Reset

TheStandard®

Standard Insurance Company
800.634.1743 Tel 833.289.5001 Fax
PO Box 2800 Portland OR 97208
SupplementalNewClaim@standard.com

Accident Benefits Claim Instructions

Your Accident Benefit Claim

This packet contains the forms necessary to apply for Accident Benefits. 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, write **"NA"** 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.** For specific information about your Accident insurance coverage, refer to your group insurance certificate. The group policy and certificate are the ultimate authority for Accident Benefit claim decisions.

How to Apply For Benefits

Please complete the following forms included in this Accident Benefits Claim Packet. Refer to your group insurance certificate for covered benefits.

1. **Employee's Statement**

   Answer all questions that apply to this Accident Claim.

   If this is an **Accidental Death Claim**, please complete this form on behalf of the Insured. A separate form will need to be completed and signed for each beneficiary.

   Please attach the following, where applicable:

   - ☐ A copy of the **hospital bill**. Make sure the bill includes the Patient's diagnosis and the number of days they were in the hospital.
   - ☐ A copy of the **ambulance bill**
   - ☐ A copy of the **accident report**
   - ☐ A copy of the **toxicology report**
   - ☐ A copy of the **injury report** filed with the employer if the accident occurred in the workplace
   - ☐ A copy of any **other bills** pertaining to this claim
   - ☐ A copy of the **autopsy**
   - ☐ A copy of the **death certificate** and the completed Employee's Statement
   - ☐ If you are signing on behalf of an estate or entity for an **Accidental Death Claim**, a copy of the authorization to sign on behalf of the estate or entity

   Additional evidence may be required in order to determine payment of additional benefits under the policy/certificate.

   Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

2. **Authorization to Obtain and Release Information**

   Please sign and date the Authorization to Obtain and Release 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 and Release Information also lets The Standard release this information to specific persons.

   If this is an **Accidental Death Claim**, you do not need to complete this Authorization.

3. **Attending Physician's Statement**

   Please complete Section A of the form.

   Your physician will need to complete all remaining sections. **If you have seen more than one physician for your hospitalization, a statement should be completed by each physician.** Your physician(s) should mail or fax the completed form directly to The Standard.

   If this is an **Accidental Death Claim**, you do not need to have the Attending Physician's Statement completed.

You are responsible for making sure all required forms are completed and returned to our office. If you submit claim information by email, please keep in mind that communications via email are not secure. While unlikely, there is a possibility that information can be intercepted in transmission or misdirected and read by other parties besides the person to whom it is addressed. Please consider communicating any sensitive information by fax or mail. If known, please include your Employer Name and Policy Number, Insured's Name and Claim Number on documentation submitted If you have any questions, please contact your benefit administrator or call our customer service line at 800.634.1743.

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Accident Benefits Employee's Statement

A. About the Insured

Full Name		Employer/Company Name	
Group Policy No.	Social Security No.	Date of Birth	
Gender ☐ Male ☐ Female ☐ X	Phone No. ( )	Mailing Address	
City		State	Zip

B. About the Patient – Check One ☐ You ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Child ☐ Other _____

If the Insured is the Patient, then you do not need to complete this section again.

If this is an **Accidental Death Claim** and you are the Beneficiary, please complete this section with your information. A separate form will need to be completed and signed for each beneficiary.

Full Name	Social Security No.	Date of Birth	
Relationship to Insured *(if an Accidental Death Claim)*	Gender ☐ Male ☐ Female ☐ X	Phone No. ( )	
Mailing Address	City	State	Zip

C. About the Accident

Date of Accident _____ Location of Accident (City, State) _____

Explain the injuries and how the accident happened (include additional information on a separate sheet of paper if needed):

_____

_____

Was the Patient in a motor vehicle accident? ☐ Yes *(Attach accident report.)* ☐ No

Was the Patient in any other type of accident that required an incident report? ☐ Yes *(Attach the incident report.)* ☐ No

