The Standard Benefit Administrators

800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602

Disability Insurance Employer's Statement

To Be Completed By Employer

Employee's Full Name	Social Security No.	Job Title *Please attach a copy of the job description.*	1. Date Employed

Employee's Home Address	State	ZIP

Work Location Address	State	ZIP

2. Is employee insured for Short Term Disability? ☐ Yes ☐ No
   Effective Date _____
   Is employee insured for Long Term Disability? ☐ Yes ☐ No
   Effective Date_____
   Is employee insured for Group Life Insurance through Standard Insurance Company? ☐ Yes ☐ No
   Was employee given Certificate(s) of Insurance? ☐ Yes ☐ No ☐ Don't Know

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for:
   Workers' Compensation ☐ Yes ☐ No
   State Disability ☐ Yes ☐ No
   Other _____ ☐ Yes ☐ No
   Weekly Amount _____

5. Employee's Earnings $ _____
   Check one ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐ Commission ☐ Other
   ☐ Shift Differential ☐ Bonuses
   Date of last increase _____ Earnings prior to increase $ _____

6. Last active date at work

7. Job status when disability began: ☐ Full-time (____ hours/week) ☐ Part-time (____ hours/week)

8. Date employee returned to work

9. Last date through which sick leave benefits were paid by employer

10. Last date through which any compensation was paid by employer — What type(s) of compensation was paid on this date?

11. Is employee subject to:
    Social Security taxes? ☐ Yes ☐ No
    Medicare taxes? ☐ Yes ☐ No

12. What percentage of the STD premium does the **employer** pay? _____%
    What percentage of the LTD premium does the **employer** pay? _____%
    Are employer paid premiums included in the employee's salary? ☐ Yes ☐ No ☐ N/A
    IMPORTANT: Remember to calculate the premium contribution percentage information according to the IRS Group Policy (three year averaging) rule.

13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)?
    ☐ Yes ☐ No

Employer Name	Location Code (if applicable)	Phone No.	Policy No.

Mailing Address	City	State	ZIP

Name of employer representative completing this form

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 2 of this form.

Signature _____ **Date** _____

The Standard Benefit Administrators

800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602

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.