TheStandard®

Standard Insurance Company
Employee Benefits – Waiver of Premium
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Virginia Mason Medical Center
Waiver of Premium
Claim Packet Instructions

Please select the Employee Category and Division before completing or printing the form.

Employee Category and Division

CHOOSE ONE

PLEASE READ CAREFULLY

Your group insurance provides a benefit which waives further payment of Group Life Insurance premiums for eligible members who are unable to work at all reasonable occupations for which they are suited by reason of education, training and experience.

In most cases, an individual must be less than 60 years of age at commencement of disability to qualify for waiver of premium. If you have a question regarding the age requirement under your Group Life Insurance with us, please contact our office.

If you are eligible for this benefit, your Group Life Insurance will remain in force without payment of premiums for the remainder of your inability to work, or the maximum benefit period specified in the Group Policy or your Employer's Statement of Coverage. Please refer to the section of your Certificate of Insurance which deals with coverage during total disability for further information on the Waiver of Premium benefit.

In order to apply for this 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**

   Please complete the entire Statement. 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**
   Authorization to Obtain Psychotherapy Notes

   Please sign and date the Authorization to Obtain Information 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 to Obtain Information also allows us to release this information to other parties for purposes specified on the Authorization.

   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. **Attending Physician's Statement**

   Please provide the member information at 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.

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Employee's Initial Statement

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

EMPLOYEE

Full name: _____ Phone no.: (_____) _____

Street address: _____ City: _____ State: _____ Zip code: _____

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

Do you have an individual life insurance policy? ☐ Yes ☐ No

If yes, indicate insurance carrier name, address and telephone number.

_____

_____

Did you receive a Group Life Certificate of Insurance? ☐ Yes ☐ No
Brochure? ☐ Yes ☐ No

EMPLOYMENT

Name of Employer: Virginia Mason Medical Center

Employee Category, Policy No., and Division: _____

Street address: _____ City: _____ State: _____ Zip code: _____

Phone no.: (_____) _____ Job title: _____

Describe your duties.

Date hired: _____ Last day at work: _____

Date you became unable to work at your occupation as a result of illness or injury: _____

Are you working at your occupation? ☐ Yes ☐ No or another occupation? ☐ Yes ☐ No If "yes" please complete the following:

_____ _____ (_____) _____
Employer's Name Address Phone Number

Job title: _____ Date of employment: _____

_____ _____ (_____) _____
Employer's Name Address Phone Number

Job title: _____ Date of employment: _____

Are you currently seeking employment? ☐ Yes ☐ No

Are you self-employed at any activity? ☐ Yes ☐ No Job title: _____

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

SICKNESS

Date first noticed: _____ What is your illness? _____

Please describe symptoms.

Have you ever had same condition or related illness before? ☐ Yes ☐ No Date: _____

ACCIDENT

Describe Injuries: _____

Cause of Injuries: _____

Time, date and location of accident:

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DISABILITY

Explain how your illness or injury prevents you from working.

ATTENDING PHYSICIAN

Physician's Name: _____ Phone No.: (_____) _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Specialty: _____ Date first consulted for injury or illness: _____ Date last seen: _____

List all other physicians consulted for this injury or illness (you may attach separate sheet for additional physicians if needed).

Name _____
Specialty _____
Address _____
_____
_____
City State Zip

Phone no.: (____) _____ Fax no.: (____) _____
Date first visit: _____
Date last visit: _____

Name _____
Specialty _____
Address _____
_____
_____
City State Zip

Phone no.: (____) _____ Fax no.: (____) _____
Date first visit: _____
Date last visit: _____

HOSPITAL

If you were hospitalized for this condition, please complete. Please attach copy of hospital bill, if available.

Hospital name: _____ Address: _____

From _____ through _____ Reason for hospitalization: _____

From _____ through _____ Reason for hospitalization: _____

BENEFITS

Please check the benefits you have applied for and the appropriate status box.

