



PLEASE READ CAREFULLY

Your application for benefits consists of four forms (Insured's Statement, Authorization to Obtain Information, Authorization to Obtain Psychotherapy Notes, and an Attending Physician's Statement). **Every space on these forms should be filled in** to avoid delay in processing your application. If a section does not apply, or if information is not available, please write "NA" in the space so we know you did not overlook that particular question. **If an incomplete form is received, we may return it to you for completion.**

To Submit A Claim:

1. These benefits are available to individuals who become disabled on or after February 1, 2003, have applied for and been approved for disability insurance, and have been paying premiums for disability insurance as part of your monthly CalVet loan payment. If you are unsure if you have this coverage, please contact Standard Insurance Company at 866.825.5796.
2. Complete all the questions on the Insured's Statement. Sign and date both the Insured Statement and the Authorization to Obtain Information. Be certain that you have identified your loan number. **Your claim cannot be processed without this identification number.**
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.
3. Once completed give the Insured's Statement, the Authorization to Obtain Information, the Authorization to Obtain Psychotherapy Notes (if applicable), and the Attending Physician's Statement to your regular attending physician. We suggest making a copy of your completed forms prior to giving them to your physician. If you have seen more than one physician for your disability, a statement should be completed by each physician. Ask him/her to complete the Attending Physician's Statement and mail all forms directly to The Standard.
4. If you do not hear from The Standard within 20 days after leaving the forms with your physician, contact the physician's office to determine if the form has been completed and mailed to The Standard.
5. Continue making monthly payments as billed until receiving notice from The Standard that your claim has been approved.

You are responsible for making sure all required forms are completed and returned to our office. Should you have any questions, please contact us at the phone number listed above.

Eligibility:

1. Disability must continue for the Benefit Waiting Period as designated by your covered benefit option.
 - a. Option 1 = Through the last day of the calendar month following 90 days of disability
 - b. Option 1A = Through the last day of the calendar month following 90 days of disability
 - c. Option 2 = Through the last day of the calendar month following 365 days of disability
2. You must be disabled from all occupations. You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of any gainful occupation for which you are or become qualified by education, training and experience. Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation.
3. You must have been under age 62 when disability commenced.
4. A physician who has treated you during the period claimed must provide documentation of limitations and restrictions that prevent you from working at any occupation.

Preexisting Conditions

Your disability coverage includes an exclusion for preexisting conditions that may affect your right to receive benefits. The exclusion will apply if, during the 12-month period before the effective date of your coverage, you, or a reasonably prudent person would have, consulted a physician or licensed medical professional; received medical treatment, services or advice; underwent diagnostic procedures, including self-administered procedures; or took prescribed drugs or medications for a mental or physical condition (diagnosed, misdiagnosed or suspected) causing or contributing to your disability. This exclusion will not apply if you have been continuously insured under the policy for 12 months.

Payment of Benefits

Should your claim be approved, your Total Monthly Loan Installment will be paid by The Standard after your Benefit Waiting Period has been served. Proof of disability from all occupations will be periodically requested during the continuation of your claim.

Standard Insurance Company

Disability Benefits 866.825.5796 Tel 877.282.7713 Fax
 PO Box 2800 Portland OR 97208

Department of Veterans Affairs,
 State of California
 Disability Benefits
 Insured's Statement

Please type or print. Form may be returned for unanswered questions.

1. INSURED

Full Name: _____ Social Security No.: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Is address above your primary residence? Yes No Home Phone No.: (____) _____ Loan No.(s): _____
 Birthdate: _____ Sex: Male Female Height: _____ Weight: _____
 Marital Status: Single Married Number of Dependent Children: _____

2. EMPLOYMENT

Income and duties when disability began

Employed By (when disability began): _____ Self employed?
 Employer Address: _____ Employer Phone: (____) _____
 Your Occupational Title when disability began: _____
 A. Monthly earned income at time disability commenced \$ _____ Hours worked per week: _____
 B. Describe all important duties and percent of time usually spent on each: _____

 Last full day at work: _____ When do you expect to be able to return to work? _____
 Are you now or have you worked at your occupation or any other occupation since the date of your injury including self employment? Yes No
 If yes, list names of employers, addresses, telephone numbers, and dates of employment. _____

