Standard Insurance Company

CTA Benefits and Services
PO Box 2773 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0390

Disability Insurance Employer's Statement

Policy No.: ______________________ ☐ Voluntary Insurance Coverage ☐ District Paid Insurance Coverage

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

1. EMPLOYEE

Name of employee: ______________________

Address: ______________________ City: ______________________ State: _______ Zip Code: ______________

Job Title: ______________________

Class: ☐ Faculty/Teacher ☐ Education Support Professional ☐ Administration ☐ Secretarial/Clerical ☐ Other: ______________

Phone No.: (_______) ______________________ Date Employed: ______________ Social Security No.: ______________

2. INFORMATION

Last day worked: ______________ Number of hours worked on last day: __________ First full day of absence for this disability (mo/da/yr): __________

Status on day of disability: ☐ Full-time ☐ Part-time ☐ 11 or 12 month employee

Insured's premium paid to date: ______________ Are you required to make Medicare contributions for this employee? ☐ Yes ☐ No

Are you required to make Social Security contributions for this employee? ☐ Yes ☐ No

Has employee retired? ☐ Yes ☐ No

Does the employee participate in your formal retirement plan? ☐ Yes ☐ No

Is the employee eligible but not participating in your formal retirement plan? ☐ Yes ☐ No Is the formal retirement plan carrier ☐ STRS ☐ PERS ☐ Other

If other, provide name and address ______________________

Is employment terminated? ☐ Yes ☐ No Date of termination: ______________________

Reason for termination: ______________________

Is employment scheduled for termination? ☐ Yes ☐ No

Has employee returned to work? ☐ Yes ☐ No If yes, ☐ Full-time ______________ (Return date) ☐ Part-time ______________ (Return date)

If intermittent absences, please show dates: ______________________

Was this disability due to occupational cause? ☐ Yes ☐ No If yes, include name and address of Workers' Compensation carrier: ______________________

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Workers' Compensation carrier Telephone No.: ______________________ Last day of occupational cause leave: ______________

3. SALARY AT TIME OF DISABILITY

Salary at start of disability: Hourly: __________ Monthly: __________ Annual Contract: __________

Average number of hours worked: Day: __________ or Week: __________ Total days of required attendance this school year: __________

Daily rate of pay: ______________

First required day of attendance: ______________ Winter vacation starts – and ends: ______________ – ______________

Spring vacation starts – and ends: ______________ – ______________ Last required day of attendance: ______________

Is school on 12 month schedule? ☐ Yes ☐ No If yes, please attach track schedule.

If part-time, please attach schedule.

If vacation schedule differs from above, please indicate employee's scheduled vacation. ______________________

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Claimant's Name: ______________________

4. COMPENSATION FOR PERIOD AFTER DISABILITY

Sick Leave days available at start of this disability: ______________ Last day at full pay (mo/da/yr): ______________

When accumulated sick leave is exhausted, do you pay the difference between monthly contract salary and the total paid to a substitute for the number of work days in that month? ☐ Yes ☐ No

If no, please describe method used: ______________

Number of days at Sub or other pay (if applicable): ______________ Date Sub deductions start from employee's pay (mo/da/yr): ______________

Sub pay rate: ______________ When will Sub rate change? (mo/da/yr) ______________ What amount will it change to? ______________

Date Salary Continuance or Sub Differential pay ends (mo/da/yr): ______________ Any other pay received from the district? ______________

Is the employee eligible for any other income replacement plan? ☐ Yes ☐ No Carrier: ______________

Address and/or Telephone No.: ______________

Is employee eligible to draw from any other benefits? ☐ Yes ☐ No

If yes, please explain ______________

Effective date: ______________ No. of days: ______________

5. EXTRA DUTY PAY

***Extra Duty Pay** includes, but is not limited to, income received from coaching, after-school programs, summer school sessions, advising or mentoring stipends. Extra duty pay must be defined in a special contract or letter of agreement between the insured and the district. It does not include additional compensation such as overtime pay, bonuses or district-funded fringe benefits.

Attach a copy of the agreement and the work schedule.

Begin date: ______________ End date: ______________

Please indicate dates this pay was NOT PAID due to the employee's disability: ______________

Applicable rate of pay NOT PAID due to disability.

Hourly rate: __________ Number of hours per day: __________ Daily rate: __________ Weekly rate: __________ Monthly rate: __________

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 Enrollment form(s), if applicable.***

Amount of Basic life insurance $__________ Additional/Optional $__________ Supplemental $__________ AD&D $__________

Dependent's coverage? ☐ Yes ☐ No

IMPORTANT: Please continue payment of premiums until otherwise notified.

7. TAX INFORMATION

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

*If yes, what percentage of the Disability Benefits 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

IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.

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8. ATTACHMENTS

Please attach copies of the following.

a. Job Description
b. Employment Application or Resume
c. Income From Other Sources (Deductible Benefits) Documents (Social Security, Worker's Compensation, PERS, etc.)
d. Enrollment form(s), if applicable

9. SCHOOL DISTRICT REPRESENTATIVE COMPLETING THIS FORM

Employer/School District Name: ______________________ Phone No.: __________ Policy Number: __________

Address: ______________________ City: ______________ State: ______ Zip Code: __________

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: ______________

Prepared by: ______________________________ Title: ______________________________

Phone No.: (______) ______________________ Fax No.: (______) ______________________

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Disability Insurance
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.