



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.**

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, State Teachers Retirement System, Workers’ Compensation 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 and Release Information The Authorization to Obtain and Release Psychotherapy Notes

- Please sign and date the Authorization to Obtain and Release Information and attach it to the Employee’s Statement. Your signature lets Standard Insurance Company (The Standard) get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain and Release 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 and Release Information **and** the Authorization to Obtain and Release 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.** Your physician(s) should mail the completed form directly to The Standard.

4. The Employer’s Statement

- This form should be completed by your employer, who will mail it to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. If you have any questions, our office is here to help you.

**Disability Insurance
Employee's Statement***Please print clearly. Form may be returned for unanswered questions.***1. CLAIMANT**

Last Name: _____		First Name: _____	
Middle Name: _____		Suffix: _____	
Social Security No.: _____		Email: _____	
Preferred Language: _____		Address: _____	
City: _____		State: _____	
Zip Code: _____		Phone No.: _____	
Patient No.: _____		Birthdate: _____	
Gender: ☐ Male ☐ Female		Height: _____	
Weight: _____		Did you receive a Certificate of Insurance? ☐ Yes ☐ No	
Did you receive a Brochure? ☐ Yes ☐ No		If no, please contact The Standard.	

2. EMPLOYMENT

School District Name: _____		Group Policy No.: _____	
Address: _____			
City: _____		State: _____	
Zip Code: _____		Phone No.: _____	
Have you transferred school districts this year? ☐ Yes ☐ No		Job title: _____	
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: _____			
Have you returned to work? ☐ Yes ☐ No		Full-time ☐ Part-time ☐ Date: _____	
Are you self-employed at any activity? ☐ Yes ☐ No		Work Phone: _____	

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

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: _____	

4. INJURY

Describe Injuries: _____	
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5. PREGNANCY

Date you expect to cease work: _____		Expected delivery date: _____	
Actual delivery date: _____		Expected return to work date: _____	
Delivery Type: C-Section ☐ Vaginal Delivery ☐			

Standard Insurance Company

CTA Benefits and Services
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390
CTAService@standard.com

Disability Insurance Employee's Statement

Claimant's Name: _____

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

Physician's Last Name: _____	First Name: _____
Specialty: _____	Phone No.: _____ Fax No: _____
Address: _____	
City: _____	State: _____ Zip Code: _____
Date first consulted for this injury or illness: _____ Date last consulted: _____	

Physician's Last Name: _____	First Name: _____
Specialty: _____	Phone No.: _____ Fax No: _____
Address: _____	
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: _____	
City: _____	State: _____ Zip Code: _____
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 of treatment: _____
Physician's Last Name: _____	First Name: _____
Address: _____	
City: _____	State: _____ Zip Code: _____

Ailment: _____	Date of treatment: _____
Physician's Last Name: _____	First Name: _____
Address: _____	
City: _____	State: _____ Zip Code: _____

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Disability Insurance Employee's Statement

Claimant's Name: _____

DEDUCTIBLE INCOME/INCOME FROM OTHER SOURCES

Your Group Disability plan is designed so that the income you receive from The Standard and other sources (Social Security, Workers' Compensation and other benefits as described in your Group Policy) will equal the percentage described in your Group Policy. You should check your Group Policy to determine how other benefits may impact your disability benefits. You must send The Standard copies of all of your benefit determinations and related determinations. The policy under which you are insured may require that The Standard benefit payment be reduced by actual or estimated benefits payable from additional sources.

9. DEDUCTIBLE INCOME

Have you applied for or are you receiving benefits from:	Applied		Receiving		Date Applied For	Amount Received		Effective Date
	Yes	No	Yes	No		Weekly	Monthly	
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, etc.) Please specify type _____	☐	☐	☐	☐				
e. Other _____ (e.g., unemployment or union benefits, etc.)	☐	☐	☐	☐				

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

10. INCOME FROM OTHER SOURCES

Are you receiving income from:	Effective Date	Daily Amount Received	Limit Date
a. Substitute Differential Pay			
b. Fully Paid Sick Leave			

11. STUDENT LOAN INFORMATION FOR VOLUNTARY DISABILITY PARTICIPANTS

As a participant in the CTA-endorsed Disability Insurance plan, you may be eligible for Student Loan benefits. If you are currently paying on a student loan*, **please provide our office with a student loan statement from the Financial Lending Institution holding the loan, showing the total balance owing on the loan, dated within 60 days from your date of Disability.**

*Student Loan does not include your credit card debt or any loan for which a parent is legally liable.

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

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 HAMPSHIRE RESIDENTS

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO RESIDENTS

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

TEXAS RESIDENTS

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.

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.

Authorization to Obtain and Release Information

Employer/Policyholder Name _____ Group Policy Number _____

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 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 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) _____ Claim Number _____

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.

Standard Insurance Company

CTA Benefits and Services
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390
CTAService@standard.com

Authorization to Obtain and Release Information

Employer/Policyholder Name _____ Group Policy Number _____

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

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Authorization to Obtain and Release Psychotherapy Notes

Employer/Policyholder Name _____ Group Policy Number _____

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 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 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 9. 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. _____

Claim Number _____

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.

Authorization to Obtain and Release Psychotherapy Notes

Employer/Policyholder Name _____ Group Policy Number _____

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.

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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.

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Standard Insurance Company

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Disability Insurance Attending Physician's Statement

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		School District Name		Group Policy No.	
Social Security No.	Phone No.	Birthdate		Gender	Occupation
Address		City		State	ZIP
Email Address		Patient No./MRN			

To Be Completed By The Attending 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. Forms may be returned for unanswered questions.

