



Your application for an Accidental Dismemberment Benefit consists of four forms. Every space 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 we know you did not overlook a particular question. **If a form is received incomplete, it may be returned for completion.**

This claim packet may also be used if you are a Dependent applying for Accidental Dismemberment insurance benefits.

The four forms are:

### 1. The Employee's Statement

- Answer every question completely. Be sure to completely describe your injury/loss and how your accident occurred.
- Use an additional page, if necessary, to complete all questions.
- Enclose photocopies of all medical records pertaining to your loss.
- Enclose Accident Report if available.
- Remember to sign and date your statement. **An unsigned or undated statement may be returned to you.**

### 2. The Employer's Statement

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

### 3. The Authorization to Obtain and Release Information

- Please sign and date this form and attach it to the Employee's Statement. Your signature on this form enables us to obtain the necessary information about you to determine your eligibility for the Accidental Dismemberment benefit. The authorization also allows us to release information to a specific person. **You will receive a copy of the Authorization upon your request.**

### 4. The Attending Physician's Statement

- **Part 1** should be completed by you.
- **Parts 2 & 3** should be completed by your physician. If you have seen more than one physician for your loss, a statement should be completed by each one (this form may be photocopied). Your physician(s) should mail the completed form directly to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. Processing of your claim will begin when all completed forms are received. Should you have any questions, our office is available to assist you.

Standard Insurance Company

Life Benefits Department  
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Accidental Dismemberment  
Employee's Statement

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

Employee Data

Full Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone No. (\_\_\_\_) \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

Complete Dependent Data section only if Dependent is applying for insurance benefits.

Dependent Data

Full Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone No. (\_\_\_\_) \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

Accident Data

Date of Accident \_\_\_\_\_ City and State Accident Occurred in \_\_\_\_\_  
What injuries/losses were sustained?  
  
Describe how accident occurred.

Medical

Describe your present medical condition and indicate any changes.  
  
*Please list all physicians who have treated you for this injury/loss.*  
Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Have you had any hospitalizations or surgeries as a result of the accident? *If so, please indicate.*  
Hospital Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_  
*Please enclose photocopies of pertinent medical records. Also, include a copy of the hospital bill if claiming the Hospital Confinement Benefit.*

Signature

I certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice on page 3 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 AND TEXAS 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 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.

**ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Standard Insurance Company

Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Accidental Dismemberment
Employer's Statement

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

Employee Information

Full Name
Date of employment or association membership (union or other)
Date employee's insurance became effective
Employee's Status: Actively at Work?
Number of Hours Worked per Week Last Day of Work
Is employee now terminated?
Reason
Provide Dependent name and Social Security No. below only if Dependent is applying for insurance benefits.
Dependent's Name Dependent's Social Security No.

Amount of Insurance

Does employee have group Life Insurance under more than one policy number?
If yes, list all policy numbers
Amount of Member's Basic Life Insurance \$
Amount of Member's Additional Life Insurance \$
Amount of Member's Accidental Death & Dismemberment Insurance \$
Amount of Dependent Life Insurance \$
Amount of Additional Dependent Life Insurance \$
Amount of Dependent Accidental Death and Dismemberment Insurance \$
If life insurance is based on Member's earnings, please check appropriate box and fill in the amount of salary.
Basic Monthly Earnings Monthly Rate \$
Basic Yearly Earnings Annual Rate \$
Basic Contract Earnings Contract Amount \$ Length of Contract
Basic Weekly Earnings Weekly Rate \$
Basic Hourly Earnings Hourly Rate \$
Commissions. Please attach list of commissions paid for each of last 12 months.
Insurance Class. Refer to policy schedule of benefits.
Amount of benefit being claimed \$
Date of last increase in earnings or benefit?
Earnings Prior to Increase \$ per

Premiums

Please advise last month premiums paid

Employer Representative Completing this Form

Employer
Address
City State ZIP
Phone No. Policy No.
Signature
I certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice on page 5 of this form.
Signature Title Date

Please attach copies of all enrollment cards.

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

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**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.

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**NEW YORK RESIDENTS**

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**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.

## Authorization to Obtain and Release 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.
- 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, THE STANDARD BENEFIT ADMINISTRATORS 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 The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators 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) \_\_\_\_\_ 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.

## **Authorization to Obtain and Release Information**

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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.

**Part 1. To Be Completed By Patient**

Full Name \_\_\_\_\_ Policy No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_

To Physicians and Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Standard Insurance Company, Portland, Oregon, any information you have regarding my medical history and physical condition.

**Signature**

I certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice on page 10 of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Part 2. To Be Completed By Physician**

Diagnosis \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History. *Please describe how accident occurred, please attach physician notes, operative reports if available.*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If amputation occurred, please describe \_\_\_\_\_

\_\_\_\_\_

On what date did amputation take place? \_\_\_\_\_

Condition:  Regressed  Unimproved  Improved  Recovered

If patient is in a coma, please complete the following:

Date coma began: \_\_\_\_\_ Has patient been in a continuous coma?  Yes  No

Duration of coma: \_\_\_\_\_

For brain damage within 30 days of a covered accidental injury, please complete the following:

Was the individual hospitalized due to a brain injury for at least 5 days?  Yes  No

Did the individual have a Glasgow Coma Scale score of 8 or less?  Yes  No

Has the brain injury lasted at least 12 months?  Yes  No

Is the individual unable to work in any occupation?  Yes  No



If loss of sight, please complete the following:

Is insured totally blind? \_\_\_\_\_ Was eye enucleated? \_\_\_\_\_

If not, please describe the extent of visual field loss \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If not totally blind, what was vision at last observation?

With Glasses: Left \_\_\_\_\_ Right \_\_\_\_\_ Date \_\_\_\_\_

Without Glasses: Left \_\_\_\_\_ Right \_\_\_\_\_ Date \_\_\_\_\_

Can vision be improved by treatment, operation or lenses?  Yes  No

If so, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospital Confinement

Hospital Name \_\_\_\_\_

Admitted \_\_\_\_\_ Discharged \_\_\_\_\_ Was confinement continuous?  Yes  No

Other Physicians: Names and addresses of other treating or referring physicians

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Part 3. Physician Completing This Form**

Name of Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone No. (\_\_\_\_\_) \_\_\_\_\_

**Signature**

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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