TheStandard®

Standard Insurance Company
Employee Benefits Department 800.628.9696 Tel 800.437.0961 Fax
PO Box 2800 Portland OR 97208

south carolina peba state health plan | retirement systems

Long Term Disability Benefits Instructions

PLEASE READ CAREFULLY

NOTE: The South Carolina long term disability *(LTD)* program consists of the employer-provided fully self-funded Basic LTD plan number 627284 and the optional fully insured employee-paid Supplemental LTD plan under group policy 621144 issued by Standard Insurance Company. The Standard is acting only in an administrative capacity with respect to the self-funded Basic LTD plan. The State of South Carolina is ultimately responsible for payment or non-payment of claims under the self-funded Basic LTD plan. However, The Standard is ultimately responsible for payment or non-payment of claims under the Supplemental LTD policy.

Welcome to Standard Insurance Company

We realize that being disabled is difficult. Even though you are unable to work, your financial obligations do not go away. To help you through these difficult times, your employer has provided Basic LTD coverage for employees enrolled in the State Health Insurance Plan or HMO plan. If you were eligible, enrolled and 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 either State of South Carolina LTD plan. It also addresses common questions about benefit claims. **Please save this information for future reference.**

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.**

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, South Carolina Retirement System *(SCRS)*, Workers' Compensation, Leave Pool (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 calculate accurately 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 allows The Standard get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain Information also allows The Standard to release this information to certain state agencies.
   - 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 the completed form directly to The Standard.
4. **The Employer's Statement**
   - This first section (1) should be filled out by you. The rest of the form should be completed by your employer, who will mail it to The Standard.

NOTE: You are responsible for making sure the above listed forms are completed and returned to our office. 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 plan, Basic LTD benefits will be payable after the benefit waiting period of 90 days from the date you became disabled is completed. The Supplemental LTD plan offers either a 90 day or 180 day benefit waiting period.

LTD benefits under the basic employer-provided plan are paid monthly at the lesser of 1) 62.5% of the first $1,280 of your predisability earnings or 2) 62.5% of your predisability earnings less deductible income. Deductible income includes, but is not limited to, SCRS disability and service retirement benefits, sick leave, salary continuation *(including leave pool)*, Social Security primary benefits, Workers' Compensation, a portion of your earnings from work (if working while disabled), as well as income received from or on behalf of a third party because of your disability, whether by judgment, settlement or other method.

If you are insured under the supplemental plan, Supplemental LTD benefits are paid monthly at 65% of your predisability earnings *(up to a monthly maximum benefit of $8000.00 for members disabled after 9/1/00, $6500.00 for those disabled before 9/1/00)*, reduced by deductible income, including but not limited to SCRS disability and service retirement benefits, sick leave, salary continuation *(including leave pool)*, both primary and dependent Social Security benefits, Workers' Compensation, a portion of your earnings from work *(if working while disabled)*, income received from or on behalf of a third party because of your disability, and any benefits payable under the basic employer-provided LTD plan. This supplemental plan has a minimum benefit of $100.00 per month.

It is your responsibility to apply promptly for all deductible income you may be eligible to receive. As some income sources have strict application deadlines, please contact the income source directly for application details. **Specifically, SCRS requires that you must be still in service in order to apply for SCRS disability benefits.** There may be an overpayment on your claim if The Standard is not promptly informed that you are receiving income from other sources. Any overpayment must be repaid in full. This can occur if other income is awarded retroactively.

Preexisting Conditions

Your LTD coverage has an exclusion for preexisting conditions that may affect your right to receive benefits. The exclusion will apply if, during the 6 months before the effective date of your coverage, you consulted a physician, received medical treatment or services, or took prescribed drugs or medications for a mental or physical condition and that condition causes or contributes to your disability. However, this exclusion will not apply if:

1. you have been continuously covered under the plan for 12 months prior to your date of disability, or
2. a period of at least 12 consecutive months has elapsed since you last consulted a physician, received medical treatment or services, or took prescribed drugs or medications for the preexisting condition, and your coverage became effective during that period and remained continuously in effect until the date you became disabled.