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	☐ Vaginal ☐ C-section	
3. History and Treatment		A. Date you recommended the patient stop work (MM/DD/YYYY)		B. When did symptoms appear or accident happen?	
C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?					
D. Is this condition related to the patient's employment? ☐ Yes ☐ No			E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No		
F. Date of first visit for this condition		G. Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other _____		H. Date of most recent visit	
I. Describe planned course and duration of treatment					
J. Hospitalization? ☐ Yes ☐ No	K. Date Admitted	Date Discharged	L. Surgery? ☐ Yes ☐ No	M. Date Surgery Completed/Scheduled	
N. Reason/Surgery Type			O. Surgery/Post-Surgery Complications? ☐ Yes ☐ No If yes, please describe		
4. Level of Functional Impairment Please attach recent chart notes/pertinent records.					
A. Describe patient's physical and/or mental limitations and restrictions (functional capacity).					
B. Factors Delaying Recovery (if applicable)					
C. When do you anticipate the patient can return to work? ☐ Date _____ ☐ Unable to determine, follow up in _____ weeks ☐ Never					
5. Physician Information Please type or print.					
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 11 of this form.					
Signature _____				Date _____	

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

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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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.

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Disability Insurance Employer's Statement

Policy No.: _____ ☐ Voluntary Insurance Coverage ☐ District Paid Insurance Coverage

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

1. EMPLOYEE

Name of employee: _____	
Address: _____	City: _____ State: _____ Zip Code: _____
Job Title: _____	
Class: ☐ Certificated	☐ Classified ☐ Other: _____
Phone No.: _____	Email: _____
Date Employed: _____	Social Security No.: _____

2. INFORMATION

Last day worked: _____		Number of hours worked on last day: _____		First full day of absence for this disability (mo/da/yr): _____	
Status on day of disability: ☐ Full-time ☐ Part-time ☐ 11 or 12 month employee					
Insured premiums paid to date: ☐ Yes ☐ No		Are you required to make Medicare contributions for this employee? ☐ Yes ☐ No			
Are you required to make Social Security contributions for this employee? ☐ Yes ☐ No					
Does the employee participate in your formal retirement plan? ☐ STRS ☐ PERS ☐ Other _____					
Is employment terminated? ☐ Yes ☐ No		Date of termination: _____			
Has employee returned to work? ☐ Full-time _____		☐ Part-time _____		Return date _____	
Was this disability due to occupational cause? ☐ Yes ☐ No		If yes, include name and address of Workers' Compensation carrier: _____			
Workers' Compensation carrier Telephone No.: _____					

3. SALARY & CALENDAR AT TIME OF DISABILITY

Salary as of last day worked:	Hourly: _____	Monthly: _____	Annual Contract: _____
Average number of hours worked: Day: _____	or Week: _____	Total days of required attendance this school year: _____	
Daily rate of pay: _____	First required day of attendance: _____	Last required day of attendance: _____	
Spring vacation starts – and ends: _____	– _____	Winter vacation starts – and ends: _____	– _____
Does employee work a customized calendar work schedule? ☐ Yes ☐ No If yes, attach calendar.			

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Total number of Sick Leave days available at the start of disability: _____		From date: _____	To date: _____
Is employee receiving: ☐ Substitute Differential Pay ☐ Half Pay ☐ Other _____	From date: _____ To date: _____		
Sub pay rate: _____	Will Sub pay rate change? ☐ Yes ☐ No	If yes, date: _____	Sub pay rate change amount: _____
Is employee receiving any other pay (i.e., Catastrophic Leave, maternity leave pay, etc.)? ☐ Yes ☐ No			
Type of pay: _____	Full Pay ☐ Yes ☐ No	If no, rate of pay _____	

Standard Insurance Company

CTA Benefits and Services
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390
CTAService@standard.com

Disability Insurance Employer's Statement

Claimant's Name: _____

5. EXTRA DUTY PAY

***Extra Duty Pay** includes, but is not limited to, income received from coaching, after-school programs, summer school sessions, advising or mentoring stipends. Extra duty pay must be defined in a special contract or letter of agreement between the insured and the district. It does not include additional compensation such as overtime pay, bonuses or district-funded fringe benefits.

Attach a copy of the agreement and the work schedule.

Did employee have an Extra Duty Pay contract in place prior to their last day of work? ☐ Yes ☐ No

If yes, will they continue to be paid the Extra Duty Pay while out on Disability? ☐ Yes ☐ No

6. LIFE INSURANCE

Was employee covered by Group Life Insurance with The Standard on cease work date? ☐ Yes ☐ No

If yes, list policy number(s): _____

Please attach Enrollment form(s), if applicable.

Dependent's coverage? ☐ Yes ☐ No

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. TAX INFORMATION

Does this employee pay all or a portion of the premium for Disability Benefits insurance coverage? ☐ Yes ☐ No ☐ Pre-tax ☐ Post-tax

*If yes, what percentage of the Disability Benefits premium does the employer pay _____ %.

***IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.**

8. ATTACHMENTS

Please attach copies of the following.

- | | | |
|-------------------------------------|--|--------------------------------------|
| a. Job Description | c. Income From Other Sources (Deductible Benefits) Documents | d. Enrollment form(s), if applicable |
| b. Employment Application or Resume | (Social Security, Worker's Compensation, PERS, etc.) | e. Calendar |

9. SCHOOL DISTRICT REPRESENTATIVE COMPLETING THIS FORM

Employer/School District Name: _____ Phone No.: _____ Policy Number: _____

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 14 of this form.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

Phone No.: _____ Extension: _____ Employer Email Address: _____

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 HAMPSHIRE RESIDENTS

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO RESIDENTS

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

TEXAS RESIDENTS

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.

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.

