TWU 2017 Benefits Meeting

TheStandard®

Union Sponsored
Short Term Disability Benefits

- Benefit percentage: Weekly STD benefit is 50% of the first $8,000 of your weekly insured pre-disability earnings, reduced by deductible income
- Plan Maximum: $4,000
- Plan Minimum: $15
- Maximum Benefit Period: 26 weeks. STD benefits end, though, upon payment of Long Term disability benefits payable under a group plan provided by the employer
- Benefit Waiting Period: The longer of the period of sick leave to which you are entitled or 7 days of disability

Union Sponsored
Short Term Disability Benefits

- Definition of disability-You will be considered disabled if, as a result of physical disease ,injury, pregnancy or mental illness:
  - You are unable to perform with reasonable continuity the material duties of your own occupation, and
  - You suffer a loss of at least 20 percent in your pre-disability earnings when working in your own occupation
- Rehabilitation Plan
- Reasonable Accommodation Expense Benefit
- Exclusions/Limitations

Claim Intake

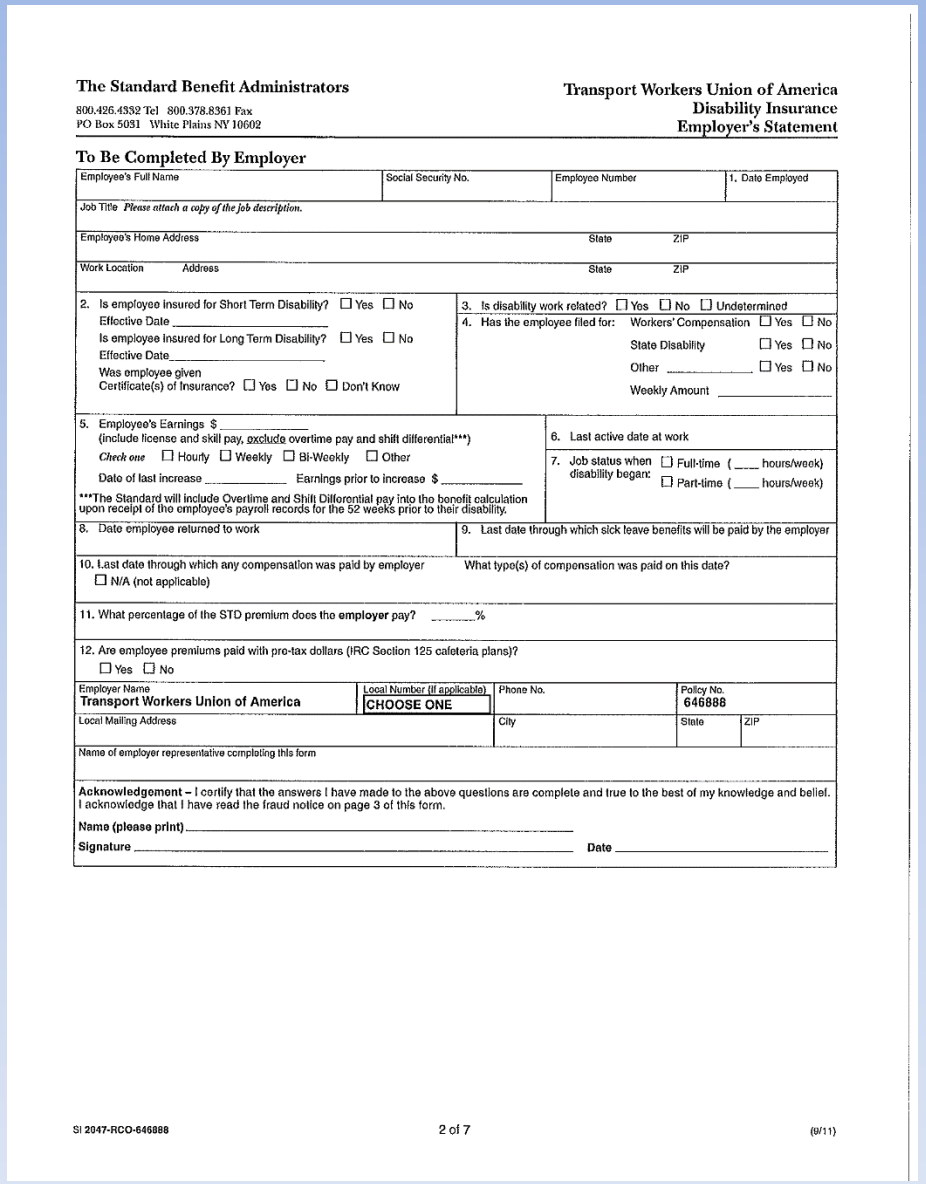
Intake Method	Paper/Fax	Web
Cost of Service	No additional cost	No additional cost
High-level Claim Submission Process	Employee and employer complete paper packet of forms and submits the completed form to us by mail or fax. Claim packet includes an Employee Statement, Employer Form, Attending Physician Statement and Authorization. Completed claim forms may be scanned and e-mailed to: NYDBSR@standard.com or faxed to: 1-800-378-8361	Claimant logs onto our website to submit information for the Employee Statement. The claimant then prints off the remaining forms (Employer Statement, Attending Physician Statement, and Authorization) for completion.

