Department of Administrative Services

Processing LTD Insurance Claims

Group Long Term Disability (LTD) insurance from Standard Insurance Company (The Standard) helps provide financial protection for insured members by paying a monthly benefit in the event of a covered disability. The cost of this insurance is paid by the State of Iowa.

If an employee's medical condition will prevent them from working for more than 90 working days, (excluding weekends and holidays) they may be eligible to receive disability benefits. Typically, the manager or employee will reach out to you for assistance.

The State of Iowa's Standard Group Policy number is - 754414

Additional information may be found on the **Life Insurance webpage**: https://das.iowa.gov/state-employees/human-resources/employee-benefits-programs/long-term-disability-ltd-insurance

All LTD insurance forms and templates may be found on **the HR Info for HRAs webpage**: https://das.iowa.gov/state-employees/human-resources/hr-info-hras

If you have questions, please contact the LTD Plan Administrator at 515-281-8866 or email the LTD/Life claims inbox: claimsltdlife@iowa.gov

The employee may submit the LTD application in one of the following ways:
Online (***preferred method)*** To file a claim online, go to *www.standard.com/individuals-families/file-claim* to begin the claim process. From the drop-down box, choose ***Insurance benefits through work***. Begin claim process.
Phone To file a claim by telephone, contact The Standard's Claim Intake Service Center at 844.480.5547
Mail/Fax To file a claim by paper application please complete the required sections on the paperwork included in this mailing and submit. Mail: Standard Insurance Company-Employee Benefits Department PO Box 2800 Portland, OR 97208 Fax: 971-321-8400

IOWA | Department of Administrative Services

Processing LTD Insurance Claims

<table>
<tr><th colspan="2">Follow these steps upon request for an LTD application</th></tr>
<tr><td>Send the employee an LTD claim packet</td><td>Include the following information in your LTD claim packet to the employee
LTD Claim Cover letter for employee
Long Term Disability Benefits Claim Packet
Pages 1 – 9 is the LTD Employee's Statement (this is to be completed by the employee)
Pages 10 – 12 are the Attending Physician's Statement (this needs to be completed by the physician)
Long Term Disability Certificate (Policy)
Extended Illness, Disability or Death Benefit Guide
NOTE: If the date of disability (or beginning of the employee's leave) is before 12/31/2016, you will use The Hartford's claim form and instructions. Do not continue to follow these steps. Please contact the LTD Plan Administrator at DAS for additional information.</td></tr>
<tr><th colspan="2">Complete the Long-Term Disability Insurance Employer's Statement</th></tr>
<tr><td>1. Employee:</td><td>Long Term Disability Employer's Statement
Complete basic employee information – Name, Address, Job Title and Job Classification
Insurance Class - check appropriate box
Phone Number, Date Employed (original date of employment) and Social Security Number</td></tr>
<tr><td>2. Information:</td><td>Date employee's LTD coverage became effective - date the employee became covered by The Standard. (The Standard contract with the State of Iowa became effective 1/1/2017.)
Work Location – Physical address where employee primarily works
Was the employee given a certificate – Check "yes" if you have given the employee the Group LTD certificate
Was the employee insured under the previous LTD carrier – see table
<table>
<tr><th>If the employee…</th><th>then…</th></tr>
<tr><td>started after January 1, 2017</td><td>no, they were not covered by the prior LTD carrier</td></tr>
<tr><td>was hired prior to January 1, 2008</td><td>the effective date is January 1, 2008</td></tr>
<tr><td>was hired after January 1, 2008</td><td>Use the actual benefit effective date (30 days of employment and the 1st of the month)</td></tr>
</table>
Employee's status on date disability commenced, Actively at Work – Check Yes or No
Number of hours worked per week – employee's regular work schedule
Last day of work before disability commenced – the last date that the employee worked</td></tr>
</table>

Processing LTD Insurance Claims

	• *Exempt or Non-Exempt* – Check the appropriate box • *Number of Hours worked on this day* – indicate the number of hours that the employee worked on the last date from above • *Have you considered allowing the claimant to work*– talk with the manager to confirm if any alternatives were offered to the employee. If offers were made, describe in detail what they were. • *Is disability caused or contributed to by employment* – Check Yes, No or Undetermined by logging into Via One for confirmation. • *Has the employee filed a Workers' Compensation claim* – Check Yes, No or Don't Know based on answer from Via One. If you do not have Via One you can skip answering the work comp questions. • *Worker's Compensation Carrier Name* – Sedgwick CM, PO Box 14628 Lexington KY 40512 • *Claim number and Date of Injury* – If there is a claim, provide the claim number and date of injury. • *Address, Phone number and Person to Contact* – Contact Sedgwick for the claim representative's name. • *Is employment now terminated or scheduled for termination* – Check appropriate box. If yes, indicate date and reason for termination on form.
3. Salary at Time of Disability:	• *Employee pay is based on* – Check Hourly or Annual Salary • Check Bi-weekly Earnings, Basic Yearly or Basic Hourly Earning - Enter rate • *Date of last increase and Earnings prior to increase and effective date* – Indicate date and amount of increase from payroll system. • If employee received shift differential, longevity pay, subsistence allowance or lead worker pay - C*heck the box* *NOTE: You only need to select one option.*
4. **Compensation for Period After Disability:**	• *Sick Pay/Salary Continuation* – Indicate date that sick pay will end and the amount/rate. **NOTE:** Do <u>not include vacation</u> time. • *Wages/salary, earned after disability* – If the employee is working part-time enter the amount. If they are not working, indicate N/A. *NOTE: Employees on paid leave may still receive pay increases*
5. Deductible Income/Benefits from Other Sources:	You may not be able to answer all of the questions in the table. If you are unable to do so, check the box "Don't know" and move to the next section. • Social Security • Workers' Compensation • Other
6. Life Insurance:	Respond to the following questions: • *Was the employee covered by Group Life Insurance with the Standard on cease work date*? Indicate Yes or No • If yes, List policy number(s) - **754414** • *Date life insurance became effective -enter date employee became eligible for insurance*

Processing LTD Insurance Claims

	• *Enter Amount of Basic Life Insurance* - Basic will be $20, 000. • *Additional/Optional: (if applicable)* - Refer to Workday for any supplemental insurance amount
7. Tax Information:	• We are a public sector (government entity employer) – this box should be checked • *If subject to Social Security taxes what are the employee's year to date Social Security wages* – This can be found in your payroll system. The wages are under the FICA Earn OASDI • *Does the employee pay all or a portion of the premium for LTD insurance*? Check "no", as the State pays for the benefit. The only exception is Class 3 (Part Time General Assembly). If your employee is in Class 3, you will indicate that the Employer pays 0% and Employee pays 100% with funds that have been taxed.
8. Attachments:	Assemble the following employee documents as You will submit this documentation with the Employer Statement • Current copy job description/PDQ • Initial life insurance enrollment form or print screen of Workday • Most recent beneficiary designation from Workday • Any paperwork workers' compensation or social security paperwork • Enrollment or Election form for Long Term Disability Insurance for (class 3 only) *NOTE: You are not required to provide an employment application or resume.*
9. Employer Representative Completing this Form:	The information listed below is required: • *Signature, Date* • *Prepared by, Title* • *Phone Number, Fax Number*
Send documents to the Life/LTD claims inbox: claimsltdlife@iowa.gov	• Employer Statement (completed and signed) • All Attachments identified in Section 8 above. *NOTE: If you have the Employee's Statement and Attending Physician's Statement, please send those too.*

If you have questions, please contact the LTD Plan Administrator at 515-281-8866 or email the LTD/Life claims inbox: claimsltdlife@iowa.gov