TheStandard®

The Standard Life Insurance Company of New York
800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602

Long Term Disability Benefits Claim Packet Instructions

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, 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 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 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 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 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 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.

Reset

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Long Term Disability Benefits
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 Code: _____

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

Brochure? ☐ Yes ☐ No **If no, please contact your employer to obtain a copy.**

2. EMPLOYMENT

Name of Employer: _____ Group Policy No.: _____

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 # _____

Last full day at work: _____

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

Are you now 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 _____

_____ 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 _____

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Employee's Statement

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 Code: ________

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

Physician's Name: ____________________ Specialty: ____________________ Phone No.: (____) ____________

Street Address: ____________________ Fax No.: (____) ____________

City: ____________________ State: ________ Zip Code: ________

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

Physician's Name: ____________________ Specialty: ____________________ Phone No.: (____) ____________

Street Address: ____________________ Fax No.: (____) ____________

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: ____________________

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

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9. DEDUCTIBLE INCOME/BENEFITS FROM OTHER SOURCES

Your Group Disability plan is designed so that the income you receive from The Standard Life Insurance Company of New York and other sources (e.g., Social Security, Worker's 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 The Standard Life Insurance Company of New York informed of your application for and receipt of deductible income or benefits. Additionally, your Group Policy may allow The Standard Life Insurance Company of New York 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 The Standard Life Insurance Company of New York.

Have you applied for or are you receiving benefits from:	**Applied** Yes	No	**Receiving** Yes	No	Date Applied For	Amount Received Weekly	Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐				
d. Retirement or Pension *(Employer, PERS, STRS, PERA, 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. 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:		

Acknowledgement

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.

SIGNATURE _____ DATE _____

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Long Term Disability Benefits
Authorization to Obtain Information

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit 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 (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK (THE STANDARD).

- 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 page 6. 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 or conservator), please attach documentation of legal status.

This Authorization is a two-page document. Please see page 6 for additional terms and information. Both pages are part of the Authorization.

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

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

The accompanying Authorization to Obtain Information allows The Standard Life Insurance Company of New York 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 The Standard, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The Standard 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 The Standard. Within 30 business days of receiving the request, The Standard 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. The Standard 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 The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.

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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.

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- 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.)
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_____ _____

Name *(please print)* Social Security No.

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Long Term Disability Benefits
Attending Physician's Statement

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.: _____

Occupation: _____ Employer: _____ Group Policy No.: _____

I returned to work: Date _____ I expect to return to work: Date _____

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 for unanswered questions.

1. INFORMATION

Primary Diagnosis: ICD Code (_____) _____

Secondary Diagnosis: ICD Code (_____) _____

Other diagnoses and ICD Codes related to this claim: _____

_____

Symptoms: _____

_____

Patient's Height: _____ Weight: _____ BP: _____ (Right arm) BP: _____ (Left arm) Pulse: _____ (Radial)

Is condition primarily related to:

a. Patient's Employment ☐ Yes ☐ No
b. Mental Disorder ☐ Yes ☐ No
c. Alcohol or Drug Condition ☐ Yes ☐ No
d. Pregnancy ☐ Yes ☐ No

Dominant Hand: ☐ Left ☐ Right

Expected Delivery Date: _____

Para: _____ Gravida: _____ Actual Delivery Date: _____

Complications: _____ ☐ Vaginal ☐ Caesarean Section

2. HISTORY

If patient was referred to you, indicate by whom: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No

If yes, indicate when: _____ Describe: _____

Do, or have, other conditions contributed to this condition? ☐ Yes ☐ No

If Yes, please explain: _____

Date patient first consulted you for **this** condition: _____ For **any** condition: _____

Dates of subsequent treatment: _____

Date of most recent visit: _____

If patient was hospitalized, please provide dates. Admitted: _____ Discharged: _____

Admitting Diagnosis: _____ Discharge Diagnosis: _____

Name of Hospital: _____

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

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Long Term Disability Benefits
Attending Physician's Statement

Claimant's Name: _____

3. ASSESSMENT

Date you recommended patient should stop working: _____ Why? _____

Describe the patient's physical, mental and cognitive limitations and work activity limitations: _____

How long from today's date will the described limitations impair the patient? _____

Is the 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

4. TREATMENT

Planned course of treatment. (Please include expected duration, surgeries, therapy, etc.) _____

Medications prescribed: dosage, frequency and date of prescription(s). _____

List other treating or referring physicians. (Continue on separate page, if necessary.)

NAME	ADDRESS		
1.			
Phone No. ( )	City	State	Zip Code
2.			
Phone No. ( )	City	State	Zip Code

What reasonable work or job site modifications could the employer make to assist the individual to return to work? Please specify:

Assessment and treatment are complicated by:
☐ Malingering
☐ Significant emotional or behavioral disorder such as: ☐ Depression ☐ Anxiety ☐ Hysteria (Check pertinent areas.)
☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.
☐ Dependence on drugs/medication. Specify: _____
☐ Other (please describe): _____

5. PROGNOSIS

Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

When do you expect a fundamental or marked change in patient's condition? ☐ Never ☐ Condition expected to regress ☐ Condition expected to improve

State anticipated date: _____ or, Unable to determine, follow up in: _____ months

When do you anticipate the patient can return to work? State anticipated date: _____ or, Unable to determine, because of: _____

_____ follow up in: _____ months

Remarks: _____

Acknowledgement

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.

