



Your Disability Benefit Claim

This packet contains the forms necessary to apply for disability benefits. It also addresses common questions about Disability claims. **Please save this material for your future reference.** For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator or call our customer service line at 800.368.2859.

How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete the Employer's Statement on page 2, and mail or fax it to Standard Insurance Company, before giving the claim packet to you.
2. Complete and sign your part of the claim form (on page 4), and then have your treating physician complete their part of the claim form (the Attending Physician's Statement, also on page 4). If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefits administrator. Your physician may return the completed form to you for you to send to us with the other completed forms, or your physician may mail or fax the completed form to us directly, using the contact information at the top of the form.
3. Read the Claim Form Fraud Notice on page 5, then provide it to your treating physician with the Attending Physician's Statement.
4. Sign and date the Authorization and send it, along with the completed claim forms, to The Standard at the above address. This authorization allows us to request further information about your claim, if necessary.

Once we receive your completed claim application, it will take approximately one week to make a claim decision. If we have not reached a decision within one week, you will be notified with the details.

Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive, or may be eligible to receive, may reduce the amount of Disability benefits due you. Your coverage or group insurance certificate lists these benefits which may include, but are not limited to, sick leave, Workers' Compensation, State Disability, Social Security and Retirement.

To avoid a possible overpayment on your claim, which would need to be repaid to The Standard, please inform The Standard if you receive other benefits.

When You Return To Work

Your disability benefits usually stop when you return to work. **Be sure that you notify The Standard immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

To Be Completed By Employer

Employee's Full Name		Social Security No.	Birthdate
Employee's Home Address		State	ZIP
Work Location Address		State	ZIP
Job Title <i>Please attach a copy of the job description.</i>			*1. Date Employed
2. Is employee insured for Short Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Is employee insured for Long Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Is employee insured for Group Life Insurance through The Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No Was employee given Certificate(s) of Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		*4. Has the employee filed for: Workers' Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly Amount _____ Will the employee be using Paid Parental Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Expected Start Date _____ Expected End Date _____	
3. Is disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined			
*5. Employee's Earnings \$ _____ Check one <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Commission <input type="checkbox"/> Other <input type="checkbox"/> Shift Differential <input type="checkbox"/> Bonuses Date of last increase _____ Earnings prior to increase \$ _____		*6. Last active date at work 7. Job status when disability began: <input type="checkbox"/> Full-time (____ hours/week) <input type="checkbox"/> Part-time (____ hours/week)	
8. Date employee returned to work		9. Last date through which sick leave benefits were paid by employer	
*10. Last date through which any compensation was paid by employer		What type(s) of compensation was paid on this date?	
11. Is employee subject to: Social Security taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. What percentage of the STD premium does the employer pay? _____% What percentage of the LTD premium does the employer pay? _____% Are employer paid premiums included in the employee's salary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Are taxes withheld from employee paid premiums? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A IMPORTANT: Remember to calculate annually the premium contribution percentage information according to the IRS 3 year averaging rule for group coverage.	
13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer Name Postdoctoral Scholar Benefits Plan		Location Code (if applicable)	Phone No.
			Policy No. 643383
Mailing Address		City	State ZIP
Name of employer representative completing this form		Employer representative's Email Address	
Acknowledgement – I certify that the answers I have made to the above questions are 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 _____		Date _____	

* Must be completed to submit claim.

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 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

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.

To Be Completed By Employee *For a prompt review of your claim, ALL of this form must be thoroughly completed by the appropriate persons.*

Full Name		Employer/Company Name Postdoctoral Scholar Benefits Plan		Group Policy No. 643383	
Social Security No.	Phone No. ()	Birthdate		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate of Youngest Child
Address			City	State	ZIP
Email Address					
1. Is your disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No					
2. Do you plan to use Paid Parental Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Expected Start Date _____ Expected End Date _____					
3. Last date at work before disability _____ Date you returned or expect to return to work _____					
4. Cause of Disability: <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy If accident or illness, please explain (include date and location, if applicable)					
5. Please describe all work activity, including self-employment, since the start of your disability. If none, initial here _____					
Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form and will provide it to the physician completing the Attending Physician's Statement.					
Signature _____				Date _____	

To Be Completed By The Attending Physician

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to The Standard. Please complete this form and mail or fax it to The Standard using the contact information listed above.

1. Diagnosis		A. Diagnosis		ICDA Classification	
B. Symptoms			Height	Weight	B/P
2. Pregnancy (if applicable)	A. Expected date of delivery	B. Actual date of delivery		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section	
3. History and Treatment	A. Date you recommended the patient stop work		B. When did symptoms appear or accident happen?		
C. Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?					
D. Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			E. Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No		
F. Date of first visit for this condition	G. Frequency of subsequent visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		H. Date of most recent visit		
I. Describe planned course and duration of treatment					
J. Hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	K. Date Admitted	Date Discharged	L. Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	M. Date Surgery Completed/Scheduled	
N. Reason/Surgery Type			O. Surgery/Post-Surgery Complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe		
4. Level of Functional Impairment <i>Please attach recent chart notes/pertinent records.</i>					
A. Describe patient's physical and/or mental limitations and restrictions (functional capacity).					
B. Factors Delaying Recovery (if applicable)					
C. How long do you expect these limitations and restrictions to impair your patient? <input type="checkbox"/> Date _____ <input type="checkbox"/> Unable to determine, follow up in _____ weeks <input type="checkbox"/> Permanently					
5. Physician Information <i>Please type or print.</i>					
Name of physician completing this form			Specialty		Phone No. ()
Address			City	State	ZIP
					Fax No. ()
Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.					
Signature _____				Date _____	

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**Postdoctoral Scholar Benefits Plan
Authorization to Obtain and Release Information**

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 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 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) _____

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.

Postdoctoral Scholar Benefits Plan 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. 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.