Standard Insurance Company

Standard Insurance Company PO Box 2800 Portland OR 97208
800.368.2859 Tel 800.378.6053 Fax
DiMartino Associates 1325 Fourth Avenue Suite 1705 Seattle WA 98101
206.623.2430 Tel 206.957.5145 Fax

Washington State Council of Fire Fighters
Long Term Disability Insurance
Employer's Statement

1. Employee

Name of Employee ______

Address ______ City ______ State ______ ZIP ______

Job Title ______

Phone No. (______) ______ Date Employed ______ Social Security No. ______

2. Information

Date employee's LTD coverage became effective: ______

Local Name: ______ Address ______ State ______ ZIP ______

Was employee insured under previous LTD carrier? ☐ Yes ☐ No ☐ Effective Date ______

Employee's Medical Insurance carrier ______

Phone No. (______) ______ Effective date for medical insurance ______

Employee's status on date disability commenced:
Actively at Work? ☐ Yes ☐ No If no, reason ______ Number of hours worked per week ______

Last day of work before disability commenced ______ ☐ Exempt or ☐ Non-Exempt ☐ Union or ☐ Non-Union

Number of hours worked this day ______ Date employee returned to work after disability ended ______

Does the employee have income from other employment? ☐ Yes ☐ No Name of other employer:

Have you considered allowing the claimant to work in another occupation, or modify or alter the job duties of the claimant's occupation, how the job is done (i.e., work schedule), or worksite? ☐ Yes ☐ No If yes, what alternatives were offered to the claimant?

Is disability caused or contributed to by employment? ☐ Yes ☐ No ☐ Undetermined

Has employee filed a Workers' Compensation claim? ☐ Yes ☐ No ☐ Don't Know

Workers' Compensation Carrier Name **Labor and Industries (L&I)** Claim No. ______ Date of Injury ______

Address ______ City ______ State ______ ZIP ______

Phone No. (______) ______ Person to contact ______

Is employment now terminated? ☐ Yes ☐ No Is employment scheduled for termination? ☐ Yes ☐ No

Reason ______ Date of termination ______

3. Salary at Time of Disability *Please check only one box.*

☐ Basic Monthly Earnings Monthly Rate $ ______ ☐ Basic Weekly Earnings Weekly Rate $ ______

☐ Basic Yearly Earnings Annual Rate $ ______ ☐ Basic Hourly Earnings Hourly Rate $ ______

☐ Basic Contract Earnings Contract Amount $ ______ Length of Contract ______

If employee is covered under a collective bargaining agreement, please provide detailed payroll records for the previous 3 full calendar months prior to last day worked.

Date of last increase ______ Earnings prior to increase $ ______ per ______ Effective date ______

4. Compensation for Period After Disability

Type	Last date through which paid or payable	Amount / Rate
Sick Pay/Salary Continuation		
Self-insured Short Term Disability		
Wages/salary, *earned after* disability		
Donated or Shared leave		

Does the bargaining agreement (or similar agreement) under which the employee is covered require the employee to remit payment of any disability benefits back to the employer or sick leave bank ☐ Yes ☐ No

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5. Deductible Income/Benefits From Other Sources

Is employee covered by or now receiving benefits from the following?	Covered		Receiving			Date of Application	Amount		Effective Date
	Yes	No	Yes	No	Don't Know		Weekly	Monthly	
a. Social Security	☐	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) *Please specify* ____________	☐	☐	☐	☐	☐				
e. Other ____________ (e.g., unemployment or union benefits)	☐	☐	☐	☐	☐				

6. Life Insurance

Was employee covered by Group Life Insurance with The Standard on cease work date? ☐ Yes ☐ No

If yes, list policy number(s) ____________

Date life insurance became effective ____________

Please attach original enrollment card.

Amount of Basic Life insurance $ ________ Additional/Optional $ ________ Supplemental $ ________ AD&D $ ________

Dependent's Coverage? ☐ Yes ☐ No If yes, ☐ Spouse ☐ Child If child, what are their ages? ____________

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. Tax Information

Employer's Federal Tax I.D. Number ____________

Check one: ☐ We are a private-sector employer
☐ We are a public-sector (government entity) employer

Is this employee subject to:

Social Security taxes? ☐ Yes ☐ No	Medicare taxes?	☐ Yes ☐ No
Railroad Tier 1 taxes? ☐ Yes ☐ No	Tier 1 Medicare taxes?	☐ Yes ☐ No
State Disability taxes? ☐ Yes ☐ No	Unemployment Compensation taxes?	☐ Yes ☐ No

If subject to Social Security taxes what are the employee's year to date Social Security wages? ____________

Does this employee pay all or a portion of the premium for LTD insurance coverage? ☐ Yes ☐ No

*If yes, what percentage of the LTD premium does the employer pay ________ %.

*the employee pay ________ % with "pre-tax" funds.

*the employee pay ________ % with funds that have been taxed.

*If yes, are employer paid premiums included in the employee's salary? ☐ Yes ☐ No

*If yes, are taxes withheld from employer paid premiums? ☐ Yes ☐ No

IMPORTANT: Remember to calculate annually the premium contribution percentage information according to the IRS 3 year averaging rule for group coverage.

8. Attachments

Please attach copies of the following:

a. Job Description
b. Employment Application or Resume
c. Enrollment or Election Form for Long Term Disability Insurance
d. Income From Other Sources (Deductible Benefits) Documents (Social Security, Workers' Compensation, PERS, etc.)

9. Employer Representative Completing This Form

Employer ____________

Phone No. ____________

Address ____________

City ____________ State ________ ZIP ________

Local/Admin Code ____________

Group ID Number - 10141971

Policy Number:

☐ Washington State Council of Fire Fighters - #771100

☐ WSCFF Custom Plan:

Local Name ____________

Policy Number ____________

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 applicable fraud notice on page 3 of this form.

Signature ____________ Date ____________

Prepared by ____________ Title ____________

Phone No. (______) ____________ Fax No. (______) ____________

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Claim Form Fraud Notices

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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.

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.

DISTRICT OF COLUMBIA RESIDENTS

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 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.