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

Long Term Disability Insurance Employee's Statement

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

1. Claimant

Full Name ____________________ Social Security No. ____________________

Address ____________________ City ____________________ State ______ ZIP __________

Phone No. (______) ____________________

Birthdate ____________________ Sex ☐ Male ☐ Female Height ______ Weight ______

Name of Spouse ____________________ Birthdate ____________________

No. of Dependent Children ______________ Birthdate of Youngest ______________

Did you receive a Certificate of Insurance? ☐ Yes ☐ No Did you receive a Brochure? ☐ Yes ☐ No

If you did not receive a Certificate of Insurance or Brochure, please contact your employer to obtain a copy.

2. Employment

Name of Employer ____________________ Group Policy No. ____________________

Address ____________________ City ____________________ State ______ ZIP __________

Phone No. (______) ____________________

State your job title and describe your duties at work.

Is your disability work-related? ☐ Yes ☐ No Date of Injury ____________________

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No If yes, W.C. claim number ____________________

Last full day at work ____________________

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

Are you now working at, or have you worked at, your occupation or any other occupation since the date of your injury? ☐ Yes ☐ No

If yes, list names of employers, addresses, telephone numbers, and dates of employment.

Are you self-employed at any activity? ☐ Yes ☐ No

Date you resumed part-time work ______________ Work Phone (______) ______________ Extension ______________

Date you resumed full-time work ______________ Work Phone (______) ______________ Extension ______________

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

Illness ____________________ Date First Noticed ______________

Illness ____________________ Date First Noticed ______________

State what you believe caused your illness.

Describe your symptoms ____________________

Have you ever had the same condition or a related illness before? ☐ Yes ☐ No Date ____________________

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4. Injury

Describe Injuries ______

Cause of Injuries ______

Time, Date and Location of Injuries.

5. Pregnancy

Date you expect to cease work ______ Expected delivery date ______

Actual delivery date ______ Expected return to work date ______

Please indicate any foreseeable complications.

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

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

Street Address ______ Fax No. (____) ______

City ______ State ______ ZIP ______

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

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

Street Address ______ Fax No. (____) ______

City ______ State ______ ZIP ______

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

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

Street Address ______ Fax No. (____) ______

City ______ State ______ ZIP ______

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

7. Hospital *If you were hospitalized for this condition, please complete. Please attach copy of hospital bill if available.*

Hospital Name ______ Address ______

From ______ Through ______ Reason for Hospitalization ______

From ______ Through ______ Reason for Hospitalization ______

8. History *List all illnesses or injuries for which you have received treatment over the past five years. Use separate sheet if needed.*

Ailment	Date	Physician's Name	Complete Address

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9. Deductible Income/Benefits From Other Sources

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

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) *Please specify* ______	☐	☐	☐	☐				
e. Other ______ (e.g., unemployment or union benefits, etc.)	☐	☐	☐	☐				
Please send copies of any letters or notices approving or denying benefits.								

10. Vocational *Complete the following and/or attach a resume.*

Education level	Yes	No	If no, last grade attended.	
Grade School Graduate	☐	☐		
High School Graduate	☐	☐		
GED	☐	☐		
College Graduate	☐	☐	Degree	Major
Post Graduate	☐	☐	Degree	Major

Have you attended any trade schools or received other special training? ☐ Yes ☐ No If yes, please describe.

Work Experience: *Complete the following starting with your most recent work experience.*

Job Title & Employer	Dates of Employment	Duties	Last Salary
1.	From: To:		
2.	From: To:		
3.	From: To:		
4.	From: To:		
5.	From: To:		

11. Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the applicable fraud notice on page 5 of this form.

Signature ______________________________ **Date** ______________