



Your application for an Accidental Dismemberment Benefit consists of four forms. Every space 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 we know you did not overlook a 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 completely describe your injury/loss and how your accident occurred.
- Use an additional page, if necessary, to complete all questions.
- Enclose photocopies of all medical records pertaining to your loss.
- Enclose Accident Report if available.
- Remember to sign and date your statement. **An unsigned or undated statement may be returned to you.**

2. The Employer's Statement

- This form should be completed by your employer who will mail it to Standard Insurance Company (The Standard).

3. The Authorization to Obtain Information

- Please sign and date this form and attach it to the Employee's Statement. Your signature on this form enables us to obtain the necessary information about you to determine your eligibility for the Accidental Dismemberment benefit. The authorization also allows us to release information to a specific person. **You will receive a copy of the Authorization upon your request.**

4. The Attending Physician's Statement

- **Part 1** should be completed by you.
- **Parts 2 & 3** should be completed by your physician. If you have seen more than one physician for your loss, a statement should be completed by each one (this form may be photocopied). Your physician(s) should mail the completed form directly 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 Monday through Friday from 11:00 a.m. until 8:00 p.m. EST at 1-800-628-8600.

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

EMPLOYEE DATA

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

Birthdate: _____ Social Security No. : _____

Date of Accident: _____

What injuries/losses were sustained?

Describe how accident occurred.

MEDICAL

Describe your present medical condition and indicate any changes.

Please list all physicians who have treated you for this injury/loss.

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Have you had any hospitalizations or surgeries? If so, please indicate.

Hospital name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

From: _____ To: _____

From: _____ To: _____

Please enclose photocopies of pertinent medical records.

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 4 of this form.

Signature: _____ Date: _____

(Next page to be completed by employer.)

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

EMPLOYEE INFORMATION

Full Name: _____

Date of employment or association membership (union or other): _____

Date employee's insurance effective: _____

Employee's status: Actively at Work? Yes No

Number of Hours Worked per Week: _____ Last day of work: _____

Is employee now terminated? Yes No Date of Termination: _____

Reason: _____

AMOUNT OF INSURANCE

Does employee have group life insurance under more than one policy number? Yes No

If yes, list all policy numbers: _____

Amount of Basic Life Insurance \$ _____

Amount of Accidental Death & Dismemberment Insurance \$ _____

The life insurance is based on earnings, please fill in the amount of salary.

Basic Yearly Earnings Annual rate \$ _____

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.**

Amount of benefit being claimed \$ _____

Date of last increase in earnings or benefit? _____

Earnings prior to increase \$ _____ per year

PREMIUMS

Please advise last month premiums paid: _____

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: **State of Ohio**

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

City: **Columbus** State: **OH** Zip Code: **43215**

Phone No.: (_____) _____ Policy No.: **645571**

Acknowledgement

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Signature: _____ Title: _____ 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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 6. 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 6 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.

PART 1. TO BE COMPLETED BY PATIENT

Full Name: _____ Policy No.: **645571**

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

To Physicians and Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Standard Insurance Company, Portland, Oregon, any information you have regarding my medical history and physical condition.

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 9 of this form.

Signature: _____ Date: _____

PART 2. TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

History (please describe how accident occurred, please attach physician notes, operative reports if available):

Please describe amputation: _____

On what date did amputation take place? _____

Condition: Regressed Unimproved Improved Recovered

If loss of sight, please complete the following:

Is insured totally blind? _____ Was eye enucleated? _____

If not, please describe the extent of visual field loss: _____

If not totally blind, what was vision at last observation?

With glasses: left: _____ right: _____ date: _____

Without glasses: left: _____ right: _____ date: _____

Can vision be improved by treatment, operation or lenses? Yes No

If so, please explain: _____

Hospital confinement

Hospital name: _____

Admitted: _____ Discharged: _____

Other Physicians:

Name & Addresses of other treating or referring physicians:

PART 3. PHYSICIAN COMPLETING THIS FORM

Name of Physician: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____

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