VACORP
Short Term Disability Claim Form

The Standard
Disability Claims Service Center
P.O. Box 2717
Portland, OR 97208-9830
Phone: 844-404-2111
Fax: 800-850-0017
Email: AL-Claims@standard.com

Important notice to employee – Please read carefully: You or someone acting on your behalf should complete Section 1 and then have your employer complete Section 2. Have your physician complete Section 3. Also complete and sign the *Authorization for Release of Information*, *Communication Consent*, and *Reimbursement Agreement* forms. Submit the forms to us at the address or fax number listed to the right. Your cooperation will facilitate payments promptly when they are due.

Any person who knowingly, and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal penalties.

Notice to customers regarding telephone service observance – To ensure our customers receive quality service, all of our phone calls are recorded. These calls, between our customers and employees, are evaluated by supervisors. This is to assure that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

Section 1: To be completed by the employee

Last name	First name	M.I.	Gender ☐ Male ☐ Female	Birth date (MMDDYYYY)

Social Security no.	Employee street address	City	State	ZIP code

Primary phone no.	Alternate phone no.	Fax no.	Email address

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Employer name

Disability due to ☐ Illness ☐ Injury	Date you last worked due to your disability	Date you returned to work	If not yet returned, date you expect to return

If disability due to injury, what type? ☐ Auto ☐ Workers' Compensation ☐ Home ☐ Other: _____

Please provide complete details to accident, date and time. Attach a separate sheet if necessary.

_____

I authorize the release to or by one or more of the following, herein referred to as 'Insurance Company': Standard Insurance Company, any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing the Insurance Company to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. Your signature is required for benefit consideration.

For New York residents, the following statement applies: 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 violation.

Employee signature **X**	Date (MMDDYYYY)

Section 2: To be completed by the employer

Group policy no.	Date employed (MMDDYYYY)	Effective date of insurance	Occupation/job title

Employee Social Security no.	Employee no. (if applicable)	Employee benefit class ☐ Part-time ☐ Full-time	Standard no. of hours worked per week

Date employee last worked	No. of hours	Date employee scheduled to return to work	Date employee returned to work

Amount of weekly benefits	Employee's wage $ _____ per ☐ Hour ☐ Week ☐ Month ☐ Year	Employee's compensation ☐ Hourly ☐ Salaried

Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No

Is claim being made for Workers' Compensation? ☐ Yes ☐ No

What percentage of the Short Term Disability premium does the employer pay? _____%

If the employee contributes to the premium, contributions are made: ☐ Pre-tax ☐ Post-tax

Is the employee receiving any compensation (sick pay, vacation, salary continuation)? ☐ Yes ☐ No Attach additional sheets if needed.
If so, please provide dates and amounts: _____

Group name	Branch or division address	Phone no.

Signature of employer representative **X**	Printed name of employer representative	Title	Date (MMDDYYYY)

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

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Short Term Disability Claim Form
Attending Physician Statement

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Email: AL-Claims@standard.com

Section 3: To be completed by the physician

Note to physician: Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

Patient last name	First name	M.I.	Birth date (MMDDYYYY)

Patient street address	City	State	ZIP code

Current diagnosis: _____

ICD10/DSM5: _____

Subjective complaints: _____

Objective findings: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, specify dates of treatment: _____

Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

Is disability due to pregnancy? ☐ Yes ☐ No EDC: _____ Type of delivery: ☐ Vaginal ☐ C-section

Was patient hospitalized? ☐ Yes ☐ No If yes, please provide date of confinement: _____
Name of hospital/facility: _____

Nature of surgical procedure, if any. Date performed: _____
Describe in full: _____

Date patient first unable to work	Date of first visit	Date of last visit	Date of next visit

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____

Treatment plan: _____

Functional impairments: _____

Current medications and dosages: _____

Patient released to return to work? ☐ Yes ☐ No
If yes: ☐ Full-time, no restrictions Date able to return to full duty: _____
☐ Light duty Date able to return to light duty: _____
Please specify restrictions, limitations, hours, graduated return to work schedule, etc.:
_____

Is this patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No

Printed physician name	Physician tax ID no.	Physician specialty

Physician street address	City	State	ZIP code

Physician phone no.	Physician fax no.	Physician email address

Physician signature X	Date (MMDDYYYY)

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VACORP
Disability
Employee Authorization for Release of Information
(HIPAA compliant)

To be signed and dated by the insured/claimant.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefit manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, health or other insurance or reinsuring company, health benefits administrator, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the payment for any such diagnosis, prognosis and treatment, including any information about care management or coordination services I may receive from my health insurer or health plan administrator, and any non-medical information about me, to give any and all such information to authorized representatives of the following, herein referred to as 'Insurance Company': Standard Insurance Company. I understand such information may include but not be limited to medical, dental and hospital records and other records related to mental or psychiatric health, alcohol and drug use, communicable diseases and HIV/AIDS information, and claims and other administrative records.

I understand that the information obtained by use of this authorization will be used by the Insurance Company representatives to evaluate and adjudicate my disability claim(s), and for the Insurance Company's internal analysis and for reporting of its business as allowed or required by law. I understand the information obtained through this authorization may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing the Insurance Company to assist with the evaluation and adjudication of my disability claim(s).

To the extent that I have health insurance coverage through Elevance Health Inc. (aka Anthem, Inc.), or one of its affiliates or subsidiaries ("Elevance"), I authorize Insurance Company to share my disability insurance coverage and claim information with Elevance for the purpose of possible coordination of services that may benefit me. Information that may be shared includes, but is not limited to, my name, claim number, disability date, return to work date, claim closure date, health information such as medical diagnoses, diagnoses code(s), health status and medical limitations and restrictions.

This authorization is valid during the pendency of my claim and shall expire on the earlier of (a) 12 months from the date signed below or (b) the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying the Insurance Company in writing, of my revocation. However, such revocation is not effective to the extent that the Insurance Company has relied previously upon this authorization for the use or disclosure of my information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair the Insurance Company's ability to evaluate my disability claim(s)and as a result may be a basis for denying my disability claim(s) for benefits.

Health information obtained will not be re-disclosed without my authorization unless permitted or required by law, in which case it may not be protected under federal privacy rules.

Signature — To be signed and dated by the insured/claimant.

Claimant printed name	Birth date (MMDDYYYY)
Claimant signature **X**	Date (MMDDYYYY)

Relationship of authorized person	Description of personal representative's authority, if applicable (If signed by authorized representative, attach verification of identity.)

Send completed form to:
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Portland, OR 97208-9830

For customer service:
Call:844-404-2111
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The laws of some states require us to provide you with the following information

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

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

California: For your protection California law requires the following statement to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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 a 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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: '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: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York: For New York residents, the following statement applies: 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 materials 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 violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

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

Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

Texas: 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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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