Please consult your certificate or Insurance Benefits Guide 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 checks can be mailed directly to your bank account if you make your request in writing and provide a deposit slip with your account number. Benefits are issued by the end of each month in which payments are due.

Tax Information

LTD benefits issued under the basic employer-provided plan are subject to Federal and State taxes. We will use the current W-4 form on file with your employer to determine the amount of your federal income tax deduction. We will also withhold a mandatory 7% in State income tax for South Carolina residents. State tax for other states may vary. Contact our office for details.

LTD benefits issued under the supplemental plan are not subject to Federal and State taxes if you pay the premiums with after-tax dollars.

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

Questions:

For specific information about your LTD coverage, please refer to your Insurance Benefits Guide, Certificate of Coverage or Certificate of Insurance. The group policy or plan document is the ultimate authority for all claims decisions. If you do not have an Insurance Benefits Guide or certificate, you should contact your benefits administrator.

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.

Reset

Standard Insurance Company

Employee Benefits Department 800.628.9696 Tel 800.437.0961 Fax
PO Box 2800 Portland OR 97208

State of South Carolina
Long Term Disability Benefits
Employee's Statement

Please type or print. (Form may be returned for unanswered questions.)
NOTE: Standard Insurance Company is acting only in an administrative capacity for the Basic LTD Plan.

1. CLAIMANT

Full Name: _____ Social Security No.: _____

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

Phone No.: (_____) _____ Birthdate: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ Dominant Hand: ☐ Right ☐ Left

Name of Spouse: _____ Birthdate: _____

No. of Children under age 25: _____ Birthdate of Youngest: _____

Are you enrolled in the State Health Insurance Plan or HMO Plan *(required for coverage under Basic LTD Plan)*? ☐ Yes ☐ No

Are you enrolled in the Supplemental LTD Plan and have you paid the required premiums? ☐ Yes ☐ No

Are you enrolled in another LTD Plan? ☐ Yes ☐ No Name of Carrier: _____

Address: _____

Did you receive a Certificate of Coverage or Insurance for each effective coverage? ☐ Yes ☐ No

Insurance Benefits Guide? ☐ Yes ☐ No If no, please contact your employer to obtain a copy.

2. EMPLOYMENT

Name of Agency/Institution: _____

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 Workers' Compensation claim? ☐ Yes ☐ No If Yes, W.C. Claim No.: _____

Last full day at work: _____

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

Are you now working 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 Monthly Earnings: _____

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: _____

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. DISABILITY

Explain how your illness or injury prevents you from working at your occupation: ______

______

Do you feel a third party is responsible for your disability, or has made your condition worse? ☐ Yes ☐ No

If yes, please explain, giving name of third party. ______

______

Do you plan to bring a claim or lawsuit against this third party? ☐ Yes ☐ No

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

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

Address: ______ City: ______ State: ____ Zip Code: ______

Date First Consulted for this injury or illness: ______ Date Last Consulted: ______

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

Address: ______ City: ______ State: ____ Zip Code: ______

Date First Consulted for this injury or illness: ______ Date Last Consulted: ______

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

Address: ______ City: ______ State: ____ Zip Code: ______

Date First Consulted for this injury or illness: ______ Date Last Consulted: ______

8. HOSPITAL

Hospital Name: ______ Address: ______

From: ______ through: ______ Reason for hospitalization: ______

From: ______ through: ______ Reason for hospitalization: ______

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

Ailment	Date	Medical Professional's Name	Complete Address & Phone No.

