The Standard Benefit Administrators

800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602

Virginia Association of Counties Group Self Insurance Risk Pool Disability Insurance Claim Packet Instructions

Your Disability Benefit Claim

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 your employer has provided you with a fully self-funded Short Term Disability (STD) plan and a fully insured Long Term Disability (LTD) policy. Your employer is ultimately responsible for payment or non-payment of claims under the self-funded STD plan. Standard Insurance Company is ultimately responsible for payment or non-payment of claims under the insured LTD policy. The Standard Benefit Administrators on behalf of Standard Insurance Company is the administrative consultant with respect to the claims filed under the self-funded STD plan and is the claims administrator for the insured LTD policy. If you have questions about your claim's management, please contact The Standard Benefit Administrators.

This packet contains the forms necessary to apply for disability benefits. It also addresses common questions about Disability claims. **Please save this material for your future reference.** For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator or call our customer service line at (800) 426-4332.

How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete the Employer's Statement on (page 2), and mail or fax it to The Standard Benefit Administrators, before giving the claim packet to you.
2. Complete and sign your part of the claim form (on page 4), and then have your treating physician complete their part of the claim form (the Attending Physician's Statement, also on page 4). If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefits administrator. Your physician may return the completed form to you for you to send to us with the other completed forms, or your physician may mail or fax the completed form to us directly, using the contact information at the top of the form.
3. Read the Claim Form Fraud Notice (on page 5), then provide it to your treating physician with the Attending Physician's Statement.
4. Sign and date the Authorization (on page 6), and send it, along with the completed forms, to The Standard Benefit Administrators at the above address. The Standard Benefit Administrators is acting as the claims administrator on behalf of Standard Insurance Company. This authorization allows us to request further information about your claim, if necessary.

Once we receive your completed claim application, it will take approximately one week to make a claim decision. If we have not reached a decision within one week, you will be notified with the details.

Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive, or may be eligible to receive, may reduce the amount of Disability benefits due you. Your coverage or group insurance certificate list these benefits, which may include, but are not limited to, sick leave, Workers' Compensation, State Disability, Social Security and Retirement.

To avoid a possible overpayment on your claim, which would need to be repaid to The Standard Benefit Administrators, please inform The Standard Benefit Administrators if you receive other benefits.

When You Return To Work

Your disability benefits usually stop when you return to work. **Be sure that you notify The Standard Benefit Administrators immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

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Virginia Association of Counties
Group Self Insurance Risk Pool
Disability Insurance
Employer Statement

TO BE COMPLETED BY EMPLOYER

Employee's Full Name:	Social Security No.:	Job Title: *(Please attach a copy of the job description.)*	1. Date Employed:
Jane C. Jones	123-45-6789	Admin. Assistant	01/01/14

Employee's Home Address: 400 Any Street Pleasantville, State: VA Zip Code: 22000

Employee's Email Address: jcjones@pleasantville.gov

Work Location: Address: County Govt., One Government Way. Pleasantville State: VA Zip Code: 22001

2. Is the employee participating in the Virginia hybrid retirement program? ☒ Yes ☐ No
When did the employee begin their participation in the Virginia retirement program? Jan. 1, 2014

3. Is disability work related? ☐ Yes ☒ No ☐ Undetermined

4. Has the employee filed for: Workers' Compensation: ☐ Yes ☒ No
State Disability: ☐ Yes ☒ No
Other: _____ ☐ Yes ☒ No
Weekly Amount: _____

5. Employee's earnings: $ 52,000
(Check one) ☐ hourly ☐ weekly ☐ monthly ☒ annual ☐ commission ☐ other ☐ shift differential ☐ bonuses
Date of last increase: _____ Earnings prior to increase: $ _____

6. Last active date at work: 3/25/15

7. Job status when disability began: ☒ Full-time (____ hours/week) ☐ Part-time (____ hours/week)

8. Date employee returned to work: —

9. Last date through which sick leave benefits were paid by employer: 4/01/15

10. Last date through which any compensation was paid by employer: 4/01/15
What type(s) of compensation was paid on this date? sick leave

11. Is employee subject to: Social Security taxes? ☒ Yes ☐ No Medicare taxes? ☒ Yes ☐ No

Employer:	VACoRP Member Number:	Phone No.:	Policy No.:
Pleasantville Co. Gov't.	0111 *	(555) 555-1212	649393

Mailing Address:	City:	State:	Zip Code:
P.O. Box 1111	Pleasantville	VA	22001

Employer's Email Address: cjsmith@pleasantville.gov

Name of Employer representative completing this form: Cecil J. Smith, Human Resources Manager

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Signature: C.J. Smith **Date:** April 1, 2015

* EXAMPLE - 4-digit number