TheStandard®

Standard Insurance Company
Employee Benefits Department 888.641.7186 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

State of Georgia
Disability Claim Packet Instructions

Welcome to Standard Insurance Company

We realize that being disabled is difficult. Even though you are unable to work, your financial obligations do not go away. To help you through these difficult times, the State of Georgia has made both Short Term Disability (STD) and Long Term Disability (LTD) insurance available for eligible employees to purchase at affordable group rates. If you were eligible, enrolled and paid the required premiums, this packet contains the forms you need to apply for STD and/or LTD disability benefits. Only one application is necessary. The Standard will determine your coverage levels and evaluate your entitlement to benefits under each plan. This packet also addresses common questions about benefit claims, so please save the instruction sheet for future reference.

PLEASE READ CAREFULLY

If you have a work-related disability and are receiving or eligible to receive over 60% of your *benefit salary* in Workers' Compensation Benefits, you will not be eligible to receive Short Term Disability Benefits. Therefore, we would encourage you to wait to file a STD claim until after your Workers' Compensation Benefits end. However, as the Long Term Disability plan includes a $100 minimum benefit that could be payable in addition to your Workers' Compensation Benefits, we encourage employees insured under the LTD plan to file for benefits as soon as it appears you will be disabled for 180 days or longer.

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, 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 benefits. If you are unable to make a copy for yourself, let us know and we can return a copy to you for your files.
   - 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 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 related to this disability request, 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 or download a copy from the GaBreeze web site (GaBreeze.ga.gov) or by calling the GaBreeze Call Center (1-877-342-7339).

4. **The Employer's Statement**
   - This form should be completed by your agency, who will mail it to The Standard.

NOTE: You are responsible for making sure the Employee Statement is completed and returned to The Standard. Your Employer and Physician will complete their statements and return them directly to The Standard on your behalf.

Short Term Disability Benefits

The terms of the STD plan are set forth in the STD Certificate of Insurance (also known as the Summary Plan Description, or SPD). If you are insured for STD, benefits are paid weekly at 60% of your weekly *benefit salary,* up to the maximum specified in the group policy, less *deductible income. Deductible income* includes, but is not limited to, any other group disability plan benefits, State retirement systems disability or retirement benefits, fault and no-fault automobile policy benefits, and/or workers' compensation benefits. If *deductible income* totals more than 60% of your weekly *benefit salary,* the short-term disability plan will not pay any STD benefits. Thus, in most instances if you receive workers' compensation benefits you will not be eligible to receive any STD benefits. If your claim for any of this deductible income is retroactively accepted, compromised or settled, you must repay any STD overpayment caused by your receipt of an unreduced STD benefit.

How STD Works

In general:

- If your claim is approved, you are eligible to receive STD benefits after you have been *disabled* due to a *physical disease, pregnancy, or mental disorder* for your *benefit waiting period* – usually either 30 continuous calendar days or 7 continuous calendar days, depending on the coverage level you have chosen. However, if you did not enroll in your current coverage level when you were first eligible, a *late enrollment penalty* may apply. Refer to your Certificate of Insurance (SPD) for details about this *late enrollment penalty* which could result in your *benefit waiting period* being up to 60 days.
- No STD benefits will be paid to you when you are receiving sick leave, donated leave, special injury leave, or any other salary continuation (but not vacation pay).
- It is your responsibility to notify The Standard if you recover or return to work. In some cases, you may be eligible to receive a modified benefit if you are working while *disabled.*

Refer to the STD Certificate of Insurance (SPD) for details.

Long Term Disability Benefits

The terms of the LTD plan are set forth in the LTD Certificate of Insurance (SPD). If you are insured for LTD, benefits are paid monthly at 60% of your monthly *benefit salary,* up to the maximum specified in the group policy, less *deductible income. Deductible income* includes, but is not limited to, Social Security benefits, workers' compensation, other governmental disability program benefits, any other group disability plan benefits, State retirement systems disability or retirement benefits, fault and no-fault automobile policy benefits, sick leave, donated leave, and any special injury benefits. The plan will pay at least $100 a month, even if your benefits from all other sources (*deductible income*) total more than 60% of your monthly *benefit salary,* unless you are in an overpayment situation.

These benefits will begin after you have been disabled for 180 calendar days and are reduced by any sick leave you use. Benefits are paid monthly at the end of the monthly period. It is your responsibility to notify The Standard if you recover or return to work. In some cases, you may be eligible to receive a modified benefit if you are working while *disabled.*

It is your responsibility to apply promptly for deductible income you may be eligible to receive. There may be an overpayment on your claim if The Standard is not promptly informed that you are receiving income from other sources. Overpayments can also occur if other income is awarded retroactively. Any overpayment must be repaid in full.