Standard Insurance Company

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PO Box 2800 Portland OR 97208

State of South Carolina
Long Term Disability Benefits
Employee's Statement

10. DEDUCTIBLE INCOME

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. Retirement or Pension *(Employer, SCRS, ORP, etc.)* Please specify type _____	☐	☐	☐	☐				
d. Leave Pool or Shared Leave	☐	☐	☐	☐				
e. Third party income: weekly time loss, or from judgment, settlement or other award (related to current condition)	☐	☐	☐	☐				
f. Short term or long term disability benefits from another carrier	☐	☐	☐	☐				
g. Other: _____ *(e.g., unemployment or union benefits, etc.)*	☐	☐	☐	☐				

Please send copies of any letters or notices you have now or receive in the future which approve or deny benefits, to allow us to properly calculate disability payments.

11. 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. _____

_____

Licenses or certificates? ☐ Yes ☐ No

If yes, please describe. _____

_____

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

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

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 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 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.

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.
- Any insurance or annuity company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program or an annuity program.
- Any educational, vocational or rehabilitational 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, 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, or eligibility for other benefits including retirement benefits and retirement plan contributions *(for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO STANDARD INSURANCE COMPANY, AND IF BENEFITS ARE CLAIMED UNDER THE BASIC EMPLOYER-PROVIDED LTD PLAN, THE INFORMATION MAY ALSO BE GIVEN TO THE STATE OF SOUTH CAROLINA, EMPLOYEE INSURANCE PROGRAM AND VOCATIONAL REHABILITATION DEPARTMENT.

- 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 The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. 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 Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I understand that The Standard complies with State and Federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations *(if applicable)* on the following page. 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/Guardian/Representative Date

This Authorization is a two-page document. Please see page 8 for additional terms and information. Both pages are part of the Authorization.

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.

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; and
- Any hospital, clinic, or other medical or medically related facility or association.

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, AND IF BENEFITS ARE CLAIMED UNDER THE BASIC EMPLOYER-PROVIDED LTD PLAN, THE INFORMATION MAY ALSO BE GIVEN TO THE STATE OF SOUTH CAROLINA, EMPLOYEE INSURANCE PROGRAM AND VOCATIONAL REHABILITATION DEPARTMENT.

- 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 The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. 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 Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I understand that The Standard complies with State and Federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations (if applicable) on the following page. 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/Guardian/Representative	Date

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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.

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Standard Insurance Company

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State of South Carolina
Long Term Disability Benefits
Attending Physician's Statement

NOTE: Standard Insurance Company is acting only in an administrative capacity for the Basic LTD Plan.

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.: _____

Health Plan: _____

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 due to unanswered questions.)

The following information is needed to document the Patient's inability to work:

1. DIAGNOSIS

A. Primary Diagnosis: _____ ICDA Classification: _____

B. Secondary Diagnosis *(related to patient's disability):* _____

C. Current Symptoms: _____

_____

D. Objective findings *(Clinical Exam, Imaging Studies, Lab Results):* _____

_____

E. Patient's Height: _____ Weight: _____ Most recent blood pressure: _____ Pulse: _____

2. PREGNANCY *(If applicable.)*

Expected date of delivery: _____ Anticipated to be normal? ☐ Yes ☐ No

Actual date of delivery: _____ Type of delivery: ☐ Vaginal ☐ Caesarean Section

3. HISTORY

A. When did symptoms appear or accident happen? _____

B. Did you recommend to the patient to stop work? ☐ Yes ☐ No

If yes, as of what date: _____

Why? _____

If no, who recommended that the patient stop work? _____

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when? _____

Describe: _____

D. Is the condition related to the patient's employment? ☐ Yes ☐ No ☐ Undetermined

E. Did you complete a Workers' Compensation Report for this condition? ☐ Yes ☐ No

F. Who was the patient referred to you by: _____

4. TREATMENT

A. Date patient first consulted you for this condition: _____ , for any condition: _____

B. Dates of subsequent visits: _____

C. Date of most recent visit: _____

D. Treatment Plan *(include surgery, physical therapy, psychiatric counseling):* _____

_____

E. Medications: _____

_____

F. Response to Treatment Plan: _____

_____

Standard Insurance Company

Claims Administrator 800.628.9696 Tel 800.437.0961 Fax
PO Box 2800 Portland OR 97208