Was the Patient at work when the accident occurred? ☐ Yes *(Attach a copy of the report filed with the employer.)* ☐ No

Was the Patient hospitalized? ☐ Yes ☐ No If Yes, complete the following:

Admission Date _____ Discharge Date _____

Name of Hospital _____ City _____ State _____ County _____

D. Additional Benefits Claimed

☐ Lodging Benefit – attach copies of receipts for lodging

☐ Transportation Benefit – attach copies of receipts for travel or provide mileage here if traveled by personal car _____

☐ Youth Organized Sport Benefit – attach proof of the Child's registration in the Organized Sport Event

☐ Accidental Death Benefit – Date Death Occurred _____. Please attach a copy of the Death Certificate

E. 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 notices on page 3 of this Claim Packet.

Signature of Insured/Beneficiary _____ Date _____

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 HAMPSHIRE RESIDENTS

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO RESIDENTS

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

TEXAS RESIDENTS

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.

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

Employer/Policyholder Name _____ Group Policy Number _____

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 that follows. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Claim Number _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, Guardian, Conservator, Personal Representative, Executor), please attach documentation of legal status.

Employer/Policyholder Name _____ Group Policy Number _____

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.

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Accident Benefits
Attending Physician's Statement

Instructions

- Insured or Patient to complete section A and submit to Attending Physician for completion.
- Attending Physician to complete sections B, C (if applicable) and D.
- Attending Physician to submit the completed and signed Attending Physician's Statement and supporting documentation to the address or fax number listed above.

A. About the Insured and the Patient

Insured's Information

Full Name	Employer/Company Name	Group Policy No.	
Social Security No.	Date of Birth	Phone No. ( )	
Mailing Address	City	State	Zip

Patient's Information

Full Name	Social Security No.	Date of Birth	Gender ☐ Male ☐ Female ☐ X

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Child

B. About the Accident and Treatment - to be completed by Attending Physician. Please attach supporting documentation.

The Patient is responsible for obtaining a complete form without expense to The Standard.

Date of Service	Diagnosis Description/ICD9	Procedure Code (CPT)	Procedure Description

Date of the Patient's accident or injury _____

Was the Patient treated in the Emergency Room? ☐ Yes ☐ No If Yes, give date treated _____

Was the Patient treated in an urgent care facility? ☐ Yes ☐ No If Yes, give date treated _____

Has the Patient been hospitalized? ☐ Yes ☐ No

If Yes, give Admission Date _____ Discharge Date _____

Has the Patient undergone surgery? ☐ Yes ☐ No

If Yes, give date, procedure and result _____

_____

If No, do you expect surgery to be performed in the future? ☐ Yes ☐ No

If Yes, give date and type of surgery _____

Name of Facility/Hospital where accident or injury was treated (including City, State and County)

_____

Describe any other disease or infirmity affecting the patient's present condition and injury(ies). _____

_____

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C. Accidental Dismemberment and Impairment *(if applicable)* - to be completed by Attending Physician. Please attach supporting documentation.

Did the accident result in a loss of hearing in one or both ears? ☐ Yes ☐ No

If Yes, then please describe _____

_____

Did the accident result in a loss of **sight** in one of both eyes? ☐ Yes ☐ No

If Yes, then please describe _____

_____

Did the accident result in a loss of **limb(s)**? ☐ Yes ☐ No

If Yes, then please describe _____

_____

Did the accident result in **paralysis**? ☐ Yes ☐ No

If Yes, then please describe _____

_____

D. Attending Physician Information, Acknowledgement and Signature

Name of Physician _____ Specialty _____

Address _____

City _____ State _____ ZIP _____

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 above fraud notice on page 8 of this form.

Physician's Signature _____ Date _____

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

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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CALIFORNIA RESIDENTS

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COLORADO RESIDENTS

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DISTRICT OF COLUMBIA RESIDENTS

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NEW YORK RESIDENTS

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PENNSYLVANIA RESIDENTS

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TEXAS RESIDENTS

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ALL OTHER RESIDENTS

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