TheStandard®

Standard Insurance Company
Employee Benefits Department 800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208-2800

OCEA

Orange County Employees Association
Claim Packet Instructions

PLEASE READ CAREFULLY

Your application for benefits consists of four forms. **Every space on these forms 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 that we know you did not overlook that 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 use the appropriate section for injury, sickness or pregnancy. If a question does not apply to you write "NA".
   - Use an additional page, if necessary, to give full and complete answers.
   - Attach copies of any Social Security, Orange County Employee's Retirement System OCERS, Workers' Compensation or other benefit determinations you have received. If you have applied for any other benefits but have not yet received them, please send a copy of the application receipt. This information is needed to accurately calculate your monthly benefits. If you are unable to make copies of these documents please send the originals. We will photocopy and return them to you promptly.
   - Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

2. **The Authorization to Obtain Information**
   The Authorization to Obtain Psychotherapy Notes
   - Please sign and date the Authorization to Obtain Information and attach it to the Employee's Statement. Your signature lets Standard Insurance Company (The Standard) get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain Information also lets The Standard release this information to specific persons.

     If you have seen or been treated by a Psychiatrist, Psychotherapist, Psychologist, Clinical Social Worker (MSW, MCSW, etc.), or any other provider of treatment for a mental condition, please sign and return the Authorization to Obtain Information **and** the Authorization to Obtain Psychotherapy Notes.

     You will receive copies of these Authorizations upon your request.

3. **The Attending Physician's Statement**
   - **Part A** should be completed by you.
   - **Part B** should be completed by your physician. **If you have seen more than one physician for your disability, a statement should be completed by each physician.** (You may request additional forms from OCEA.) Your physician(s) should mail the completed form directly to OCEA at the address below.

4. **The Association's Statement**
   - This form is not part of your claim packet; however, it is required to complete the processing of your claim. OCEA has copies of the Association's Statement which will be completed upon OCEA's receipt of your claim forms and made part of your claim which will be forwarded directly to The Standard.

WHERE TO SEND YOUR COMPLETED CLAIM FORM

Once you have ceased working, please mail or fax all completed sections of your claim form to:

OCEA
830 N. Ross Street
Santa Ana, CA 92701
Fax (714) 543-1107

You are responsible for making sure all required forms are completed and returned to our office. If you have any questions, our office is here to help you.

Standard Insurance Company
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Reset

Orange County Employees Assocation
Employee Statement

TO BE COMPLETED BY INSURED EMPLOYEE

First Name _____ Last Name _____

Phone No. (_____) _____ Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security number _____ Sex ☐ Male ☐ Female

Name of Spouse _____ No. of dependent children under age 25 _____ Birthdate of youngest _____

Name of Plan Sponsor **Orange County Employees Association Health and Welfare Trust – 608843**

Name of Supervisor _____ Work No. of Supervisor (_____) _____

State your job title and your duties at work _____

Is your disability work related? ☐ Yes ☐ No Have you filed a Workers' Comp. claim? ☐ Yes ☐ No Do you intend to file? ☐ Yes ☐ No

If you have filed a Workers' Comp. claim, please list claim number _____

Last day of work _____ Last partial day at work, if applicable _____ Date you became unable to work at your occupation _____

Are you now working for any employer or self-employed? ☐ Yes ☐ No If yes, please list the name, address and phone number of the employer on a separate piece of paper and attach to this form or provide details of your self-employment.

Date you resumed full-time work _____ or part time work _____

Did you receive a certificate of insurance or brochure? ☐ Yes ☐ No If no, please contact your employer to obtain a copy.

Nature of illness/accident _____

Date first noticed _____ What do you believe caused your disability? (include the time, date and location of accident) _____

Explain how your illness/injury prevents you from working _____

Have you ever had the same condition or a related illness before? ☐ Yes ☐ No

Do you feel a third party is responsible for your disability, or has made your condition worse? ☐ Yes ☐ No

If yes, please explain, giving the name of the third party _____

Do you plan to bring a claim or law suit against this third party? ☐ Yes ☐ No

Pregnancy:

Expected delivery date _____ Actual delivery date _____

Type of delivery (if known): ☐ Vaginal ☐ C-Section Expected return to work date _____

VOCATIONAL Complete the following and/or attach a resume.

Education level	Yes	No	If no, last grade attended.	
Grade School Graduate	☐	☐		
High School Graduate	☐	☐		
GED	☐	☐		
College Graduate	☐	☐	Degree	Major
Post Graduate	☐	☐	Degree	Major

Have you attended any trade schools or received other special training? ☐ Yes ☐ No
If yes, please describe.

Return to: OCEA, 830 N. Ross Street, Santa Ana, CA 92701 (714) 543-1107 Fax

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Orange County Employees Assocation
Employee Statement

Work Experience: Complete the following starting with your most recent work experience.

Job Title & Employer	Dates of Employment	Duties	Last Salary
1.	From: To:		
2.	From: To:		
3.	From: To:		
4.	From: To:		
5.	From: To:		

Physician's Name _____ Date first consulted for this injury or illness _____

Street Address _____

Phone No. (_____) _____ City _____

State _____ Zip Code _____

List all other medical professionals consulted for any injury or illness within the past three years. ***(continue on a separate page if necessary)***

1. _____ (_____) _____ _____
Name Phone No. Date first consulted

_____ _____ _____
Address City State Zip

2. _____ (_____) _____ _____
Name Phone No. Date first consulted

_____ _____ _____
Address City State Zip

If you were hospitalized within the past three years, please complete.