State of South Carolina
Long Term Disability Benefits
Attending Physician's Statement

5. PHYSICAL CAPACITIES

A. Based on the patient's physical limitations and restrictions, he/she can *(circle the appropriate level of ability):*

Frequently lift *(in pounds):*	50+	50	20	10	0				
Maximum lift:	50+	50	20	10	0				
Walk/Stand at one time (in hours):	8	7	6	5	4	3	2	1	0
Walk/Stand in an 8-hour work day:	8	7	6	5	4	3	2	1	0
Sit at one time (in hours):	8	7	6	5	4	3	2	1	0
Sit in an 8-hour work day:	8	7	6	5	4	3	2	1	0

Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently Fine Manipulation: Right: ☐ Yes ☐ No
Grasp: ☐ Never ☐ Occasionally ☐ Frequently Left: ☐ Yes ☐ No
Reach: ☐ Never ☐ Occasionally ☐ Frequently

6. LEVEL OF FUNCTIONAL IMPAIRMENT

A. The patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

B. Describe the patient's mental and cognitive limitations and restrictions: _____

C. Is this 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

D. Other impairments *(please be specific):* _____

E. Dominant hand: ☐ Right ☐ Left

7. HOSPITALIZATION

A. Date admitted: _____ Date discharged: _____ Date surgical procedure performed: _____

B. Reason for admittance to hospital: _____

C. Describe nature of any surgical procedure performed: _____

D. Outcome: _____

Name of hospital: _____

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

8. OTHER TREATING MEDICAL PROFESSIONALS *(if known)*

A. Name: _____ Specialty: _____
Address: _____ City: _____ State: _____ Zip Code: _____

B. Name: _____ Specialty: _____
Address: _____ City: _____ State: _____ Zip Code: _____

9. PROGNOSIS

A. Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed

B. When do you expect a fundamental or marked change in patient's condition? _____
☐ Unable to determine, follow up in _____ weeks _____ months ☐ Never

C. When do you anticipate the patient can return to work?
Full-time: _____ Part-time: _____ (_____ hrs/day,_____ number days/weeks)
☐ Unable to determine, follow up in _____ weeks _____ months ☐ Never

D. What reasonable work or job site modifications could the employer make to assist the individual to return to work? _____

E. Assessment and Treatment are complicated by: ☐ Malingering ☐ Significant exaggeration, inconsistent findings ☐ Dependence on drugs/medications

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

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 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.: (_____) _____

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 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.

Standard Insurance Company

Employee Benefits Department 800.628.9696 Tel 800.437.0961 Fax
PO Box 2800 Portland OR 97208

State of South Carolina
Long Term Disability Benefits
Employer's Statement

Please type or print. Form may be returned for unanswered questions.
NOTE: Standard Insurance Company is acting only in an administrative capacity for the Basic LTD Plan.

1. EMPLOYEE

Full Name: _____ Social Security No.: _____

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

Phone No.: (_____)_____ Birthdate: _____

2. INFORMATION

Job Title: _____ Date Employed: _____
(Please attach a copy of position description.)

Employee's work location *(agency/institution):* _____ Group No.: _____

Employee's coverage effective date: ☐ State Basic LTD _____

☐ Supplemental LTD _____ ☐ 90-day ☐ 180-day Benefit Waiting Period

Is employee currently insured with another carrier for disability coverage? ☐ Yes ☐ No Carrier: _____

Did employee receive a certificate of coverage for each appropriate plan? ☐ Yes ☐ No ☐ Don't Know *(Please forward Certificate of Coverage for State Basic LTD plan for covered employee when filing disability claim.)*

Last day of work before disability commenced: _____

Date employee returned to work after disability ended: _____

Is medical condition due to employment? ☐ Yes ☐ No ☐ Undetermined

Workers' Compensation claim? ☐ Yes ☐ No Carrier Name: _____

Claim No.: _____ Address: _____

Have you considered allowing the employee to work in another occupation, or to modify and/or alter the job duties of the current occupation?

