TheStandard®

Standard Insurance Company
Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

# State of Ohio Exempt Employees Accelerated Benefit Instructions

**PLEASE READ CAREFULLY**

1. The receipt of an Accelerated Benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. If you meet the definition of "terminally ill individual" in the Internal Revenue Code Section 101, your accelerated benefit may be non-taxable. You should consult your personal tax advisor and/or legal advisor before you apply for an Accelerated Benefit.
2. Your Group Policy provides a benefit which allows you to receive an early payment of a portion of your group life insurance once during your lifetime, if you meet certain requirements. Please consult the Accelerated Benefit provision of your certificate for details.
3. To be eligible for this benefit, you must have a Qualifying Medical Condition as defined in the group policy. If you have questions regarding the Qualifying Medical Conditions, please contact your Employer or our office.
4. If you are eligible for this benefit, you may apply to receive part of your Life Insurance Benefit as an accelerated benefit.
5. The minimum Accelerated Benefit is $5,000 or 10% of your group life insurance, whichever is greater.
6. In order to apply for the benefit, you must submit a completed claim packet. Your claim packet consists of four forms. All questions on these forms are important. Please answer them to the best of your ability. If a section does not apply to you, or the information is unavailable, please indicate that in the space provided.

The four forms in your claim packet are:

1. **Employee's Statement/Consent To Payment**

   You must fill out this Statement completely. If not enough space is given on the form, please use an additional sheet. Remember to sign and date the Statement. An unsigned Statement will be returned for your signature.

2. **Authorization To Obtain Information**

   Please sign and date this form and attach it to the Employee's Statement. Your signature on this form enables Standard Insurance Company (The Standard) to obtain the information necessary to determine your eligibility for this benefit. The authorization also allows us to release this information to other parties for purposes specified on the authorization. You will receive a copy of this Authorization upon your request.

3. **Attending Physician's Statement**

   Please provide the member information on the top of the form and the remainder of the form should be completed by your physician. If you have seen more than one physician for your disability, a statement should be completed by each one. Your physician(s) should mail the completed form directly to The Standard.

4. **Employer's Statement**

   This form should be completed entirely by your Employer. Please see that your Employer returns the form to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. Processing of your claim will begin when all completed forms are received. Should you have any questions, our office is available to assist you. You may contact us at 1-800-628-8600 between the hours of 11:00 a.m. and 8:00 p.m. EST Monday through Friday.

Transmittal Date: _____

**This application must be completed and returned no later than 30 days from this date.**

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# State of Ohio Exempt Employees Accelerated Benefit Employee's Claim

Reset

***Please make sure that you have answered all questions completely and accurately. If there are unanswered questions, the review of your claim may be delayed. An Employer's Statement and Attending Physician's Statement must also be submitted to The Standard. (Please print or type.)***

Full name _____

Street address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Birthdate _____ Social Security No. _____

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Have you received a Certificate of Insurance, brochure or other written description of the Accelerated Benefit? ☐ Yes ☐ No

Name of Employer **State of Ohio**

Street address **Benefits Department, 30 E. Broad Street, 28th Floor**

City **Columbus** State **OH** ZIP **43215**

Date hired _____

Have you stopped working? ☐ Yes ☐ No If yes, last day at work _____

Are you self-employed at any activity? ☐ Yes ☐ No

Are you now working at your occupation or another occupation? ☐ Yes ☐ No

Are you covered under more than one group life insurance policy issued by Standard Insurance Company? ☐ Yes ☐ No

Have you applied for waiver of premium? ☐ Yes ☐ No

Describe your present medical condition.

***Please provide the following information regarding any physicians who have treated you. Attach a separate sheet for additional physicians.***

Physician's name _____ Speciality _____

Street address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Date first consulted _____ Date last consulted _____

Please indicate if you are currently confined to a hospital ☐ Yes ☐ No Nursing home ☐ Yes ☐ No

If you answered yes, please provide the date confinement began _____ Is confinement permanent? ☐ Yes ☐ No

Please provide the name and address of hospital or nursing home.

_____
Name

_____
Street City State ZIP

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# State of Ohio Exempt Employees Accelerated Benefit Employee's Claim

Are you currently receiving in-home care? ☐ Yes ☐ No If yes, care is ☐ Full-time ☐ Part-time

Please describe type of care and by whom provided.

What amount of accelerated benefit are you claiming? _____ % $ _____

| | |
|---|---|
| 10% minimum* | $5,000 minimum* |
| 25% minimum* | $250,000 maximum* |
| 50% maximum* | $500,000 maximum* |
| 75% maximum* | |

* *Subject to the terms in your policy, the minimums and maximums indicated here may vary. Please read the Accelerated Benefit provision in your Certificate of Insurance.*

***Please respond to the following.***

Is part or all of your Life Insurance required to be paid to your children, spouse or former spouse as a part of a court-approved divorce decree, separate maintenance agreement or property settlement agreement? ..... ☐ Yes ☐ No

Are you married and living in a community-property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin)? ..... ☐ Yes ☐ No

**If yes, your spouse must complete the attached written consent for payment of an Accelerated Benefit.**

Have you made an assignment of all or part of your insurance? ..... ☐ Yes ☐ No

If yes, the assignee must complete the attached written consent for payment of an Accelerated Benefit.
(An assignment is a transfer of your rights under this policy; it does not refer to your beneficiary designation.)