Applied	Receiving	Effective	Denied	Appealing
☐ Social Security	☐	_____	☐	☐
☐ Worker's Compensation	☐	_____	☐	☐
☐ Short Term Disability	☐	_____	☐	☐
☐ Long Term Disability	☐	_____	☐	☐
☐ Other: _____ (e.g. retirement, union benefits, unemployment, etc.)	☐	_____	☐	☐

Please send copies of any letters/notices from the above sources/agencies with this application.

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Employee's Initial Statement

EDUCATION

Please indicate the highest grade of school completed: _____

Did you receive a high school diploma? ☐ Yes ☐ No Year _____ GED diploma? ☐ Yes ☐ No Year _____

Did you attend college? ☐ Yes ☐ No Major _____ Did you graduate? ☐ Yes ☐ No Degree _____ Year _____

Graduate School? ☐ Yes ☐ No Major _____ Did you graduate? ☐ Yes ☐ No Degree _____ Year _____

Please describe any vocational or technical education training programs you have attended (i.e. Welding, Auto Mechanics, Clerical, etc.)

School or Institute: _____ Dates From: _____ To: _____

Degree or Certificate received: _____ Type of skills acquired: _____

Please describe any apprenticeship training programs you have attended: (i.e. Plumbing, Construction, etc.)

School or Institute: _____ Dates From: _____ To: _____

Degree or Certificate received: _____ Type of skills acquired: _____

Please describe any in-house training sessions you have attended.

Please describe any machines or tools you have used.

Please describe any supervisory duties you have had.

Please list any professional licenses you have obtained (Real Estate, Teaching Cert., Pilots, etc.) Are they current? ☐ Yes ☐ No

Do you now have a valid driver's license? ☐ Yes ☐ No Chauffer's license? ☐ Yes ☐ No Commercial? ☐ Yes ☐ No

Are you or have you been engaged in a vocational retraining program? ☐ Yes ☐ No

If yes, please list participation dates _____ through _____

Is a counselor assisting you with your job search? ☐ Yes ☐ No If yes, please complete the following.

Counselor's name: _____ Type of program: _____

Firm/agency name: _____

Address: _____ Phone No.: (____) _____ Fax No.: (____) _____

WORK HISTORY AND EXPERIENCE

Complete the following, starting with your most recent work experience. If you have a resume, please attach. If necessary attach additional pages to complete work history. List all job titles you've had at each employer.

Dates of Employment	Company Name and Job Title	Describe Duties/Responsibilities	Salary (mo)
From:	Company Name:		
To:	Job Title:		
From:	Company Name:		
To:	Job Title:		
From:	Company Name:		
To:	Job Title:		
From:	Company Name:		
To:	Job Title:		
From:	Company Name:		
To:	Job Title:		
From:	Company Name:		
To:	Job Title:		
From:	Company Name:		
To:	Job Title:		

Please describe any **Military Service** you have had.

Branch: _____ Rank: _____ Dates From: _____ To: _____

Type of training received: _____

In the space below briefly describe your personal interests, occupational interests, and any hobbies that you may have.

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 6 of this form.

Signature _____ 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.

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.

MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 a 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 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.

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.

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 10. 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.

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.

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Virginia Mason Medical Center
Waiver of Premium
Attending Physician's Statement

Name:		Claim Number:	Date:
Date of Birth:	Soc. Sec. No:	Analyst Name:	
Employee Category, Policy No., and Division:			

DEAR DOCTOR: _____ ,

The purpose of this form is to help us determine whether the clinical condition of this individual is disabling. It is necessary for us to document functional impairment. Please complete the following report as completely as possible and provide copies of all objective data.

1. **Primary Diagnosis:** (_____) _____
   ICD Code — Major source of impairment

   Secondary Diagnosis: (_____) _____
   ICD Code — Diagnosis not contributing to this impairment

2. Describe the symptoms and how the above diagnoses effect this individual's ability to work in at least a sedentary level work environment.

