



TheStandard®

Standard Insurance Company
Employee Benefits Department 800.252.5577 Tel
PO Box 2800 Portland OR 97208



State of Colorado Disability Claim Instructions

Welcome to Standard Insurance Company.

We realize that being disabled is difficult. Even though you are unable to work, your financial obligations don't go away. We at The Standard have prepared this claim packet to assist you with your application for Disability benefits.

This packet contains the forms to apply for Disability benefits under the State of Colorado group policy. It also addresses common questions about benefit claims. **Please save this information for future reference.**

To help you through these difficult times, your employer has purchased **Short Term Disability (STD)** coverage through Standard Insurance Company. **Long Term Disability (LTD)** coverage is also available to eligible employees who have enrolled for it and have paid the required premiums. For specific information about your STD or LTD insurance coverage, refer to your Certificate of Insurance. The group policy is the ultimate authority for all claims decisions. If you do not have a Certificate of Insurance, you should contact your agency benefits representative.

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, "NONE" should be written in the space so that we know you did not overlook the particular question. **If a form is received incomplete, it may be returned for completion. Each form must be completed and submitted to The Standard.** It is recommended that all these forms be submitted at the same time.

The four forms are:

Employee/Employer Statement

- Answer every question under Part A completely. Be sure to use the appropriate section for accident, sickness or pregnancy. If a question does not apply to you, write "NONE".
- Attach copies of any Social Security, Public Employees Retirement Assn., No-Fault Auto, Workers' Compensation or any other benefit determinations you have received or are available to you. This information is necessary to ensure proper calculation of your benefits. If you are unable to make copies of these documents, please forward the originals. We will photocopy them and return the documents to you promptly.
- Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**
- Part B of this form should be completed by your employer.

Authorization to Obtain Information

Authorization to Obtain Psychotherapy Notes

- Sign and date the Authorization to Obtain Information and send it to The Standard with the Employee Statement.
- Your signature on the Authorization to Obtain Information enables The Standard to obtain the necessary information about you to determine your eligibility for and entitlement to benefits.

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.

Attending Physician's Statement

- **Part A:** Complete this part and give the form to your physician.
- **Part B:** Your physician completes this part and sends the form directly to The Standard.

If more than one physician is treating your disabling condition, each should complete a form. Your employer can give you extra forms.

You are responsible for making sure all required forms are completed. Processing of your claim will begin when all completed forms are received at Standard Insurance Company. Should you have any questions, Standard Insurance Company is available to assist you. Please call at 1-800-252-5577.



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SHORT TERM DISABILITY

If you qualify under the terms of the group policy for Short Term Disability (STD) benefits, you are entitled to benefits once you serve your benefit waiting period (the greater of 30 days of disability or the entire period for which you are entitled to receive injury leave and sick leave). Annual leave may be used to complete or extend your benefit waiting period. Your STD benefit is computed at 60% of your basic weekly earnings to a maximum benefit of \$2,310.00 per week, less deductible benefits.

Your maximum benefit period is 180 days minus the number of days of your benefit waiting period.

STD benefits are subject to Federal and State taxes. Standard Insurance will automatically deduct Medicare taxes from your benefits if your State hire date is on or after April 1, 1986. If you desire Federal Income taxes to be withheld, obtain a W-4S form from your Personnel/Payroll office and submit it with your claim. The minimum deduction is \$20 per week.

If you qualify for STD benefits, your employer will receive weekly benefit checks made payable to you. Your employer will forward the checks to you or you may pick them up in person.

Reduction of Benefits

Your STD benefit will be reduced by deductible income if you receive other benefits as a result of your disability or retirement. The deductible income includes:

PERA disability or retirement; Workers' Compensation benefits or settlement for a work-related disability; Social Security; income replacement paid as a result of the Colorado Auto Accident Reparations Act (No-Fault); etc. which are paid for the same period of time that STD benefits were payable. If full STD benefits are paid pending a decision from these sources, you **MUST REPAY** Standard Insurance Company when you get your first check from the other income source. It is your responsibility to contact Standard with this information about your other claims. No STD benefits are payable if deductible income is greater than 60% of your basic weekly earnings.

