and State taxes because the premiums are paid by your employer.

LTD benefits issued under the supplemental plan are not subject to Federal and State taxes because the premiums are paid by you, not your employer.

For specific tax information and advice you should consult your tax professional.

Questions

For specific information about your LTD coverage, please refer to your State of Washington LTD Plan booklet. The group policy is the ultimate authority for all claims decisions. If you do not have an LTD Plan booklet, you should contact your employer.

If Standard Insurance Company can be of service to you as you file your claim, please feel free to contact us. We look forward to working with you.

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability Benefits
Employee's Statement

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

Reset

1. EMPLOYEE

Full Name: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone No.: (_____) _____ Patient No.: _____

Birthdate: _____ Sex: ☐ Male ☐ Female

Name of Spouse: _____ Birthdate: _____

No. of dependent children: _____ Birthdate of youngest: _____

Did you receive an LTD Plan booklet? ☐ Yes ☐ No **If no, please contact your employer to obtain a copy.**

2. EMPLOYMENT

Name of Employer: **WA Health Care Authority School Employees Benefits Board (SEBB) Program** Group Policy No.: **756494**

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

State your job title and describe your duties at work.

Is your disability work-related? ☐ Yes ☐ No Date of injury: _____

Have you filed a Labor & Industries claim? ☐ Yes ☐ No If Yes, Labor & Industries claim #: _____

Last full day at work: _____

Date you became unable to work at your occupation as a result of disability: _____

Are you now or have you worked at your occupation or any other occupation since the date of your injury? ☐ Yes ☐ No

If yes, list names of employers, addresses, telephone numbers, and dates of employment.

Are you self-employed at any activity? ☐ Yes ☐ No

Date you resumed part-time work: _____ Work Phone: (_____) _____ Extension: _____

Date you resumed full-time work: _____ Work Phone: (_____) _____ Extension: _____

3. SICKNESS *Please list all illnesses which contribute to your being unable to work at your occupation.*

Illness: _____ Date First Noticed: _____

_____ Date First Noticed: _____

State what you believe caused your illness.

Describe your symptoms: _____

Have you ever had the same condition or a related illness before? ☐ Yes ☐ No Date: _____

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

4. INJURY

Describe Injuries: _____

Cause of Injuries: _____

Time, Date and Location of Injuries.

5. PREGNANCY

Date you expect to cease work: _____ Expected delivery date: _____

Actual delivery date: _____ Expected return to work date: _____

Please indicate any foreseeable complications.

6. ATTENDING PHYSICIAN *List all physicians consulted for this injury or illness. Use separate sheet, if needed.*

Physician's Name: _____ Specialty: _____ Phone No.: (____) _____

Street Address: _____ Fax No.: (____) _____

City: _____ State: _____ Zip Code: _____

Date first consulted for this injury or illness: _____ Date last consulted: _____

Physician's Name: _____ Specialty: _____ Phone No.: (____) _____

Street Address: _____ Fax No.: (____) _____

City: _____ State: _____ Zip Code: _____

Date first consulted for this injury or illness: _____ Date last consulted: _____

Physician's Name: _____ Specialty: _____ Phone No.: (____) _____

Street Address: _____ Fax No.: (____) _____

City: _____ State: _____ Zip Code: _____

Date first consulted for this injury or illness: _____ Date last consulted: _____

7. HOSPITAL *If you were hospitalized for this condition, please complete. Please attach copy of hospital bill if available.*

Hospital Name: _____ Address: _____

From: _____ through: _____ Reason for hospitalization: _____

From: _____ through: _____ Reason for hospitalization: _____

8. HISTORY *List all illnesses or injuries for which you have received treatment over the past five years. Use separate sheet if needed.*