   _____

   _____

Based upon objective findings, please indicate below the amount of activity this individual can tolerate in a work day, for any employer. Indicate the functional capacities of this individual given two breaks, positional changes, and meal break(s).

3. Person can:	1 Hr.	2 Hrs.	3 Hrs.	4 Hrs.	5 Hrs.	6 Hrs.	7 Hrs.	8 Hrs.	9 Hrs.	10 Hrs.	11 Hrs.	12 Hrs.	NOT AT ALL	Total Wrk. Day Hrs.	Duration of Restriction PERM.	TEMP.	DURATION
a. Sit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____	☐	☐	_____
b. Stand	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____	☐	☐	_____
c. Walk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____	☐	☐	_____

4. What assistive devices are currently in use? _____

5. Dominant Hand: Right _____ Left _____ Height _____ Weight _____

6. NOTE: In terms of a work day: "OCCASIONALLY" = 1%-33%; "FREQUENTLY" = 34%-66%; "CONTINUOUSLY" = 67%-100%

	OCCASIONALLY			FREQUENTLY			CONTINUOUSLY		
Individual can:	**Lift**	**Carry**	**Push/Pull**	**Lift**	**Carry**	**Push/Pull**	**Lift**	**Carry**	**Push/Pull**
1-10 lbs.									
11-20 lbs.									
21-50 lbs.									
51-75 lbs.									
76-100 lbs.									

Are there any limitations on the patient's ability to do repetitive upper extremity activities? Please describe. _____

_____

Specifically: fingering, reaching and grasping? _____

_____

Specifically: ability to do overhead lifting or overhead reaching? _____

_____

7. CARDIAC (If applicable) Functional and Therapeutic classification according to the New York Heart Association.

Functional capacity: _____ ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood Pressure (last visit): SYSTOLIC: _____ DIASTOLIC: _____ PULSE: _____

Please base this assessment on your most recent examination. **(Please circle one in each classification.)**

CLASSIFICATION OF THE SEVERITY OF HEART DISEASE

A. Functional Classification (Based on the patient's symptoms during various grades of activity.)

Class I Patients with cardiac disease but with no limitation of physical activity. Ordinary activity causes no undue dyspnea, anginal pain, fatigue or palpitation.

Class II Patients with cardiac disease and with slight limitation of physical activity. They are comfortable with mild exertion but experience symptoms with the more strenuous grades of ordinary activity.

Class III Patients with cardiac disease and with marked limitation of physical activity. They are comfortable at rest, but experience symptoms with the milder forms of ordinary activity.

Class IV Patients with cardiac disease and with inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or angina pectoris may be present, even at rest, and are intensified by activity.

B. Therapeutic Classification (Based on the physician's prescription of activity for the patient.)

Class A Patients with cardiac disease whose physical activity need not be restricted.

Class B Patients with cardiac disease whose ordinary physical activity need not be restricted but who should be advised against severe or competitive efforts.

Class C Patients with cardiac disease whose ordinary physical activity should be moderately restricted and whose more strenuous efforts should be discontinued.

Class D Patients with cardiac disease whose ordinary physical activity should be markedly restricted.

Class E Patients with cardiac disease who should be at complete rest.

8. **Current medication(s):** (Include dosage and frequency)

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

9. **Current treatment and/or therapy:** _____

_____

10. **Hospitalizations:** Date: _____ Reason: _____

Date: _____ Reason: _____

11. **Surgery:** ☐ Date and Procedure: _____

_____

_____

Anticipated Surgery: ☐ Date and Procedure: _____

_____

_____

12. Are there any limitations on the patients visual accuity? _____

_____

Specifically: best corrected vision - right eye _____ left eye _____

13. **Date first seen:** _____ /_____ /_____ (month / day / year) **Date last seen:** _____ /_____ /_____ (month / day / year) **Date of next visit:** _____ /_____ /_____ (month / day / year)

14. **Assessment and treatment are complicated by:**

☐ Significant emotional or behavioral disorder such as: (please check all that apply) ☐ Depression ☐ Anxiety ☐ Somatization ☐ Malingering

☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

☐ Dependence on drugs/medication. Specify _____

☐ Other (please describe) _____

15. **Prognosis**

Do you expect the individual's condition to: ☐ Improve ☐ Regress ☐ Remain the same

When do you anticipate change will occur _____

16. **Anticipated return to some type of work date:** _____ /_____ /_____ (month / day / year) ☐ Full Time: Restrictions/Duration? _____

☐ Part Time: Restrictions/Duration? _____

17. **Comments:** _____

Please type or print clearly

Physician's Name:		Specialty:		
Address:		City:	State:	Zip:
Taxpayer ID #:	Phone No.: ( )	Fax 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 fraud notice on page 14 of this form.

Signature _____ 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.

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.

MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 a 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.

Standard Insurance Company

Employee Benefits – Waiver of Premium
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

Virginia Mason Medical Center
Waiver of Premium
Employer's Statement

EMPLOYEE

Name of Employee: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Job Title: _____

Social Security No.: _____ Date of Birth: _____

Employee Category, Policy No., and Division: _____

WORK STATUS INFORMATION

Employee's employment status on date disability commenced _____ Employee's insurance effective date _____

Was employee actively at work the day before disability commenced? ☐ Yes ☐ No. If yes, please list the number of hours worked per week _____ and the last day of work before disability commenced. _____

Has job been modified or hours reduced due to illness or injury prior to last day of work? ☐ Yes ☐ No

Is employee terminated? ☐ Yes ☐ No If yes, please list the effective date of termination _____. (**Note: If yes, please stop premium payments for this employee.**)

Reason for termination: _____

If premiums have already been terminated, please provide date premiums have been paid through : _____

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

Contact person: _____

OTHER INFORMATION

A. Carrier

Does employee have any of the following insurance with Standard Insurance Company or with another carrier?

	The Standard	Other Carrier	Applied	Receiving
Long Term Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If The Standard is the carrier, please list the group number: _____ If the policy or your employer's statement of coverage has class numbers, please provide the employee's class number: _____

If there is a carrier other than The Standard, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

	The Standard	Other Carrier	Applied	Receiving
Short Term Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If The Standard is the carrier, please list the group number: _____ If the policy or your employer's statement of coverage has class numbers, please provide the employee's class number: _____

If there is a carrier other than The Standard, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

	The Standard	Other Carrier	Applied	Receiving
Life Insurance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If The Standard is the carrier, please list the group number: _____ If the policy or your employer's statement of coverage has class numbers, please provide the employee's class number: _____

If there is a carrier other than The Standard, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

B. Worker's Compensation Carrier: Has employee applied? ☐ Yes ☐ No Is employee receiving? ☐ Yes ☐ No If yes, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

Contact person _____ Has employee applied for benefits? ☐ Yes ☐ No Is employee receiving benefits? ☐ Yes ☐ No

C. Social Security Benefits: Has employee applied for benefits? ☐ Yes ☐ No Is employee receiving benefits? ☐ Yes ☐ No

Standard Insurance Company

Employee Benefits – Waiver of Premium
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

Virginia Mason Medical Center
Waiver of Premium
Employer's Statement

Amount of Basic Life Insurance with The Standard $ _____

Amount of Voluntary Life Insurance with The Standard $ _____

Amount of Additional Life Insurance with The Standard $ _____

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.

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 from date of last increase, please give effective date of increase _____

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM (Please Print or Type)

Employer: **Virginia Mason Medical Center** Representative: _____

Address: _____ Zip Code: _____

Phone No.: (_____) _____ Fax No.: (_____) _____

Employee Category, Policy No., and Division: _____

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 17 of this form.

Signature _____ Date _____

Title _____

IMPORTANT NOTICE

Attachments

Please attach the following.

a. **Original** Enrollment card and all subsequent coverage selections or changes

b. **Original** Beneficiary designations and subsequent changes

c. Copy of Job Description

d. Copy of Employment Application or Resume

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