Standard Insurance Company
Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Long Term Disability Insurance
Employee's Statement

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

1. Claimant

Full Name _____ Social Security No. _____

Address _____ City _____ State _____ ZIP _____

Phone No. (_____) _____

Birthdate _____ Sex ☐ Male ☐ Female Height _____ Weight _____

Name of Spouse _____ Birthdate _____

No. of Dependent Children _____ Birthdate of Youngest _____

Did you receive a Certificate of Insurance? ☐ Yes ☐ No Did you receive a Brochure? ☐ Yes ☐ No
If you did not receive a Certificate of Insurance or Brochure, please contact your employer to obtain a copy.

2. Employment

Name of Employer _____ Group Policy No. _____

Address _____ City _____ State _____ ZIP _____

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 number _____

Last full day at work _____

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

Are you now working at, 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 _____

Illness _____ 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 800.368.1135 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Long Term Disability Insurance
Employee's Statement

Claimant's Name _____

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_____

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

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

Street Address _____ Fax No. (____) _____

City _____ State _____ ZIP_____

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

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

Street Address _____ Fax No. (____) _____

City _____ State _____ ZIP_____

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 800.368.1135 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

Claimant's Name _____

9. Deductible Income/Benefits From Other Sources

Your Group Disability plan is designed so that the income you receive from Standard Insurance Company and other sources (e.g., Social Security, Workers' Compensation, retirement system, and other income or benefits as described in your Group Policy as deductible income or benefits) combined will provide you with a percentage of predisability earnings, as defined in your Group Policy. Please review your Group Policy to determine how receipt of or eligibility for deductible income or benefits may impact your disability benefits. Please review your obligation to keep Standard Insurance Company informed of your application for and receipt of deductible income or benefits. Additionally, your Group Policy may allow Standard Insurance Company to reduce your disability benefit by estimated deductible income or benefits you are eligible to receive even if you have not applied for them. If your Group Policy states that Social Security benefits will be "deemed payable" even if not received, we will deduct from your disability benefit an estimated Social Security benefit for you and your dependents, based on your Social Security wage record. Please also understand that when deductible income or benefits are awarded you may receive a retroactive award (earlier date) and payment. This retroactive payment may result in an overpayment of your disability benefits because you would receive deductible income or benefits for a period during which you already have received disability benefits from Standard Insurance Company.

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. State Disability Insurance	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) *Please specify* _____	☐	☐	☐	☐				
e. 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:		

11. 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 5 of this form.

Signature _____ **Date** _____

Standard Insurance Company
Employee Benefits Department 800.368.1135 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 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.