Check List for Filing STD Claim

Employer Statement	Employee/ Attending Physician Statement	Authorization to Obtain and Release Information	Pay Stub & Identification
Page 2 of 7	Page 4 of 7	Page 6 of 7	
To be filled out by Benefit Coordinator or Local Union Representative.	Top portion to be completed by employee. Physician Statement must be completed by the physician certifying disability.	To be completed by employee. This form authorizes The Standard to obtain necessary medical information.	Employee to provide most recent pay stub from prior to last day worked and copy of drivers license. If claiming benefits for overtime, employee must provide pay stubs from 52 weeks prior to last day worked.

Employer Statement Elements

- EIN and Date Employed are important in determining eligibility
- LTD enrollment information needed to determine when STD benefits end
- Other benefits and workers' compensation
- Predisability Earnings
- Sick leave pay and other compensation
- Local Number: drop down box to chose Local Union #
- Include all contact information for representative completing the form



The Standard Benefit Administrators
800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602

Transport Workers Union of America
Disability Insurance
Employer's Statement

To Be Completed By Employer

Employee's Full Name	Social Security No.	Employee Number	1. Date Employed
Job Title *Please attach a copy of the job description.*			
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 _____
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 $ _____
(include license and skill pay, exclude overtime pay and shift differential***)
Check one ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Other
Date of last increase _____ Earnings prior to increase $ _____
***The Standard will include Overtime and Shift Differential pay into the benefit calculation upon receipt of the employee's payroll records for the 52 weeks prior to their disability.

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 will be paid by the employer

10. Last date through which any compensation was paid by employer ☐ N/A (not applicable)
What type(s) of compensation was paid on this date?

11. What percentage of the STD premium does the **employer** pay? _____%

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

Employer Name	Local Number (If applicable)	Phone No.	Policy No.
Transport Workers Union of America	CHOOSE ONE		646888
Local 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 3 of this form.

Name (please print) _____

Signature _____ **Date** _____

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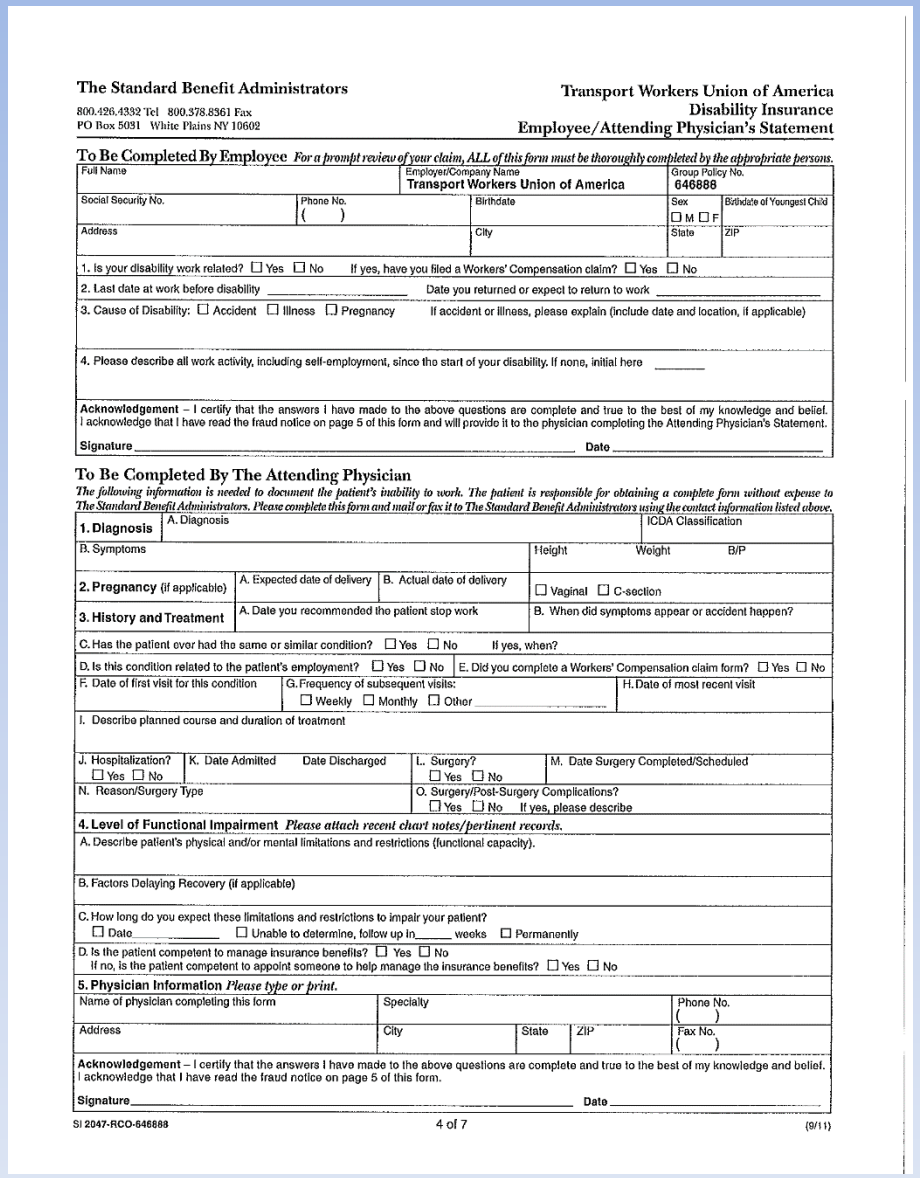
Employee/Attending Physician Statement