What is a *Preexisting Condition?*

You have a *preexisting condition* if you have a mental or physical condition, whether or not diagnosed or misdiagnosed, for which you have done or for which a reasonably prudent person would have done any of the following: consulted a medical professional; received medical treatment, services or advice; underwent diagnostic procedures, including self-administered procedures; or took prescribed drugs or medications in the 180-day period just prior to your effective date of coverage; which, as a result of any medical examination, including routine examination, was discovered or suspected at any time during the 180-day period just before your insurance becomes effective.

LTD benefits will not be payable for a *disability* caused or contributed to by a *preexisting condition* or medical or surgical treatment of a *preexisting condition* unless, on the date you become *disabled,* you have been continuously insured under the *group policy* for 12 months and have been *actively at work* for at least one full day after the end of that 12 months. If you become *disabled* during the first 12 months of your coverage, prior to making a decision on your claim we will be required to gather your medical records to determine if the *preexisting condition* exclusion applies.

Tax Information

- STD and LTD premiums are generally paid with post-tax dollars, and thus are not taxable income.
- If STD or LTD premiums are paid with pre-tax dollars, the Internal Revenue Service (IRS) will consider any disability benefits paid for with pre-tax premiums to be taxable income.
- You will be responsible for paying any taxes due on your benefits from this plan.

Life Insurance

The attached application forms cannot be used to apply for a waiver of life insurance premium due to disability. Application for that benefit requires completion of separate claim statements that can be obtained by downloading a copy from the GaBreeze web site (GaBreeze.ga.gov) or by calling the GaBreeze Call Center (1-877-342-7339).

Questions:

For specific information about your LTD or STD coverage, including the specific definition of disability that applies to your claim, please refer to your Certificate of Insurance (SPD). The *group policy* is the ultimate authority for all claims decisions. If you do not have a Certificate of Insurance, please visit GaBreeze for a copy.

NOTE: Defined terms and provisions from the *group policy* are italicized.

If The Standard can be of service to you as you file your claim, please feel free to contact us toll-free at 888-641-7186. We look forward to working with you.

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State of Georgia Employee Statement

Full Name _____ Phone No. (_____) _____

Address _____ City _____

State _____ Zip Code _____ Birth Date _____ Sex ☐ Male ☐ Female

Social Security No. _____ Height _____ Weight _____ Dominant Hand ☐ Right ☐ Left

Name of Spouse _____ No. of dependent children under age 25 _____ Birthdate of youngest _____

Agency Name _____ Supervisor Name _____ Phone No. (_____) _____

State your job title and your duties at work (attach separate page if needed) _____

_____

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

If you have filed a Workers' Comp. claim, please list claim number _____

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

Are you now working for any employer or self-employed? ☐ Yes ☐ No If yes, please list the name, address and phone number of the employer on a separate piece of paper and attach to this form or provide details of your self-employment.

Date you resumed full-time work _____ or part time work _____

Did you receive a certificate of insurance or summary plan description? ☐ Yes ☐ No If no, please contact your agency to obtain a copy.

Coverage(s) for which you are currently enrolled and paying premiums:
☐ Short Term Disability (either Option A or Option B) and/or ☐ Long Term Disability

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

Do you feel a third party is responsible for your disability, or has made your condition worse? ☐ Yes ☐ No
If yes, please explain, giving the name of the third party _____

_____

Do you plan to bring a claim or law suit against this third party? ☐ Yes ☐ No

Pregnancy: Expected delivery date _____ Actual delivery date _____

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

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.

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State of Georgia Employee Statement

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:		

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

Street Address _____ City _____ State _____ Zip Code _____

Phone No. (_____) _____

List all other medical professionals consulted within the past three years *(continue on a separate page if necessary).*

1. _____ (_____) _____ _____
Name Phone No. Date first consulted

2. _____ (_____) _____ _____
Name Phone No. Date first consulted

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:

	Applied Yes	Applied No	Receiving Yes	Receiving No	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Sick Leave/Donated Leave	☐	☐	☐	☐				
b. Social Security	☐	☐	☐	☐				
c. Workers' Compensation	☐	☐	☐	☐				
d. Any other Group Disability Plans	☐	☐	☐	☐				
If yes, name of carrier: _____								
e. Retirement/Pension	☐	☐	☐	☐				
Please specify type: _____								
f. Fault and No-fault automobile policy benefits	☐	☐	☐	☐				
g. Special Injury Leave	☐	☐	☐	☐				
h. Other _____ (e.g. unemployment or union benefits)	☐	☐	☐	☐				

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

I authorize and request Standard Insurance Company (The Standard) to release the following information to the State of Georgia's Life Insurance carrier, MetLife, nine months after my accepted date of disability if my claim with The Standard is still being paid at that time: my name, social security number, disability date and age at disability. This information is to be disclosed to MetLife for a life insurance Waiver of Premium claim. I understand and agree that my authorization to release this information to MetLife will remain in force for 12 months from the date of signature of this authorization. I understand and agree 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. A copy of this authorization will be provided to me upon request.