Hospital Name and address _____

From _____ Through _____ Reason for hospitalization _____

From _____ Through _____ Reason for hospitalization _____

Have you applied for or have you received benefits from:

	Applied Yes	Applied No	Receiving Yes	Receiving No	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Social Security	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐				
c. Any other Group Disability Plans	☐	☐	☐	☐				
If yes, name of carrier _____								
d. Retirement (STRS, OCERS, etc.)	☐	☐	☐	☐				
e. State Disability	☐	☐	☐	☐				
f. Other _____ (e.g. unemployment or union benefits)	☐	☐	☐	☐				

Please send copies of any letters or notices approving or denying benefits to allow us to calculate your benefits from The Standard.

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 4 of this form.

Signature _____ Date _____

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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.

Authorization to Obtain and Release 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.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, 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, Workers' Compensation 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, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- 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 each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- 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 Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice 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.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

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

The Authorization form 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 Standard Insurance Company.

Authorization to Obtain and Release Psychotherapy Notes

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.
- Kaiser Permanente.
- Any insurance company.
- Any organization or entity administering a benefit or leave program (including statutory benefits)
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record.

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- 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 each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- 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 Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
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  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 8. 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.

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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.

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Orange County Employees Assocation
Attending Physician's Statement

PART A. TO BE COMPLETED BY EMPLOYEE (PATIENT)

First Name _____ **Last Name** _____

Address _____

City _____ State _____ Zip Code _____

Phone No. (_____) _____ Birth Date _____ Social Security No. _____

Medical Plan _____ Group Policy No. 608843

PART B. TO BE COMPLETED BY PHYSICIAN

The following information is needed to document the Patient's inability to work: Patient No. _____

1. Diagnosis

A. Primary Diagnosis _____ ICDA Classification _____

B. Secondary Diagnosis (related to patient's disability) _____

C. Symptoms _____

D. Objective findings _____

E. Patient's height _____ Weight _____ Most recent blood pressure _____

2. Pregnancy (If Applicable)

Expected date of delivery _____ Anticipated to be normal? ☐ Yes ☐ No

Para _____ Gravida _____ Abortion _____

Actual date of delivery _____ Type of delivery: ☐ Vaginal ☐ Caesarean Section

3. History

A. When did symptoms appear or accident happen? _____

B. Did you recommend the patient stop work? ☐ Yes ☐ No

If yes, as of what date? _____

Why? _____

If no, who recommended that the patient stop work? _____

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when? _____

Describe _____

D. Is the condition related to

a. Patient's Employment? ☐ Yes ☐ No ☐ Undetermined
b. Mental Disorder? ☐ Yes ☐ No ☐ Undetermined
c. Alcohol or Drug Condition? ☐ Yes ☐ No ☐ Undetermined

E. Did you complete a Workers' Compensation Report for this condition? ☐ Yes ☐ No

4. Treatment

A. Date of first visit _____

B. Date of subsequent visits _____

C. Date of most recent visit _____

D. Planned course of treatment (Include surgery, physical therapy, psychiatric counseling.) _____

Medications: _____

Return to: OCEA, 830 N. Ross Street, Santa Ana, CA 92701 (714) 543-1107 Fax

Orange County Employees Assocation
Attending Physician's Statement

5. Cardiac classification (If Applicable)

A. Functional classification (American Heart Association) ☐ Class I ☐ Class II ☐ Class III ☐ Class IV

B. Therapeutic classification ☐ Class A ☐ Class B ☐ Class C ☐ Class D ☐ Class E

6. Physical Capacities

A. Based on the patient's physical limitations and restrictions, he/she can: (Circle the appropriate level of ability.)

Frequently lift (in pounds)	50+	50	20	10	0				
Maximum lift:	50+	50	20	10	0				
Walk/Stand at one time (in hours):	8	7	6	5	4	3	2	1	0
Walk/Stand in an 8-hour work day:	8	7	6	5	4	3	2	1	0
Sit at one time (in hours):	8	7	6	5	4	3	2	1	0
Sit in an 8-hour work day:	8	7	6	5	4	3	2	1	0

Bend/Stoop: Never Occasionally Frequently

7. Level of Functional Impairment

A. The patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

B. Describe the patient's mental and cognitive limitations and restrictions: _____

C. Is this patient competent to manage insurance benefits? ☐ Yes ☐ No

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

D. Other impairments (please be specific): _____

E. How long will the above limitations impair the patient? _____

F. Dominant hand: ☐ Left ☐ Right

8. Hospitalization

A. Date admitted _____ Date discharged _____ Date surgical procedure performed _____

B. Reason for admittance to hospital: _____

C. Describe nature of any surgical procedure performed: _____

Name of hospital _____

Address _____ City _____ State _____ Zip _____

9. Other treating medical professionals (if known)

A. Name _____ Specialty _____ Phone No. (_____) _____

Address _____ City _____ State _____ Zip _____

B. Name _____ Specialty _____ Phone No. (_____) _____

Address _____ City _____ State _____ Zip _____

10. Prognosis

A. Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed

B. When do you expect a fundamental or marked change in the patient's condition? _____

☐ Unable to determine, follow up in _____ weeks _____ months. ☐ Never

C. When do you anticipate the patient can return to work?

_____ Full-time _____ Part-time (_____ hrs/day, _____ days/weeks)

☐ Unable to determine, follow up in _____ weeks _____ months. ☐ Never

Name of Physician completing this form (Please type or print.) _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone No (_____) _____ Taxpayer Identification 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 applicable fraud notice on page 11 of this form.

Signature _____ Fax No. _____ Date _____

Please send copies of chart notes, diagnostic, laboratory, and electrodiagnostic findings, as well as operative reports and hospital discharge summaries for the past year.

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