Have you filed for bankruptcy? ..... ☐ Yes ☐ No

If yes, the trustee in bankruptcy or other official of the Bankruptcy Court must complete the attached written consent for payment of an Accelerated Benefit.
(If you are covered under a policy issued in CT, IL, or TX, you are not required to respond.)

Are you required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement? ..... ☐ Yes ☐ No

(If you are covered under a policy issued in CT, you are not required to respond.)

Have you previously applied for or received an Accelerated Benefit under the Group Policy? ..... ☐ Yes ☐ No

Have you made application to convert or have you converted all or part of your coverage under the Group Policy to an individual policy? ..... ☐ Yes ☐ No

I certify the above answers are true and complete and to the best of my knowledge and belief form the basis of my claim for an Accelerated Benefit. I do understand that the receipt of an Accelerated Benefit may be taxable and affect my eligibility for Medicaid or other government benefits or entitlements. I also understand that if I meet the definition of "terminally ill individual" of the Internal Revenue Code Section 101, my Accelerated Benefit may be non-taxable and these matters should be discussed with my tax and/or legal advisor before applying for an Accelerated Benefit. I further understand that this benefit provides for an accelerated payment of life insurance and is not intended nor designed to provide health, nursing home or long term care benefits.

**Acknowledgment**

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 4 of this form.

Signature _____ Date _____

**This application must be completed and signed no more than 30 days after the transmittal date shown on page 1.**

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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.

**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 Ohio Exempt Employees Accelerated Benefit Payment Consent

STATE OF _____ )
) ss.
County of _____ )

The undersigned, on oath being first duly sworn, depose and say:

My relationship to _____ is:
(Name of Claimant)

- ☐ spouse living in a community property state
- ☐ assignee under an assignment
- ☐ trustee in bankruptcy or other official of the Bankruptcy Court

I understand that the claimant is making application to Standard Insurance Company (The Standard) for the payment of an Accelerated Benefit in the amount of $_____ under a group term life insurance policy. I consent to the payment by The Standard to claimant of the Accelerated Benefit should The Standard determine the claimant to be eligible.

_____
Signature

Subscribed and sworn to before me this _____ day of _____

_____
Notary Public for the
State of _____

My commission expires: _____

Standard Insurance Company

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# State of Ohio Exempt Employees Accelerated Benefit Authorization to Obtain 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.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit 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 (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

**TO STANDARD INSURANCE COMPANY (THE STANDARD).**

- 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 The Standard 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 The Standard. 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 Standard, 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 The Standard'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, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Life coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act [HIPAA] and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations *(if applicable)* 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.

*This Authorization is a two-page document. Please see page 7 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 The Standard, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The Standard 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 The Standard. Within 30 business days of receiving the request, The Standard 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. The Standard 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 The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.

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# State of Ohio
# Exempt Employees
# Accelerated Benefit
# Attending Physician's Statement

***Please type or print. The patient is responsible for the completion of this form at their own expense. We require comprehensive medical information in order to evaluate the insured's claim for Accelerated Benefit.***

Full name _____ Phone (_____) _____

Street address _____

City _____ State _____ ZIP _____

Birthdate _____ Social Security No. _____ Sex ☐ Male ☐ Female

Policy number 645571

**DEAR DOCTOR:** The purpose of this form is to help us determine whether your patient is eligible for accelerated payment of life insurance proceeds. We need to evaluate the clinical condition of your patient. Please advise of any clinical findings including laboratory data and results of special tests such as X-rays, CAT scan, EKG, etc. Copies of any surgical reports, hospital discharge summaries, chart notes, or narrative reports will be helpful.

Weight _____ Height _____ Blood pressure on last visit _____ Pulse _____

Diagnosis
Primary _____

Secondary _____

ICDA Classification _____

Course of treatment, including medications _____

_____

Prognosis _____

In your opinion, does the patient have a terminal condition? _____

What is the terminal condition? _____

In your professional opinion, what is the patient's life expectancy?
- ☐ Less than 6 months
- ☐ 6 to 12 months
- ☐ Greater than 12 months
- ☐ Other _____

Objective findings – Objective documentation must be included to support life expectancy _____

_____

_____

Symptoms _____

_____

_____

When did symptoms first appear? _____

Date you recommended patient should stop working _____ Why? _____

_____

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# State of Ohio Exempt Employees Accelerated Benefit Attending Physician's Statement

## DATES AND NATURE OF TREATMENT

(a) Date of first visit _____ Date of last visit _____

(b) Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) _____

(c) Will treatment substantially improve function and employability? ☐ Yes ☐ No If yes, specify _____

(d) Have you made referrals? ☐ Yes ☐ No _____ (_____) _____
Name Specialty Phone

## PROGRESS

(a) Has patient: ☐ Retrogressed ☐ Unchanged ☐ Improved ☐ Recovered

(b) Is patient: ☐ Hospital confined ☐ Bed confined ☐ House confined ☐ Ambulatory

(c) If patient has been hospitalized, please provide the name, address, and phone number of the hospital.