Signature _____ Date _____

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 fraud notice below.

Signature _____ Date _____

CLAIM FORM FRAUD NOTICE

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.

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.

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- 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:
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  - 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 9. 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.

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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 onfidentiality program, your request should be sent to Standard Insurance Company.

Return to Gay Waters
770-287-2062

Standard Insurance Company

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~~PO Box 2800 · Portland OR 97208~~

State of Georgia
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. _____

Employer State of Georgia Agency _____ Policy No. 642967

Phone No. (_____) _____ Medical Plan _____ Patient 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 ? _____

B. Is condition the result of an accidental injury? ☐ Yes ☐ No If yes, describe accident: _____

_____

C. 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? _____

D. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when? _____

Describe _____

E. Is the condition related to

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

F. 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

Return to Gray Waters
770-287-2062

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State of Georgia
Attending Physician's Statement

6. Physical Capacities

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

Frequently lift (in pounds)	50+	50	20	10	0				
Maximum lift:	50+	50	20	10	0				
Walk/Stand at one time (in hours):	8	7	6	5	4	3	2	1	0
Walk/Stand in an 8-hour work day:	8	7	6	5	4	3	2	1	0
Sit at one time (in hours):	8	7	6	5	4	3	2	1	0
Sit in an 8-hour work day:	8	7	6	5	4	3	2	1	0
Bend/Stoop:	Never		Occasionally			Frequently			

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 endorse checks and direct the use of the proceeds? ☐ 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 fraud notice below.

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
Employee Benefits Department
P.O. Box 2800
Portland, OR 97208

CLAIM FORM FRAUD NOTICE

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
Employee Benefits Department 888.641.7186 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

State of Georgia Employer's Statement

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

1. EMPLOYEE

Full Name: _____ Social Security No.: _____

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

Phone No.: (_____) _____ Birthdate: _____

2. INFORMATION

Job Title: _____ Date Employed: _____
(Please attach a copy of position description.)

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

Name of Supervisor: _____ Phone No.: _____

Agency Name: _____ Policy No.: 642967

Did employee receive a certificate of insurance (Summary Plan Description) for each appropriate plan? ☐ Yes ☐ No ☐ Don't Know
(If no or don't know, please forward Certificate of Insurance to employee when filing disability claim.)

Last day of work before disability commenced: _____

Hours worked per week before disability commenced: _____

Date employee returned to work after disability ended: _____

Is medical condition due to employment? ☐ Yes ☐ No ☐ Undetermined

Workers' Compensation claim? ☐ Yes ☐ No Carrier Name: _____ Phone No.: _____

Claim No.: _____ Address: _____

Have you considered allowing the employee to work in another occupation, or to modify and/or alter the job duties of the current occupation?

☐ Yes ☐ No Please explain: _____

On FMLA? ☐ Yes ☐ No Effective date: _____ through: _____

Is employment scheduled for termination? ☐ Yes ☐ No Effective: _____

Reason: ☐ Unable to hold job open any longer ☐ Elimination of position ☐ Retirement ☐ For cause ☐ Other: _____
(this information is needed to assist in return to work services)

Date sick leave benefits will be paid through: _____ Salary continuation from: _____ through: _____

Yearly employment schedule, indicate: ☐ 12-month period ☐ Other *(i.e. contract days, 9 mos., etc.)*: _____

3. DEDUCTIBLE INCOME

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. Sick Leave/Donated Leave	☐	☐	☐	☐	☐				
b. Special Injury Leave	☐	☐	☐	☐	☐				
c. Fault or No Fault automobile policy benefits	☐	☐	☐	☐	☐				
d. Social Security	☐	☐	☐	☐	☐				
e. Workers' Compensation	☐	☐	☐	☐	☐				
f. Retirement or Pension (Employer, ERS, TRS, JRS, LRS, PSERS, etc.) Please specify: _____	☐	☐	☐	☐	☐				
g. Any other group disability	☐	☐	☐	☐	☐				
h. Other: _____ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

Standard Insurance Company
Employee Benefits Department 888.641.7186 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

4. TAX INFORMATION

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

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

5. ATTACHMENTS

Please attach copies of the following.

a. Job Description
b. Employment Application or Resume
c. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, Retirement System)

6. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: State of Georgia Agency Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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 fraud notice below.

Signature: _____ Date: _____

Prepared by: _____ Title: _____

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

CLAIM FORM FRAUD NOTICE

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