TheStandard®

Standard Insurance Company
Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

MOSERS Continued Dependent Life Insurance for a Disabled Child Instructions

Your application for Continued Dependent Life Insurance for a Disabled Child consists of four forms. Every space should be filled in to avoid delay in processing your application. If a section does not apply, or information is not available, "NA" should be written in the space so we know you did not overlook a particular question. **If a form is received incomplete, it may be returned for completion.**

The four forms are:

1. **The Parent's Statement**
   - Answer every question completely. Be sure to completely describe your Dependent Child's disability.
   - Use an additional page, if necessary, to complete all questions.
   - Enclose photocopies of all medical records pertaining to your Child's disability.
   - Remember to sign and date your statement. **An unsigned or undated statement may be returned to you.**
2. **The Authorization to Obtain Information**
   - Please sign and date this form and attach it to the Parent's Statement. Your signature on this form enables us to obtain the necessary information about your Dependent Child to determine eligibility for Continued Dependent Life Insurance for a Disabled Child. The authorization also allows us to release information to a specific person. **You will receive a copy of the Authorization upon your request.**
3. **The Attending Physician's Statement**
   - **Part A** should be completed by you.
   - **Part B** should be completed by your Dependent Child's physician. If your Dependent Child had seen more than one physician for their condition, a statement should be completed by each one (this form may be photocopied). The physician(s) should mail the completed form directly to Standard Insurance Company (The Standard).
4. **The Employer's Statement**
   - This form should be completed entirely by MOSERS.

You are responsible for making sure all required forms are completed and returned to our office. Processing of your application will begin when all completed forms are received. Should you have any questions, our office is available to assist you.

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MOSERS Continued Dependent Life Insurance for a Disabled Child Parent's Statement

TO BE COMPLETED BY PARENT

Please type or print. The parent is responsible for the completion of this form without expense to Standard Insurance Company.

Employee/Member:	Birthdate:	Social Security No.:	Phone No.: ( )
Address:	City:	State:	Zip Code:
Name of Employer: **MOSERS**	Group Policy No.: **604201**	Phone No.: (**800**) **827-1063**	
Street Address: **P. O. Box 209**	City: **Jefferson City**	State: **MO**	Zip Code: **65102**

DISABLED CHILD DEPENDENT INFORMATION

Name of Disabled Child:	Child's Birthdate *(month, day, year)*:	Child's Social Security Number:	
Child's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Child's Relationship to you:	Child's Sex: ☐ Male ☐ Female	Child's Age when Disability Occurred:

What is your Dependent Child's medical condition?____________________________________

Is Disabled Child incapable of self-sustaining employment because of mental retardation or physical handicap? ☐ Yes ☐ No

Please explain how condition prevents self-sustaining employment and how child is chiefly dependent upon you:

Is Disabled Child chiefly dependent upon you for support and maintenance? ☐ Yes ☐ No

If yes, what part of support do you contribute?

Is Disabled Child institutionalized because of mental retardation or physical handicap? ☐ Yes ☐ No

Please list the physicians who have treated your child for their Disability:

Name:	Address:		
City:	State:	Zip Code:	Phone No.: ( )
Name:	Address:		
City:	State:	Zip Code:	Phone No.: ( )

PARENT'S STATEMENT

My Dependents Life Insurance coverage became effective on (give approximate date) ________________ and my Disabled Child became insured as my Dependent on ________________ , which was before his or her 19th birthday.

I believe my child qualifies for continued coverage as a Disabled Child because he or she is continuously: (1) Incapable of self-sustaining employment because of mental retardation or physical handicap; (2) Chiefly dependent upon me for support and maintenance, or institutionalized because of mental retardation or physical handicap; and (3) unmarried.

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.

Signature of Employee:________________________________ Date: __________________

Please sign and submit with application the Authorization to Obtain Information that complies with HIPAA requirements.

I understand this information will be used to determine the child's eligibility for continued coverage as a Disabled Child.

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

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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

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PENNSYLVANIA RESIDENTS

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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.

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MOSERS
Continued Dependent Life Insurance for a Disabled Child
Authorization to Obtain Information

I AUTHORIZE THESE PERSONS having any records or knowledge of ____________________________ (dependent child):

- 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 the dependent child, 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 the dependent child, including such things as education, employment history, earnings or finances, or eligibility for other benefits *(for example, Social Security Administration, Public Retirement System, 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 the dependent child's protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose the dependent child's entire medical record without restriction. I understand that The Standard will use the information to determine the dependent child's eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of the Continued Dependent Life Insurance for a Dependent Child 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 the application and may be a basis for denying the application.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about the dependent child. The Standard may release this information about the dependent child to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with this application.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect the dependent child's 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. (Life 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 and the state variations *(if applicable)* on page 5. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

____ ______________________________
Parent's Name *(please print)* Relationship, if other than parent

____ ______________________________
Parent's Signature Date

If signature is provided by legal representative (e.g., Attorney in Fact or guardian), please attach documentation of legal status.