Ailment	Date	Physician's Name	Complete Address

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

9. DEDUCTIBLE INCOME

Have you applied for or are you receiving benefits from:	**Applied** Yes No	**Receiving** Yes No	Date Applied For	Amount Received Weekly	Monthly	Effective Date
a. Social Security	☐ ☐	☐ ☐				
b. Washington State Paid Family & Medical Leave	☐ ☐	☐ ☐				
c. Labor & Industries Claim No. _____	☐ ☐	☐ ☐				
d. Shared leave and/or sick pay. Please Specify. _____	☐ ☐	☐ ☐				
e. Retirement or Pension (Employer, PERS, TERS, SERS, WSTRS, TIAA-CREF, etc.) Please specify type _____	☐ ☐	☐ ☐				
f. Other _____ (e.g., unemployment or union benefits, etc.)	☐ ☐	☐ ☐				

Please send copies of any letters or notices approving or denying benefits.

10. VOCATIONAL *Complete the following and/or attach a resume.*

Education level	Yes No	If no, last grade attended.	
Grade School Graduate	☐ ☐		
High School Graduate	☐ ☐		
GED	☐ ☐		
College Graduate	☐ ☐	Degree	Major
Post Graduate	☐ ☐	Degree	Major

Have you attended any trade schools or received other special training? ☐ Yes ☐ No
If yes, please describe.

Work Experience: *Complete the following starting with your most recent work experience.*

Job Title & Employer	Dates of Employment	Duties	Last Salary
1.	From: To:		
2.	From: To:		
3.	From: To:		
4.	From: To:		
5.	From: To:		

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 6 of this form.

SIGNATURE _____ DATE _____

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 employee for the purpose of defrauding or attempting to defraud the policyholder or employee 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

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.

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 except as noted above.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), 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 disability and leave of absence claim(s). 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 8 (if applicable). 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 Employee/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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. An absence manager may be hired by your employer and may be 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.

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.
- Any organization or entity administering a benefit or leave program (including statutory benefits.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record.

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 my disability or leave of absence claim(s), 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 disability and leave of absence claim(s). 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 10 (if applicable). 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 Employee/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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. An absence manager may be hired by your employer and may be 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.

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability Benefits
Attending Physician's Statement

PART A. TO BE COMPLETED BY PATIENT

Full Name: _____ Social Security No.: _____

Other Names Used: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Birthdate: _____ Patient No.: _____

Occupation: _____ Employer: **WA Health Care Authority School Employees Benefits Board (SEBB) Program** Group Policy No.: **756494**

I returned to work: Date _____ I expect to return to work: Date _____

PART B. TO BE COMPLETED BY PHYSICIAN

DEAR DOCTOR: The purpose of this form is to help us determine whether the clinical condition of your patient is disabling. We need documentation of functional impairment. Please include laboratory data and results of special tests (X-rays, CAT scan, EKG, etc.). Please attach copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes, and narrative reports.

The patient is responsible for the completion of this form without expense to The Standard. Forms may be returned for unanswered questions.

1. INFORMATION

Primary Diagnosis: ICD Code (_____) _____

Secondary Diagnosis: ICD Code (_____) _____

Other diagnoses and ICD Codes related to this claim.

Symptoms.

Patient's Height: _____ Weight: _____ BP _____ (Right arm) BP _____ (Left arm) Pulse _____ (Radial)

Is condition primarily related to:

a. Patient's Employment ☐ Yes ☐ No
b. Injury ☐ Yes ☐ No
c. Mental Disorder ☐ Yes ☐ No
d. Alcohol or Drug Condition ☐ Yes ☐ No
e. Pregnancy ☐ Yes ☐ No

Dominant Hand ☐ Left ☐ Right

Expected Delivery Date: _____

Para: _____ Gravida: _____ Actual Delivery Date: _____

Complications: _____ ☐ Vaginal ☐ Caesarean Section

2. HISTORY

If patient was referred to you, indicate by whom: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No

If yes, indicate when: _____ Describe: _____

Do, or have, other conditions contributed to this condition? ☐ Yes ☐ No

If yes, please explain: _____

Date patient first consulted you for **this** condition: _____ For **any** condition: _____