3. VOCATIONAL INFORMATION (Please provide a copy of your most recent resume or curriculum vitae.)

Education level	Yes	No	If no, last grade attended.	
Grade School Graduate	<input type="checkbox"/>	<input type="checkbox"/>		
High School Graduate	<input type="checkbox"/>	<input type="checkbox"/>		
GED	<input type="checkbox"/>	<input type="checkbox"/>		
College Graduate	<input type="checkbox"/>	<input type="checkbox"/>	Degree	Major
Post Graduate	<input type="checkbox"/>	<input type="checkbox"/>	Degree	Major

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

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:		

4. SICKNESS Please list all illnesses which contribute to your being unable to work at any occupation.

Illness: _____ Date First Noticed: _____
 _____ Date First Noticed: _____
 State what you believe caused your illness: _____

 Describe your symptoms: _____
 Have you ever had the same condition or a related illness before? Yes No Date: _____

5. ACCIDENT If disability is due to an automobile accident, please include a complete copy of the motor vehicle report.

Describe Injuries: _____
 Cause of injuries: _____
 Time, Date and Location of Accident: _____

6. DISABILITY Explain how your illness or injury prevents you from working at any occupation.

 Has your treating physician indicated when you may be able to resume work? Yes No
 If so, when? _____ With what restrictions? _____

7. ATTENDING PHYSICIAN List all physicians consulted for this injury or illness. Use separate sheet, if needed.

Physician's Name: _____ Specialty: _____ Phone No.: (____) _____
 Street Address: _____ Fax No.: (____) _____
 City: _____ State: _____ Zip Code: _____
 Date first consulted for this injury or illness: _____ Date last consulted: _____
Physician's Name: _____ Specialty: _____ Phone No.: (____) _____
 Street Address: _____ Fax No.: (____) _____
 City: _____ State: _____ Zip Code: _____
 Date first consulted for this injury or illness: _____ Date last consulted: _____
Physician's Name: _____ Specialty: _____ Phone No.: (____) _____
 Street Address: _____ Fax No.: (____) _____
 City: _____ State: _____ Zip Code: _____
 Date first consulted for this injury or illness: _____ Date last consulted: _____

8. PHARMACY List all pharmacies you have used to fill prescriptions over the past 5 years. Use separate sheet, if needed.

Pharmacy Name: _____ Phone No.: (____) _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Medications (list): _____
 Dosage: _____
 Number of refills prescribed: _____

Standard Insurance Company

Disability Benefits 866.825.5796 Tel 877.282.7713 Fax
 PO Box 2800 Portland OR 97208

Department of Veterans Affairs,
 State of California
 Disability Benefits
 Insured's Statement

9. MEDICAL INSURANCE COVERAGE

Health Insurance Provider: _____ Phone No.: (____) _____
 Address: _____
 Effective Date of Coverage: _____
 Policy/Group No.: _____ Member ID/Record Number: _____

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

Hospital Name: _____ Phone No.: (____) _____
 Address: _____
 From: _____ through: _____ Reason for hospitalization: _____
 From: _____ through: _____ Reason for hospitalization: _____

11. HISTORY *List all illnesses or injuries for which you have received treatment over the past five years. Use separate sheet if needed.*

Ailment	Date	Medical Professional's Name	Complete Address

12. OTHER INCOME

Have you applied for or are you receiving benefits from:	Applied		Receiving		Date Applied For	Effective Date	Contact Name and Phone Number
	Yes	No	Yes	No			
a. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
c. State Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Please specify type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
e. Other _____ (e.g., unemployment or union benefits, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Please attach copies of any letters or notices approving or denying benefits.

FRAUD NOTICE: 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.

Acknowledgment

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 this form.

SIGNATURE

DATE

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.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitational 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, 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, or eligibility for other benefits (*for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.*).

TO STANDARD INSURANCE COMPANY (THE STANDARD).

- 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 The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. 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 Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act [HIPAA] and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

FRAUD NOTICE: 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.

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.

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider; and
- Any hospital, clinic, or other medical or medically related facility or association.

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).

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- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
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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.

