TheStandard®

The Standard Life Insurance Company of New York
888.569.0162 Tel 833.289.5002 Fax
PO Box 5180 Portland OR 97208
SupplementalNewClaim@standard.com

Reset

Hospital Indemnity Benefits Claim Instructions

Your Hospital Indemnity Benefit Claim

This packet contains the forms necessary to apply for Hospital Indemnity Benefits. 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, write **"NA"** 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.** For specific information about your Hospital Indemnity insurance coverage, refer to your group insurance certificate. The group policy and certificate are the ultimate authority for Hospital Indemnity Benefit claim decisions.

How to Apply For Benefits

Please complete the following forms included in this Hospital Indemnity Benefits Claim Packet. Refer to your group insurance certificate for covered benefits.

1. **Employee's Statement**

   Answer all questions that apply to this Hospital Indemnity Claim.

   Please attach the following, where applicable:

   ☐ A copy of the **hospital bill**. Make sure the bill includes the Patient's diagnosis and the number of days they were in the hospital.

   ☐ A copy of any **other bill**s pertaining to this claim.

   Additional evidence may be required in order to determine payment of additional benefits under the group insurance certificate. Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

2. **Authorization to Obtain and Release Information**

   Please sign and date the Authorization to Obtain and Release Information and attach it to the Employee's Statement. Your signature lets The Standard Life Insurance Company of New York (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.

3. **Attending Physician's Statement**

   Please complete Section A of the form.

   Your physician will need to complete all remaining sections. **If you have seen more than one physician for your hospitalization, a statement should be completed by each physician.** Your physician(s) should mail or fax the completed form directly to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. If you submit claim information by email, please keep in mind that communications via email are not secure. While unlikely, there is a possibility that information can be intercepted in transmission or misdirected and read by other parties besides the person to whom it is addressed. Please consider communicating any sensitive information by fax or mail. If known, please include your Employer Name and Policy Number, Insured's Name and Claim Number on documentation submitted. If you have any questions, please contact your benefit administrator or call our customer service line at 888.569.0162.

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Hospital Indemnity Benefits Employee's Statement

A. About the Insured

Full Name		Employer/Company Name	
Group Policy No.	Social Security No.	Date of Birth	
Gender ☐ Male ☐ Female ☐ X	Phone No.	Mailing Address	
City		State	Zip

B. About the Patient – Check One ☐ You ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Child

If the Insured is the Patient, then you do not need to complete this section again.

Full Name	Social Security No.	
Phone No.	Date of Birth	Gender ☐ Male ☐ Female ☐ X

C. About the Claim

Why was the Patient hospitalized? _____

_____

If due to an injury, what was the date of the injury? _____

If due to a sickness, what was the initial Diagnosis date? _____

Please list recent hospital visit(s)/admission(s) for this Claim. Include additional information on a separate sheet of paper if needed.

Hospital Name				
Date Admitted	Date Discharged			
Address	City	State	Zip	County
Phone No.	Fax No.			

Fraud Notice – 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 above fraud notice.

Signature of Insured _____ Date _____

Sign Up for Digital Payments

Have you signed up for digital payments yet? If so, you can disregard this notice.

Get your claim payment faster with digital payments with The Standard. If your claim is approved, you can choose to have benefits paid to you via Zelle or direct deposit[1].

How do digital payments work?

1. Your digital payment eligible claim is approved[2]
2. You'll receive an email or text notification with a link to choose your payment preference[3]
3. Follow the link to complete digital payment setup

To sign up for digital payments[4], choose one of the following options:

1. **Fastest Option:** Call or text "HELLO" to 888.937.4783 and follow the prompts to choose your payment preference and to provide employee and employer information.
1. **Additional Option:** Complete and submit the form below:
   - Fax to: 888.878.3686
   - Mail to: The Standard Life Insurance Company, P.O. Box 2800, Portland, OR 97208

Digital Payment Sign Up Form

Employee First Name _____ Employee Last Name _____

Employee DOB (MM/DD/YY) _____ Employee Zip Code _____

Employer Name _____

Check "✓" to indicate preferred payment method.

Digital payment (Zelle or direct deposit) ☐ Payment by check ☐

Your contact details

Enter the mobile number or email address where you will receive notifications. This information is required for Zelle or direct deposit.

Mobile: _____ Email: _____

Email notifications will come from notification@thepaychoice.com. Text messages will come from **26489 or 21239**.

The payment method you choose can be saved for any recurring payment you may receive. **If you don't choose a notification method, we may use the method we have on file or mail a check.**

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1 By electing to receive claim payments digitally, we're not guaranteeing approval of your claim.
2 Not all benefits are eligible for digital claim payments.
3 If your claim is approved and you do not respond to the text or email notification with your preferred payment option within (3) calendar days, The Standard will automatically send a paper check.
4 If you elect to receive claim payments digitally, you authorize use of the information you provide to access your bank account information for the purpose of facilitating payment transactions.

