



Accelerated Benefit Instructions

Standard Insurance Company, Group Life Department
P.O. Box 2800 Portland OR 97208-2800 1.800.628.8600 Tel

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 at least \$10,000 group life insurance and 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. 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 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**

Part A should be completed by you.

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.



Accelerated Benefit Employee's Claim

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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 code _____
 Phone no. (____) _____ 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 _____
 Street Address _____
 City _____ State _____ Zip Code _____
 Date hired ____/____/____ Last day at work ____/____/____
 Reason you stopped working _____
 Job Title/Describe job duties _____

Are you self-employed at any activity? Yes No Are you covered under more than one group life insurance policy issued by Standard Insurance Company? Yes No
 Are you now working at your occupation or another occupation? 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 Code _____
 Phone no. (____) _____ 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 _____ Zip Code _____



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Are you currently receiving in-home care? Yes No If yes, is the care full-time part-time

Please describe type of care and by whom provided: _____

What amount of your Life Insurance Benefit do you want to accelerate? _____ % \$ _____

- 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. (Residents of CT, IL, and TX 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

(Residents of CT 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.

Some states require this statement on claim forms: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. In Florida fraud is a felony.

Signature _____

Date ____/____/____



Accelerated Benefit Payment Consent

Standard Insurance Company, Group Life Department
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ss.

STATE OF _____)
)
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 for the payment of an Accelerated Benefit in the amount of \$ _____ under a group term life insurance policy. I consent to the payment by Standard Insurance Company 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 _____, 19____.

Notary Public for the
State of _____

My commission expires: _____



Accelerated Benefit Authorization To Obtain Information

Standard Insurance Company, Group Life Department
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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 company.
- Any employer or plan administrator.
- 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.

Note: In the State of Minnesota, this Authorization does not include the performance of or the results of a test to determine the presence of the Human Immune Deficiency Virus (HIV) antibody given to (a) an offender, as defined under Minnesota law, or (b) a crime victim, because of exposure to or contact with such an offender.

 - Any communicable disease or disorder.
 - Any psychiatric or psychological condition, including test results.
 - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.
- 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 Systems, Railroad Retirement Board, claim status, benefit amounts and effective dates, etc.)

TO STANDARD INSURANCE COMPANY THE PLAN ADMINISTRATOR, AND THE POLICYOWNER.

I understand that Standard Insurance Company, the plan administrator, will use the information to determine my eligibility or entitlements for insurance benefits.

Standard Insurance Company, the plan administrator, may release 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 ACKNOWLEDGE THAT I HAVE READ THE AUTHORIZATION and I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with Standard Insurance Company. A photocopy of this authorization is as valid as the original.

Name (please print)

Signature of Claimant/Guardian/Representative

____/____/____
Date



Accelerated Benefit Attending Physician's Statement

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Please type or print. The patient is responsible for the completion of this form without expense to Standard Insurance Company. We require comprehensive medical information in order to evaluate the insured's claim for Accelerated Benefit.

Full name _____ Phone no. (____) _____

Street address _____

City _____ State _____ Zip code _____

Birthdate ____/____/____ Social Security No. ____-____-____ Sex Male Female

Policy number _____

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? _____



Accelerated Benefit Attending Physician's Statement

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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 Ph No.

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 No. (____) _____

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 endorse checks and direct the use of the proceeds thereof? Yes No

LIST OTHER TREATING OR REFERRING PHYSICIANS

NAME	ADDRESS
1. _____ City _____ State _____ Zip Code _____	
2. _____ City _____ State _____ Zip Code _____	
Name of physician _____	Specialty _____
Address _____	City _____ State _____ Zip Code _____
Telephone No. (____) _____	Taxpayer Identification No. _____

Some states require this statement on claim forms: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. In Florida fraud is a felony.

Signature _____ Date ____/____/____



Accelerated Benefit Employer's Statement

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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 Code _____
 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 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 ____/____/____ 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Short Term Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Life Ins. under more than one policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

A. Name _____ Address _____ _____ city state zip Ph No. (____) _____ Fax No. (____) _____	B. Name _____ Address _____ _____ city state zip Ph No. (____) _____ Fax No. (____) _____	C. Name _____ Address _____ _____ city state zip Ph No. (____) _____ Fax No. (____) _____
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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 Monthly Earnings Monthly rate \$ _____
- Basic Yearly Earnings Annual rate \$ _____
- Basic Contract Earnings Contract amount \$ _____ Length of contract _____
- Basic Weekly Earnings Weekly rate \$ _____
- Basic Hourly Earnings Hourly rate \$ _____
- Commissions (Please attach list of commissions paid for the period specified in your group policy.)

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 LTD with The Standard? Yes No Job classification _____

Amount of Basic Life Insurance with The Standard \$ _____

Amount of Voluntary Life Insurance with The Standard \$ _____

Amount of Additional Life Insurance with The Standard \$ _____

Policy Class Number _____

Does employee have life insurance for dependents under your group policy? Yes No

If yes, amount of Spouse Life Insurance \$ _____ Dependent Life Insurance \$ _____

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. **Original** Enrollment card and any subsequent beneficiary changes.
- b. Copy of Job Description
- c. Copy of Employment Application or Resume

***Important
Information
Please Attach***

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

Employer _____ Representative _____

Address _____ Zip code _____

Phone number (____) _____ Fax number (____) _____ Policy number _____

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Signature _____ Title _____ Date ____/____/____