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 The Standard Life Insurance Company of New York at the address above.

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Long Term Disability Benefits
Employer's Statement

1. EMPLOYEE

Name of Employee: _____

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

Job Title: _____ Class: ☐ Faculty/Teacher ☐ Technical/Professional ☐ Administration ☐ Maintenance ☐ Secretarial/Clerical ☐ Other: _____

Job Classification: _____

Phone No.: (_____) _____ Date Employed: _____ Social Security No.: _____

2. INFORMATION

Date employee's LTD coverage became effective: ☐ Basic _____ ☐ Buy-up _____

Work Location: Address: _____ State: _____ Zip Code: _____

Was employee given a Certificate? ☐ Yes ☐ No ☐ Don't know

Was employee insured under previous LTD Carrier? ☐ Yes ☐ No ☐ Effective Date _____

Employee's Medical Insurance carrier: _____

Phone No.: (_____) _____ Effective date for medical insurance: _____

Employee's status on date disability commenced:
Actively at Work? ☐ Yes ☐ No If no, reason: _____ Number of hours worked per week: _____

Last day of work before disability commenced: _____ ☐ Exempt or ☐ Non-Exempt ☐ Union or ☐ Non-Union

Number of hours worked this day: _____ Date employee returned to work after disability ended: _____

Have you considered allowing the claimant to work in another occupation, or modify or alter the job duties of the claimant's occupation, how the job is done (i.e., work schedule), or worksite? ☐ Yes ☐ No If yes, what alternatives were offered to the claimant?

Does the employee participate in your formal retirement plan? ☐ Yes ☐ No Is the plan a qualified plan? ☐ Yes ☐ No

Is the employee eligible but not participating in your formal retirement plan? ☐ Yes ☐ No

Is the formal retirement plan carrier TIAA-CREF or another carrier? Please provide name, phone number and address of contact person: _____

What is the employee's year-to-date retirement plan contribution? $ _____

Are the employee's contributions vested? _____

Is disability caused or contributed to by employment? ☐ Yes ☐ No ☐ Undetermined

Has employee filed a Workers' Compensation claim? ☐ Yes ☐ No ☐ Don't Know

Workers' Compensation Carrier Name: _____ Claim #: _____ Date of Injury: _____

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

Phone No.: (_____) _____ Person to contact: _____

Is employment now terminated? ☐ Yes ☐ No Is employment scheduled for termination? ☐ Yes ☐ No

Reason: _____ Date of termination: _____

3. SALARY AT TIME OF DISABILITY *Please check only one box.*

☐ Basic Monthly Earnings Monthly rate $ _____ ☐ Basic Weekly Earnings Weekly rate $ _____

☐ Basic Yearly Earnings Annual rate $ _____ ☐ Basic Hourly Earnings Hourly rate $ _____

☐ Basic Contract Earnings Contract amount $ _____ 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: $ _____ per _____ Effective date: _____

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Type	Last date through which paid or payable	Amount / Rate
Sick Pay/Salary Continuation		
Self-insured Short Term Disability		
Wages/salary, *earned after* disability		
Commissions, *earned after* disability		

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Long Term Disability Benefits Employer's Statement

5. DEDUCTIBLE INCOME/BENEFITS FROM OTHER SOURCES

Is employee covered by or now receiving benefits from the following?	Covered Yes	Covered No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount 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)	☐	☐	☐	☐	☐				

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): _____

Date life insurance became effective: _____
Please attach original enrollment card.

Amount of Basic life insurance $ _____ Additional/Optional $ _____ Supplemental $ _____ AD&D $ _____

Dependent's coverage? ☐ Yes ☐ No If yes, ☐ Spouse ☐ Child

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. TAX INFORMATION

Employer's Federal Tax I.D. Number: _____

Check one: ☐ We are a private-sector employer
☐ We are a public-sector (government entity) employer

Is this employee subject to:
Social Security taxes? ☐ Yes ☐ No
Railroad Tier 1 taxes? ☐ Yes ☐ No
State Disability taxes? ☐ Yes ☐ No
Medicare taxes? ☐ Yes ☐ No
Tier 1 Medicare taxes? ☐ Yes ☐ No
Unemployment Compensation taxes? ☐ Yes ☐ No

If subject to Social Security taxes what are the employee's year to date Social Security wages? _____

Does this employee pay all or a portion of the premium for LTD insurance coverage? ☐ Yes ☐ No

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

*the employee pay _____ % with "pre-tax" funds.

*the employee pay _____ % with funds that have been taxed.

* If yes, are employer paid premiums included in the employee's salary? ☐ Yes ☐ No

***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
b. Employment Application or Resume
c. Enrollment or Election Form for Long Term Disability Insurance
d. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS, etc.)

9. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

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

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

Acknowledgement

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.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

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

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