Dates of subsequent treatment: _____

Date of most recent visit: _____

If patient was hospitalized, please provide dates. Admitted: _____ Discharged: _____

Admitting Diagnosis: _____ Discharge Diagnosis: _____

Name of Hospital: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability Benefits
Attending Physician's Statement

Employee Name: _____

3. ASSESSMENT

Date you recommended patient should stop working: _____ Why? _____

Describe the patient's physical, mental and cognitive limitations and work activity limitations: _____

How long from today's date will the described limitations impair the patient? _____

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

4. TREATMENT

Planned course of treatment. (Please include expected duration, surgeries, therapy, etc.) _____

Medications prescribed: dosage, frequency and date of prescription(s). _____

List other treating or referring physicians. (Continue on separate page, if necessary.)

NAME	ADDRESS		
1.			
Phone No. ( )	City	State	Zip Code
2.			
Phone No. ( )	City	State	Zip Code

What reasonable work or job site modifications could the employer make to assist the individual to return to work? Please specify:

Assessment and treatment are complicated by:
- ☐ Malingering
- ☐ Significant emotional or behavioral disorder such as: ☐ Depression ☐ Anxiety ☐ Hysteria (Check pertinent areas.)
- ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.
- ☐ Dependence on drugs/medication. Specify: _____
- ☐ Other (please describe): _____

5. PROGNOSIS

Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
When do you expect a fundamental or marked change in patient's condition? ☐ Never ☐ Condition expected to regress ☐ Condition expected to improve

State anticipated date: _____ or, Unable to determine, follow up in: _____ months

When do you anticipate the patient can return to work? State anticipated date: _____ or, Unable to determine because of: _____

_____ follow up in: _____ months

Remarks: _____

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 13 of this form.

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Physician's Taxpayer ID No.: _____ Phone No.: ( ) _____ Fax No.: ( ) _____

**** Please send copies of chart notes, diagnostic, laboratory, and electrodiagnostic findings, as well as operative reports and hospital discharge summaries for the past years.***

Return to Standard Insurance Company at the address above.

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 employee for the purpose of defrauding or attempting to defraud the policyholder or employee 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

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
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability Insurance
Employer's Statement

1. Employee

Name of Employee _____

Address _____ City _____ State _____ ZIP Code _____

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 _____ ☐ supplemental _____

Work Location: Address _____ State _____ ZIP Code _____

Was employee given an LTD Plan booklet? ☐ 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 employee to work in another occupation, or modify or alter the job duties of the employee's occupation, how the job is done (i.e., work schedule), or worksite? ☐ Yes ☐ No If yes, what alternatives were offered to the employee?

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 Code _____

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, *earned after* disability		
Commissions, *earned after* disability		

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

5. Deductible Income/Benefits From Other Sources

Is employee covered by or now receiving benefits from the following?	Covered Yes	Covered No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Washington State Paid Family & Medical Leave	☐	☐	☐	☐	☐				
b. Social Security	☐	☐	☐	☐	☐				
c. Workers' Compensation	☐	☐	☐	☐	☐				
d. State Disability Insurance	☐	☐	☐	☐	☐				
e. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) *Please specify* _____	☐	☐	☐	☐	☐				
f. Other _____ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

6. 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
Railroad Tier 1 taxes? ☐ Yes ☐ No
State Disability taxes? ☐ Yes ☐ No
Medicare taxes? ☐ Yes ☐ No
Tier 1 Medicare 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? _____

7. 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.)

8. Employer Representative Completing This Form

Employer **WA Health Care Authority School Employees Benefits Board (SEBB) Program** Phone No. _____ Policy Number **756494**

Address _____ City _____ State _____ ZIP Code _____

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 16 of this form.

Signature _____ Date _____

Prepared by _____ Title _____

Phone No. ( ) _____ Fax No. ( ) _____

Standard Insurance Company
Employee Benefits Department 800.368.2860 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 employee for the purpose of defrauding or attempting to defraud the policyholder or employee 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

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.