PART A. TO BE COMPLETED BY PATIENT

Full Name: _____ Social Security No.: _____

Other Names Used: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Birthdate: _____ Patient No.: _____

Loan No.(s): _____

I returned to work: Date _____ I expect to return to work: Date _____

PART B. TO BE COMPLETED BY PHYSICIAN

DEAR DOCTOR: The purpose of this form is to help us determine whether the clinical condition of your patient is disabling. We need documentation of functional impairment. Please include laboratory data and results of special tests (X-rays, CAT scan, EKG, etc.). Please attach copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes, and narrative reports.
The patient is responsible for the completion of this form without expense to The Standard. Forms may be returned for unanswered questions.

1. INFORMATION

Primary Diagnosis: ICD Code (_____) _____

Secondary Diagnosis: ICD Code (_____) _____

Other diagnoses and ICD Codes related to this claim. _____

Symptoms. _____

Patient's Height: _____ Weight: _____ BP _____ Right arm BP _____ Left arm Pulse _____ Radial

Is condition primarily related to:

a. Patient's Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dominant Hand	<input type="checkbox"/> Left <input type="checkbox"/> Right
b. Mental Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Condition Caused By	<input type="checkbox"/> Accident <input type="checkbox"/> Sickness
c. Alcohol or Drug Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If accident, date of accident:	_____
d. Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	_____

2. HISTORY

If patient was referred to you, indicate by whom: _____

Has patient ever had same or similar condition? Yes No

If yes, indicate when: _____ Describe: _____

Do, or have, other conditions contributed to this condition? Yes No

If yes, please explain: _____

Date patient first consulted you for **this** condition: _____ For **any** condition: _____

Dates of subsequent treatment: _____

Date of most recent visit: _____

If patient was hospitalized, please provide dates. Admitted: _____ Discharged: _____

Admitting Diagnosis: _____ Discharge Diagnosis: _____

Name of Hospital: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Name: _____

3. ASSESSMENT

Date you recommended patient should stop working: _____ Why? _____

Physical Limitations (Please check if applicable and describe the extent of the limitation(s))	Perm.	Temp.
<input type="checkbox"/> Standing/Sitting/Walking (number of hours/day) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending/Stooping (number of hours/day) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting/Carrying (specific pounds) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Use of Hands (gross/fine manipulations) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (explain) _____	<input type="checkbox"/>	<input type="checkbox"/>

Physical Impairment Perm. Temp.

Class 1 - No limitations of functional capacity; capable of heavy work; no restrictions. (0-10%)

Class 2 - Medium manual activity. (15-30%)

Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)

Class 4 - Moderate limitation of functional capacity; capable of clerical/administration (sedentary) activity. (60-70%)

Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)

Mental Limitations/Impairment Perm. Temp.

Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)

Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)

Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)

Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)

Class 5 - Patient has significant loss of psychological, personal and social adjustment (severe limitations)

HAVE YOU RECOMMENDED ANY TREATMENT FOR THESE PSYCHOLOGICAL SYMPTOMS Yes No

IF YES, DESCRIBE RECOMMENDED TREATMENT AND/OR NAME AND ADDRESS OF SOURCE PATIENT WAS REFERRED TO _____

How long from today's date will the described limitations impair the patient? _____

Is the 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

4. TREATMENT

Planned course of treatment (Please include expected duration, surgeries, therapy, etc.) _____

Medications prescribed: dosage, frequency and date of prescription(s). _____

List other treating or referring physicians. (Continue on separate page, if necessary.)

NAME		ADDRESS		
1.				
Phone No. ()	Specialty:	City	State	Zip Code
2.				
Phone No. ()	Specialty:	City	State	Zip Code

What reasonable work or job site modifications could be made to assist the individual to return to work? Please specify: _____

Assessment and treatment are complicated by:

Malingering

Significant emotional or behavioral disorder such as: Depression Anxiety Hysteria (Circle pertinent areas).

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

Dependence on drugs/medication. Specify: _____

Other (please describe): _____

5. PROGNOSIS

Describe patient's condition since onset of symptoms: Recovered Improved Unchanged Regressed

When do you expect a fundamental or marked change in patient's condition? Never Condition expected to regress Condition expected to improve

State anticipated date: _____ or, Unable to determine, follow up in: _____ months

When do you anticipate the patient can return to work? State anticipated date: _____ or, Unable to determine, because of: _____
_____ follow up in: _____ months

Remarks: _____

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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 this form.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____ Specialty _____

Address _____ City _____ State _____ Zip Code _____

Physician's Taxpayer ID No. _____ Phone No. (_____) _____ Fax No. (_____) _____

Return to Standard Insurance Company at the address above.