Insurance Continuation

If you are presently enrolled in the state health, life and dental insurance plans, you are eligible to continue your coverage while you are on STD leave. All premiums must be paid by the 1st of the month in advance. The state share is paid by the state while you are on STD leave but you must pay the employee share by personal check directly to your agency. It is your responsibility to contact your agency payroll/personnel office before you go on leave to make your payment arrangements. If you should choose not to continue your insurance while on STD leave, you are not eligible to reenroll for your insurance benefits until the next open enrollment period. You may have rights to continue coverage under COBRA legislation. Please consult your agency for information regarding these rights or other questions you may have about your insurance coverage.

LONG TERM DISABILITY (For eligible employees who have enrolled and have paid the required premiums).

If you are disabled for longer than 180 days and have Long Term Disability (LTD) coverage, your claim will be reviewed to determine if you qualify under the terms of the group policy for LTD benefits. If your LTD claim is approved, benefits are payable after you have served a benefit waiting period of 180 days from the date you became disabled.

LTD benefits are paid monthly at 60% of your predisability earnings (up to a maximum monthly benefit of \$10,000) reduced by deductible income, including Workers' Compensation, PERA, sick leave, Social Security and a partial deduction for your earnings from work if working while disabled. The policy has a minimum benefit of \$100 per month.

LTD benefits may be subject to Federal and State taxes.

For disabilities occurring between January 1, 1994 and December 31, 1997, you need to be aware that the policy has a pre-existing condition exclusion that may affect your eligibility for benefits. For disabilities beginning during that period, you are not covered for a pre-existing condition unless you have been continuously insured for 12 months and have been actively at work for at least one full day after these 12 months. A pre-existing condition means a mental or physical condition for which you consulted a physician, received medical treatment or services or took prescribed drugs or medication during the 12 months before the effective date of your LTD insurance. Please consult your State of Colorado Disability Insurance Plans booklet for additional information regarding this or other exclusions and limitations that may apply.

For specific information about your STD or LTD insurance coverage, refer to your State of Colorado Disability Insurance Plans booklet. The group policy is the ultimate authority for all claims decisions. If you do not have a Plans booklet or Certificate of Insurance, you should contact your agency representative.



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State of Colorado
Disability Claim
Employee/Employer Statement

PART A. TO BE COMPLETED BY INSURED EMPLOYEE

Full Name _____ Phone No. (____) _____

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security No. _____ Sex Male Female

Name of Spouse _____ No. of dependent children _____ Birthdate of youngest _____

State your job title and your duties at work _____

Supervisor's Name _____ Phone No. (____) _____

Is your disability work related? Yes No Have you filed a Workers' Comp. claim? Yes No Do you intend to file? Yes No

Is your disability caused from an automobile accident? Yes No Date of Accident _____

Name of Workers' Compensation or Auto Claims Examiner _____ Phone No. (____) _____

Workers' Compensation or Auto Claim no. _____

Last day of work _____ Date you became unable to work at your occupation _____

Date you resumed full-time work _____ or part time work _____ For: A. State Yes No
B. Other Employer Yes No
C. Self Yes No

or date you expect to return to work _____

Did you receive a certificate of insurance or brochure? Yes No

Nature of illness/accident _____

Date first noticed _____ What do you believe caused your disability? (include the time, date and location of accident) _____

Explain how your illness/injury prevents you from working _____

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

Pregnancy:

Expected delivery date _____ Actual delivery date _____

Type of delivery (if known): Vaginal C-Section Expected return to work date _____



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State of Colorado
Disability Claim
Employee/Employer Statement

Physician's Name _____ Date first consulted for this injury or illness _____

Street Address _____

Phone No. (_____) _____ City _____

State _____ Zip Code _____

List all other medical professionals consulted for any injury or illness within the past three years. (continue on a separate page if necessary)

1.	_____	(_____)	_____	_____
	Name		Phone No.	Date first consulted
	_____	_____	_____	_____
	Address	City	State	Zip
2.	_____	(_____)	_____	_____
	Name		Phone No.	Date first consulted
	_____	_____	_____	_____
	Address	City	State	Zip

If you were hospitalized within the past three years, please complete.

