



Your Disability Benefit Claim

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 benefits 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 their portion of the claim form on page 2, before giving the packet to you.
2. Complete and sign your part of the claim form. Compare your responses to those of your employer to make sure you agree on all information, including **last day of work** and **sick leave** dates. Then mail these forms to: City of Pittsburgh, Department of Personnel, Room 431, City-County Bldg., 414 Grant St., Pittsburgh, PA 15219 and not to The Standard Benefit Administrators.
3. Your treating physician should complete the Attending Physician's Statement. 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.
4. Sign and date the Authorization, and send it, along with the claim 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 group insurance certificate lists 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 of your claim, 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 or your employer notify The Standard Benefit Administrators immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

TO BE COMPLETED BY EMPLOYER

Employee's Full Name:		Social Security No.:	Job Title: <i>(Please attach a copy of the job description.)</i>	1. Date Employed:
Work Location:	Address:		State:	Zip Code:
2. Is the employee insured for Short Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the employee eligible for the STD Buy-Up Option? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the employee elect the STD Buy-Up Option? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, benefits will be based on the STD core plan.		3. Is the employee insured for Long Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the employee eligible for the LTD Buy-Up Option? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the employee elect the LTD Buy-Up Option? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, benefits will be based on the LTD core plan.		
4. Is disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined		5. Has the employee filed for: Workers' Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly Amount: _____		
5. Employee's earnings: \$ _____ (Check one) <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> annual <input type="checkbox"/> commission <input type="checkbox"/> other <input type="checkbox"/> shift differential <input type="checkbox"/> bonuses Date of last increase: _____ Earnings prior to increase: \$ _____			7. Last active day at work: 8. Job status when disability began: <input type="checkbox"/> Full-time (<u>40</u> hours/week)	
9. Date employee returned to work:				
10. Last day through which the following have been paid by the employer: Comp Time: _____ Personal Time: _____ Sick Leave: _____ Vacation: _____ (Please note that benefits will be offset by the amount of income an employee received from Comp Time, Personal Time, and Sick Leave.)				
11. Is employee subject to: Social Security taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. What percentage of the STD premium does the employer pay? _____ % What percentage of the LTD premium does the employer pay? _____ %		
13. Bonus Waiver (Laborer's Trust Benefit for PJCBC and PWSA PJCBC)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, \$300 offset)				
14. Are employer paid premiums included in the employee's salary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Employer: City of Pittsburgh	Division:		Phone No.: (412) 255-2681	Policy No.: 643163
Mailing Address: Department of Personnel, Room 431, City County Building, 414 Grant Street			City: Pittsburgh	State: PA
			Zip Code: 15219	
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 on page 3 of this form.				
Signature:			Date:	

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.

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.

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

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ALL OTHER RESIDENTS

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TO BE COMPLETED BY EMPLOYEE

Employer City of Pittsburgh		Division		Group Policy No.; 643163	
Full Name:			Social Security No.:		Phone No.:
					()
Birthdate		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	No. of Dependent Children		Birthdate of Youngest
Address:			City:		State: Zip Code:
1. Is your disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined			2. Have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Do you intend to file? <input type="checkbox"/> Yes <input type="checkbox"/> No			4. Last active day at work:		
5. Date you became unable to work at your occupation because of disability:			6. Date you returned or expect to return to work:		
7. <input type="checkbox"/> Accident. When and where did it happen? <input type="checkbox"/> Illness. When did you first notice and what is the nature of your disability?			8. How does your disability prevent you from working?		
			9. Have you had a previous disability claim with The Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			10. Pregnancy: Expected delivery date: _____ Actual delivery date: _____ Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section		
11. Do you want The Standard to withhold Federal Income Tax? <input type="checkbox"/> Yes <input type="checkbox"/> 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 on page 5 of this form.					
Signature:				Date:	

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The following information is needed to document the patient's inability to work. The patient is responsible for completing this form at their own expense. Please complete this form and mail it to The Standard Benefit Administrators at the address listed above.

Employee's Full Name:	Social Security No.:
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TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Diagnosis	
A. Diagnosis:	ICDA Classification:
B. Symptoms:	C. Objective Findings: Height: Weight: B/P:

2. Pregnancy (if applicable)			
A. Expected date of delivery:	B. Actual date of delivery:	C. Type of delivery:	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section
D. Significant complications, if any:			

3. History			
A. Date you recommended the patient stop work:		B. When did symptoms appear or accident happen?	
C. Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when?	
D. Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		E. Did you complete a workers' compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Treatment			
A. Date of first visit:	B. Date(s) of subsequent visits:	C. Date of most recent visit:	
D. Planned course and duration of treatment (include surgery and medications, if any):			

5. Level of Functional Impairment				
A. Describe the patient's mental and cognitive limitations, if any.	B. In a work day given two breaks and a meal break, your patient can:			
	Lift (in pounds)	<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+		
	Carry (in pounds)	<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+		
	Total Hours		With positional change	
	Sit	8 7 6 5 4 3 2 1	(hrs)	_____
	Stand	8 7 6 5 4 3 2 1	(hrs)	_____
	Walk	8 7 6 5 4 3 2 1	(hrs)	_____
	Alternately sit/stand	8 7 6 5 4 3 2 1	(hrs)	_____
	Bend/stoop:	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently		

C. Is the patient competent to manage insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, is the patient competent to appoint someone to help manage the insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	

6. Hospitalization (if applicable)	
A. Date admitted:	B. Date discharged:
C. Reason:	D. Name of hospital:

7. Prognosis			
A. Since onset of symptoms, the patient's condition has: <input type="checkbox"/> Improved <input type="checkbox"/> Not changed <input type="checkbox"/> Retrogressed			
B. When do you anticipate the patient can return to work? <input type="checkbox"/> Date: <input type="checkbox"/> Unable to determine, follow up in: weeks <input type="checkbox"/> Never			

8. Physician Information (Please type or print.)			
Name of physician completing this form:		Phone No.: ()	
Specialty:	Tax ID. No.:	Fax No.: ()	
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 on page 7 of this form.	
Signature:	Date:

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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.
- Any insurance or annuity company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program or an annuity program.
- Any educational, vocational or rehabilitational 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, 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, or eligibility for other benefits including retirement benefits and retirement plan contributions (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.*).

TO STANDARD INSURANCE COMPANY (STANDARD INSURANCE COMPANY INCLUDES THE STANDARD BENEFIT ADMINISTRATORS).

- 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 Standard Insurance Company will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with Standard Insurance Company. 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 Standard Insurance Company, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair Standard Insurance Company's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, Standard Insurance Company may disclose to other parties information it has about me. Standard Insurance Company may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Standard Insurance Company in connection with my claim.
- I understand that Standard Insurance Company complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to Standard Insurance Company pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act [HIPAA] and therefore the release of information to Standard Insurance Company is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations (*if applicable*) 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.

This Authorization is a two-page document. Please see page 9 for additional terms and information. Both pages are part of the Authorization.

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires us to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The accompanying Authorization to Obtain Information 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 the same address above.