This Authorization is a two-page document. Please see page 5 for additional terms and information. Both pages are part of the Authorization.

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term “emergency medical personnel” includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires us to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The accompanying Authorization to Obtain Information 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 The Standard, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The Standard 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 The Standard. Within 30 business days of receiving the request, The Standard 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. The Standard 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 The Standard that you are or have been a victim of domestic abuse) and participate in The Standard’s location information confidentiality program, your request should be sent to the same address above.

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MOSERS
Continued Dependent Life Insurance for a Disabled Child Attending Physician's Statement

PART A. TO BE COMPLETED BY PARENT

Child/Patient's Full Name:	Date of Birth:	Social Security No.:
Parent's Employer/Policyowner: **MOSERS**	Policy No.: **604201**	

To Physicians and Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Standard Insurance Company, Portland, Oregon, any information you have regarding my child's medical history and physical condition.

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 8 of this form.

Parent's Name: ______________________

Parent's Signature: ______________________ Date: ______________________

PART B. TO BE COMPLETED BY PHYSICIAN

1. INFORMATION

Diagnosis:

Symptoms:

Height of patient:	Weight of patient:

Objective findings *(please forward laboratory data and results of special tests such as x-rays, EKGs, EEGs, etc.)*:

2. HISTORY & TREATMENT

History *(please provide a brief history and attach narrative report, physician's notes or operative reports if available)*:

When did symptoms first appear?	Date patient first consulted you for this condition:
Dates of subsequent treatment *(attach statement if convenient)*:	Frequency of treatments:

Hospital confinement? Hospital name:	Date Admitted:	Date Discharged:

3. ASSESSMENT

Is the child named above incapable of self-sustaining employment by reason of mental retardation or physical handicap? ☐ Yes ☐ No

Is the child chiefly dependent upon parent for support and maintenance, or institutionalized due to mental retardation or physical handicap? ☐ Yes ☐ No

Has such disability existed continuously before child attained age 19? ☐ Yes ☐ No If no, what age? ________

4. PROGNOSIS

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

When do you anticipate change will occur: ____________________

If improvement is expected, approximate date child is expected to become capable of self-sustaining employment: ____________________

5. OTHER PHYSICIANS

List other treating or referring physicians:

Name:	Address:		
City:	State:	Zip Code:	Phone No.: ( )
Name:	Address:		
City:	State:	Zip Code:	Phone No.: ( )
Name:	Address:		
City:	State:	Zip Code:	Phone No.: ( )

6. COMMENTS

7. ACKNOWLEDGEMENT

Name of Physician:	Specialty:			Phone No.: ( )
Address:	City:	State:	Zip Code:	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 8 of this form.

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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DISTRICT OF COLUMBIA RESIDENTS

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NEW JERSEY RESIDENTS

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NEW YORK RESIDENTS

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MOSERS
Continued Dependent Life Insurance for a Disabled Child Employer Statement

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

TO BE COMPLETED BY EMPLOYER

Employee/Member:				
Address:		City:	State:	Zip Code:
Birthdate:	Social Security No.:	Phone No.: ( )		
Name of Disabled Child:		Child's Date of Birth:		
Child's Sex: ☐ Male ☐ Female		Child's Social Security No.:		

Hire Date of Member (Parent): ______________ *(please send or fax us a copy of the Member's (Parent's) enrollment form with this form)*

Effective date of Member's (Parent's) insurance: ______________ Effective date of Dependent Child Insurance Coverage: ______________

Amount of Dependent Child's Life coverage: ______________

Member's Policy Class No.: ______________

Have premiums continued to be paid for this Dependent Child Life Insurance since the effective date of Dependent Child Life Insurance coverage?
☐ Yes ☐ No

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM (Please Print or Type)

Employer: **MOSERS**	Representative:		
Address: **P. O. Box 209**	City: **Jefferson City**	State: **MO**	Zip Code: **65102**
Policy No.: **604201**	Phone No.: **(800) 827-1063**	Fax No.: **(573) 632-6103**	

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 10 of this form.

Signature: ______________ Title: ______________ Date: ______________

IMPORTANT NOTICE

Attachments

Please attach the following.

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

b. Any medical documentation you have on file for the Disabled Child.

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