The Standard Life Insurance Company of New York | standard.com

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products in New York are offered by, and the sole responsibility of, The Standard Life Insurance Company of New York of White Plains, New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

Authorization to Obtain and Release Information

This authorization applies to the records of _____ who is hereinafter referred to as **"Individual"**.
(Print legibly)

I AUTHORIZE THESE PERSONS having any record or knowledge of Individual:

- Kaiser Permanente, any other health care provider, medical practitioner, coroner, prescription service, hospital, clinic, pharmacy, or other medical or medically related facility or association.
- Any health plans and insurance companies.
- Any employer, policyholder or plan sponsor.
- Any entity administering a benefit, leave or 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, Law Enforcement, 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, death certificate, autopsy or toxicology reports, and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis, treatment and recommendations 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.
- Any non-medical information requested about Individual, including such things as investigative reports, including accident or incident reports, 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 any authorized representative for one or both of them (hereinafter all collectively referred to as "The Companies") AND my Employer's Absence Management Program Administrator ("Absence Manager").

I ACKNOWLEDGE AND UNDERSTAND:

- Any prior restrictions on disclosure of Individual's protected health information do not apply to this authorization and I instruct the persons and organizations identified above to disclose Individual's entire medical record without restriction;
- Each of The Companies and Absence Manager will gather Individual's information only if they are administering or deciding any claim(s) for benefits or leave of absence applicable to Individual, and will use the information to determine Individual's eligibility or entitlement for benefits or leave of absence;
- I may refuse to sign this authorization. I may revoke this authorization at any time by sending a written statement to The Companies and Absence Manager. However, a revocation does not apply to disclosures already made under an authorization;
- A revocation of, or the failure to sign, the authorization may impair The Companies and Absence Manager's ability to evaluate or process claim(s), and may be a basis for denying or closing claims for benefits or leave of absence;
- While performing their business The Companies and Absence Manager may disclose information about Individual as allowed or required by law, for example to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with a claim;
- The Companies and Absence Manager will release information to Individual's employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of the employer's self-funded (and not insured) disability plans;
- The Companies and Absence Manager comply with applicable privacy laws. The information disclosed to them may be subject to redisclosure as permitted or required by law. Information retained and disclosed by the Companies and Absence Manager is not protected under the Health Insurance Portability and Accountability Act (HIPAA).

DURATION:

- This authorization as used to gather information shall remain in force for the duration of Individual's claim(s) or 24 months from the date signed below, whichever occurs first.
- The Companies and Absence Manager may share information with each other regarding Individual's claims and leave of absence for 12 months from the date signed below.

I acknowledge that I have read this authorization and the New Mexico notice that follows. 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/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, Guardian, Conservator, Personal Representative, Executor), please attach documentation of legal status.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines 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 Individual's 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 Individual. 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 Individual to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that they 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.

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Hospital Indemnity Benefits
Attending Physician's Statement

Instructions

- Insured or Patient to complete section A and submit to Attending Physician for completion.
- Attending Physician to complete sections B and C.
- Attending Physician to submit the completed and signed Attending Physician's Statement and supporting documentation to the address or fax number listed above.

A. About the Insured and the Patient

Insured's Information

Full Name	Employer/Company Name	Group Policy No.	
Social Security No.	Date of Birth	Phone No.	
Mailing Address	City	State	Zip

Patient's Information

Full Name	Social Security No.	Date of Birth	Gender ☐ Male ☐ Female ☐ X

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Child

B. About the Medical Condition and Treatment - to be completed by Attending Physician. Please attach supporting documentation, including patient admission and discharge paperwork. The Patient is responsible for obtaining a complete form without expense to The Standard.

Date of Service	Diagnosis Description/ICD9	Procedure Code (CPT)	Procedure Description

If the Patient's condition is due to pregnancy, what is the expected delivery date? _____

When did symptoms first appear or injury happen? Please give date. _____

When did the Patient first consult you for this condition? Please give date. _____

Has the Patient ever had same or similar condition? ☐ Yes ☐ No

If Yes, give date and description _____

_____

Has the Patient been hospitalized? ☐ Yes ☐ No

If Yes, give Admission date _____ Discharge Date _____

Hospital Name _____ Phone No. _____ Fax No. _____

City _____ State _____ Zip _____ County _____

Has the Patient undergone surgery? ☐ Yes ☐ No

If Yes, give date, procedure and result _____

_____

If No, do you expect surgery to be performed in the future? ☐ Yes ☐ No

If Yes, give date and type of surgery? _____

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C. Attending Physician Information, Acknowledgement and Signature

Name of Physician _____ Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone No. _____ Fax No. _____

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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 above fraud notice.

Physician's Signature _____ Date _____

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