☐ Yes ☐ No Please explain: _____

_____

On FMLA? ☐ Yes ☐ No Effective date: _____ through: _____

Is employee terminated? ☐ Yes ☐ No Effective: _____ Reason: _____

Is employment scheduled for termination? ☐ Yes ☐ No Effective: _____ Reason: _____

Hours worked per week before disability commenced: _____

Date sick leave benefits paid through: _____ Salary continuation from: _____ through: _____

Is Claimant on LWOP? ☐ Yes ☐ No Effective: _____ through: _____

3. SALARY *(Earnings as of last day worked before disability commenced)*

Regularly paid _____ hours per week, excluding overtime.

Please check ONE:

☐ Basic Yearly Earnings $ _____

☐ Basic Monthly Earnings $ _____ for _____ months per year

☐ Basic Hourly Earnings $ _____ for _____ months per year **OR** _____ days per year

☐ Basic Contract Earnings $ _____ 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: $ _____

Yearly employment schedule, indicate: ☐ 12-month period ☐ Other *(i.e. contract days, 9 mos., etc.):* _____

Standard Insurance Company

Employee Benefits Department 800.628.9696 Tel 800.437.0961 Fax
PO Box 2800 Portland OR 97208

State of South Carolina
Long Term Disability Benefits
Employer's Statement

4. DEDUCTIBLE INCOME

Is employee eligible for or now receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Optional Retirement Plan Acct. No.: _____ ☐ TIAA/CREF or ☐ Other: _____	☐	☐	☐	☐	☐				
b. PORS	☐	☐	☐	☐	☐				
c. SCRS	☐	☐	☐	☐	☐				
d. GARS	☐	☐	☐	☐	☐				
e. JRS	☐	☐	☐	☐	☐				
f. Social Security	☐	☐	☐	☐	☐				
g. Workers' Compensation **Claim No.:** _____	☐	☐	☐	☐	☐				
h. Leave Pool or Shared Leave	☐	☐	☐	☐	☐				
i. Other: _____ (e.g. short-term disability insurance, another long-term disability plan, unemployment or union benefits, etc.)	☐	☐	☐	☐	☐				

If this employee does not belong to SCRS, please provide our office with the name and telephone number of the contact person for this employee's retirement plan.

Person to contact: _____ Telephone: (_____) _____

5. TAX INFORMATION

Is this employee subject to Social Security taxes? ☐ Yes ☐ No

If yes, what are the employee's year-to-date Social Security wages? _____

If the employee has Supplemental LTD Coverage:

What percentage of the Supplemental LTD premium does the employer pay? _____ %

the employee pay? _____ %

Are Supplemental LTD premiums paid with pre-tax dollars under a Section 125 or cafeteria plan? ☐ Yes ☐ No

Has this Supplemental LTD contribution percentage changed within the last three years? ☐ Yes ☐ No

Are employer paid premiums included in the employee's salary? ☐ Yes ☐ No

Employer's Federal Tax ID Number: _____

6. ATTACHMENTS *(Please check and attach copies of the following)*

☐ Employee's current W-4 form, include withholding allowances

☐ EBS printout of the subscriber's coverage (using the subscriber inquiry - print the information displayed in the coverage tab).

☐ Job class specification and position description

☐ Employment Application or Resume

☐ Deductible Income Documents (Social Security, Workers' Compensation, SCRS, etc.) if available

7. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: _____ Phone No.: _____ Policy No.: _____

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

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 applicable fraud notice on page 16 of this form.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

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

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