_____

Admitted _____ Discharged _____ Phone (_____) _____

## LIMITATION *(If there is a limitation, check and describe below.)*

Are the limitations permanent? ☐ Yes ☐ No

☐ Sitting ☐ Climbing ☐ Bending ☐ Use of left hand/arm ☐ Use of right hand/arm ☐ Sitting ☐ Walking

☐ Stooping ☐ Lifting ☐ Pushing/Pulling ☐ Other clarify _____

## PHYSICAL IMPAIRMENT *(*as defined in Federal Dictionary of Occupational Titles)*

☐ Class 1 – No limitation of functional capacity; capable of heavy work*; No restrictions

☐ Class 2 – Medium manual activity*

☐ Class 3 – Slight limitation of functional capacity; capable of light work*

☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity

☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity

☐ Remarks _____

Do you believe the patient is competent to manage insurance benefits? ☐ Yes ☐ No

If no, is the patient competent to appoint someone to help manage the Insurance benefits? ☐ Yes ☐ No

## LIST OTHER TREATING OR REFERRING PHYSICIANS

| NAME | ADDRESS |
|---|---|
| 1. _____ | _____ City State ZIP |
| 2. _____ | _____ City State ZIP |

Name of physician _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone (_____) _____ Taxpayer Identification No. _____

**Acknowledgment**

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 10 of this form.

Signature _____ Date _____

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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.

**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 Ohio Exempt Employees Accelerated Benefit Employer's Statement

***Please type or print, and complete all questions. Form may be returned for completion of unanswered questions.***

## 1. EMPLOYEE

**Name of Employee** _____

Street address _____

City _____ State _____ ZIP _____

Job title _____

Social Security No. _____ Date of birth _____

## 2. WORK STATUS INFORMATION

Date of employment or association membership *(union or other)* _____ Union member ☐ Yes ☐ No

Effective date of Employee's insurance _____ Name of union _____ Contact person _____

Employee's status on date disability commenced:

Was Employee Actively at Work the day before disability commenced? ☐ Yes ☐ No

Number of hours worked per week _____ Last day of work before disability commenced _____

Is Employee terminated? ☐ Yes Effective date _____ ☐ No

*If yes, please stop premium payment for this Employee.*

Reason for termination

## 3. OTHER INFORMATION

Does Employee have any of the following insurance coverage with a carrier other than The Standard? Has Employee applied for:

| | Other Carrier | Applied | Receiving |
|---|---|---|---|
| A. Long Term Disability | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| B. Short Term Disability | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| C. Life Insurance under more than one policy | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

Please provide the name, address and contact person for the above.

A. Name _____
Address _____
_____
City State ZIP
Phone ( _____ ) _____
Fax ( _____ ) _____

B. Name _____
Address _____
_____
City State ZIP
Phone ( _____ ) _____
Fax ( _____ ) _____

C. Name _____
Address _____
_____
City State ZIP
Phone ( _____ ) _____
Fax ( _____ ) _____

**Social Security Benefits** Has Employee applied for benefits? ☐ Yes ☐ No Is Employee receiving benefits? ☐ Yes ☐ No

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## 4. EARNINGS

Please check appropriate box and fill in the amount of salary.

☐ Basic Yearly Earnings Annual rate: $ _____

**Date of last increase** _____ **Earnings prior to increase** _____ per _____

If effective date of increase in insurance is different than date of last earnings increase,

please give effective date of insurance increase _____

## 5. AMOUNT OF INSURANCE

Does Employee have group life insurance with Standard Insurance Company under more than one policy? ☐ Yes ☐ No

If yes, list all of The Standard's policy numbers _____

Does Employee have Long Term Disability with The Standard? ☐ Yes ☐ No Job classification _____

**Amount of Basic Life Insurance with The Standard $** _____

**The benefit amount is determined as follows and rounded to the next highest thousand if not already a multiple of a thousand:**

**For part-time employees: 1040 hours X hourly rate**
**For full-time employees: 2080 hours X hourly rate**
**For Firefighters in the Adjutant General's Office: 2704 hours X hourly rate**

*** For employees working less than 1040 hours per year, benefit will be calculated based on 1040 hours per year.**

**PLEASE CONTINUE PAYMENT OF PREMIUMS UNTIL OTHERWISE NOTIFIED UNLESS EMPLOYEE HAS BEEN TERMINATED.**

If premiums have already been terminated, give date paid through _____

## 6. ATTACHMENTS

*Please attach the following:*

a. Copy of Job Description
b. Copy of Employment Application or Resume

***Important Information Please Attach***

## 7. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM *Please print or type.*

Employer **State of Ohio** Representative _____

Address **Benefits Department, 30 E. Broad Street, 28th Floor, Columbus, OH** ZIP **43215**

Phone ( _____ ) _____ Fax ( _____ ) _____ Policy number **645571**

**Acknowledgment**

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 13 of this form.

Signature _____ Title _____ Date _____

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Print