Hospital Name and address _____

From _____ Through _____ Reason for hospitalization _____

From _____ Through _____ Reason for hospitalization _____

Have you applied for or have you received benefits from:

		Yes	No		Yes	No	
a.	Retirement or Disability PERA	<input type="checkbox"/>	<input type="checkbox"/>	c.	Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>
b.	Other (e.g. Unemployment, Social Security)	<input type="checkbox"/>	<input type="checkbox"/>	d.	Automobile Insurance No-Fault	<input type="checkbox"/>	<input type="checkbox"/>

Please send copies of any letters or notices approving or denying benefits to allow us to calculate your benefits from The Standard.

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 6 of this form.

Signature _____ Date _____



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State of Colorado
Disability Claim
Employee/Employer Statement

PART B. TO BE COMPLETED BY AGENCY PAYROLL/PERSONNEL OFFICE

1. Employees full name _____ Social Security No. _____
2. State Hire Date _____ Agency Hire Date _____
3. Employee Job Title _____ Class Code _____
Name of Supervisor _____ Phone No. _____

4. Is the employee's disability work related? Yes No Undetermined
Has employee filed a Workers' Compensation claim? Yes No Unknown
Workers' Compensation Claim No. _____ Name of Examiner _____ Phone No. (____) _____

5. **Has employee applied for or received benefits from:**
Income From Other Sources
(Deductible Benefits)

	Yes	No	Don't Know	Date of Application	Weekly	Monthly	Effective Date
a. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
b. No-Fault Automobile Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
c. PERA Retirement or Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
d. Other _____ (e.g. Unemployment or Social Security)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____

6. Employee's status on date disability began: Full-time Part-time

7. Last day at work before disability began _____ Number of hours worked on that day _____

8. Date returned to work _____ Full-time Part-time Full duty Modified duty

9. Total accumulated sick leave hours as of last day of work _____

Through what date are sick leave benefits payable? _____

Has the employee elected to receive annual leave? Yes No If yes, what is the last date through which annual leave will be paid? _____

10. Salary full-time: Monthly rate \$ _____ Hourly rate \$ _____

Salary part-time: Hourly rate \$ _____ Hours worked/week _____

Is the employee a part-year worker? Yes No

Total salary current year to date for part-year/part-time employees: \$ _____

Total salary prior calendar year for part-year/part-time employees: \$ _____

Total shift pay current year to date \$ _____ Total shift pay prior calendar year \$ _____

11. Is Employee subject to Medicare taxation? Yes No

12. Is Employee insured for Optional Long Term Disability? Yes, effective date _____ No

13. Is Employee insured for Employee Life Insurance? Yes No

a. State of Colorado Plan 642693 Basic Amt. \$ _____ Additional Amt. \$ _____ Dependent Amt. \$ _____

b. University of Colorado Plan 399101 Basic Amt. \$ _____ Additional Amt. \$ _____ Dependent Amt. \$ _____

14. Employment termination date, if any _____ Reason _____

15. Attachments: Please attach copies of the following:

- Long Term Disability Enrollment form
- Any medical information: i.e. return to work releases, reports, medical records, etc.
- Workers' Compensation Documents, PERA notice of filing, or No-Fault requests

Agency Name _____ Agency Number _____

Address _____ City _____ State _____ Zip Code _____

Prepared by _____ Title _____ Phone No. _____

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 6 of this form.

Signature _____ Date _____



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**State of Colorado
Disability Claim Form Fraud Notices**

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

CALIFORNIA 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.

MARYLAND AND RHODE ISLAND RESIDENTS

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

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 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 a 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.



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State of Colorado
Disability Claim
Attending Physician's Statement

PART A. TO BE COMPLETED BY EMPLOYEE (PATIENT)

Please type or print. The patient is responsible for the completion of this form without expense to Standard Insurance Company.

Full Name _____ Social Security No. _____
Address _____
City _____ State _____ Zip Code _____
Phone No. (_____) _____ Birth Date _____ Patient No. _____
Medical Plan _____ Group Policy No. _____

PART B. TO BE COMPLETED BY PHYSICIAN

The following information is needed to document the Patient's inability to work:

1. Diagnosis

A. Primary Diagnosis _____ ICDA Classification _____
B. Secondary Diagnosis (related to patient's disability) _____
C. Symptoms _____
D. Objective findings _____
E. Patient's height _____ Weight _____ Most recent blood pressure _____

2. Pregnancy (If Applicable)

Expected date of delivery _____ Anticipated to be normal? Yes No
Para _____ Gravida _____ Abortion _____
Actual date of delivery _____ Type of delivery: Vaginal Caesarean Section

3. History

A. When did symptoms appear or accident happen? _____
B. Did you recommend the patient stop work? Yes No
If yes, as of what date? _____
Why? _____
If no, who recommended that the patient stop work? _____
C. Has the patient ever had the same or similar condition? Yes No If yes, when? _____
Describe _____
D. Is the condition related to the patient's employment? Yes No Undetermined
E. Did you complete a Workers' Compensation Report for this condition? Yes No

4. Treatment

A. Date of first visit _____
B. Date of subsequent visits _____
C. Date of most recent visit _____
D. Planned course of treatment (Include surgery, physical therapy, psychiatric counseling.) _____
Medications: _____

5. Cardiac classification (If Applicable)

A. Functional classification (American Heart Association) [] Class I [] Class II [] Class III [] Class IV

B. Therapeutic classification [] Class A [] Class B [] Class C [] Class D [] Class E

6. Physical Capacities

A. Based on the patient's physical limitations and restrictions, he/she can: (Circle the appropriate level of ability.)

Table with 6 columns (50+, 50, 20, 10, 0) and 6 rows (Frequently lift, Maximum lift, Walk/Stand at one time, Walk/Stand in an 8-hour work day, Sit at one time, Sit in an 8-hour work day, Bend/Stoop).

7. Level of Functional Impairment

A. The patient is: [] Ambulatory [] House Confined [] Bed Confined [] Hospital Confined

B. Describe the patient's mental and cognitive limitations and restrictions: _____

C. Is this 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

D. Other impairments (please be specific): _____

E. How long will the above limitations impair the patient? _____

F. Dominant hand: [] Left [] Right

8. Hospitalization

A. Date admitted _____ Date discharged _____ Date surgical procedure performed _____

B. Reason for admittance to hospital: _____

C. Describe nature of any surgical procedure performed: _____

Name of hospital _____

Address _____ City _____ State _____ Zip _____

9. Other treating medical professionals (if known)

A. Name _____ Specialty _____ Phone No. (_____) _____
Address _____ City _____ State _____ Zip _____

B. Name _____ Specialty _____ Phone No. (_____) _____
Address _____ City _____ State _____ Zip _____

10. Prognosis

A. Describe patient's condition since onset of symptoms: [] Recovered [] Improved [] Not Changed [] Retrogressed

B. When do you expect a fundamental or marked change in the patient's condition? _____

[] Unable to determine, follow up in _____ weeks _____ months. [] Never

C. When do you anticipate the patient can return to work?

_____ Full-time _____ Part-time (_____ hrs/day, _____ days/weeks)

[] Unable to determine, follow up in _____ weeks _____ months. [] Never

Name of Physician completing this form (Please type or print.) _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone No (_____) _____ Taxpayer Identification No. _____

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 9 of this form.

Signature _____ Fax No. _____ Date _____

Please send copies of chart notes, diagnostic, laboratory, and electrodiagnostic findings, as well as operative reports and hospital discharge summaries for the past year.

Return to: Standard Insurance Company
Special Accounts Benefits
P.O. Box 2800
Portland, OR 97208



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DISTRICT OF COLUMBIA RESIDENTS

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PENNSYLVANIA RESIDENTS

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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 11. 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

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.

Authorization to Obtain and Release Psychotherapy Notes

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, 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 13. 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 Psychotherapy Notes

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.