- Employee section must be fully completed
- Employee must sign and date the form
- The Physician Statement must be completed by the health care provider certifying disability and be signed by a licensed practitioner or his representative



The Standard Benefit Administrators
800.426.4332 Tel 800.378.8361 Fax
PO Box 5091 White Plains NY 10602

Transport Workers Union of America
Disability Insurance
Employee/Attending Physician's Statement

To Be Completed By Employee *For a prompt review of your claim, ALL of this form must be thoroughly completed by the appropriate persons.*

Full Name	Employer/Company Name	Group Policy No.
	Transport Workers Union of America	646888

Social Security No.	Phone No. ( )	Birthdate	Sex ☐ M ☐ F	Birthdate of Youngest Child

Address	City	State	ZIP

1. Is your disability work related? ☐ Yes ☐ No If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No
2. Last date at work before disability _____ Date you returned or expect to return to work _____
3. Cause of Disability: ☐ Accident ☐ Illness ☐ Pregnancy If accident or illness, please explain (include date and location, if applicable)
4. Please describe all work activity, including self-employment, since the start of your disability. If none, initial here _____

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 5 of this form and will provide it to the physician completing the Attending Physician's Statement.

Signature _____ **Date** _____

To Be Completed By The Attending Physician

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to The Standard Benefit Administrators. Please complete this form and mail or fax it to The Standard Benefit Administrators using the contact information listed above.

1. Diagnosis	A. Diagnosis	ICDA Classification
B. Symptoms		Height Weight B/P
2. Pregnancy (if applicable)	A. Expected date of delivery / B. Actual date of delivery	☐ Vaginal ☐ C-section
3. History and Treatment	A. Date you recommended the patient stop work	B. When did symptoms appear or accident happen?

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?

D. Is this condition related to the patient's employment? ☐ Yes ☐ No E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

F. Date of first visit for this condition | G. Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other _____ | H. Date of most recent visit

I. Describe planned course and duration of treatment

J. Hospitalization? ☐ Yes ☐ No | K. Date Admitted Date Discharged | L. Surgery? ☐ Yes ☐ No | M. Date Surgery Completed/Scheduled

N. Reason/Surgery Type | O. Surgery/Post-Surgery Complications? ☐ Yes ☐ No If yes, please describe

4. Level of Functional Impairment *Please attach recent chart notes/pertinent records.*

A. Describe patient's physical and/or mental limitations and restrictions (functional capacity).

B. Factors Delaying Recovery (if applicable)

C. How long do you expect these limitations and restrictions to impair your patient?
☐ Date _____ ☐ Unable to determine, follow up in _____ weeks ☐ Permanently

D. 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

5. Physician Information *Please type or print.*

Name of physician completing this form	Specialty			Phone No. ( )
Address	City	State	ZIP	Fax No. ( )

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 5 of this form.

Signature _____ **Date** _____

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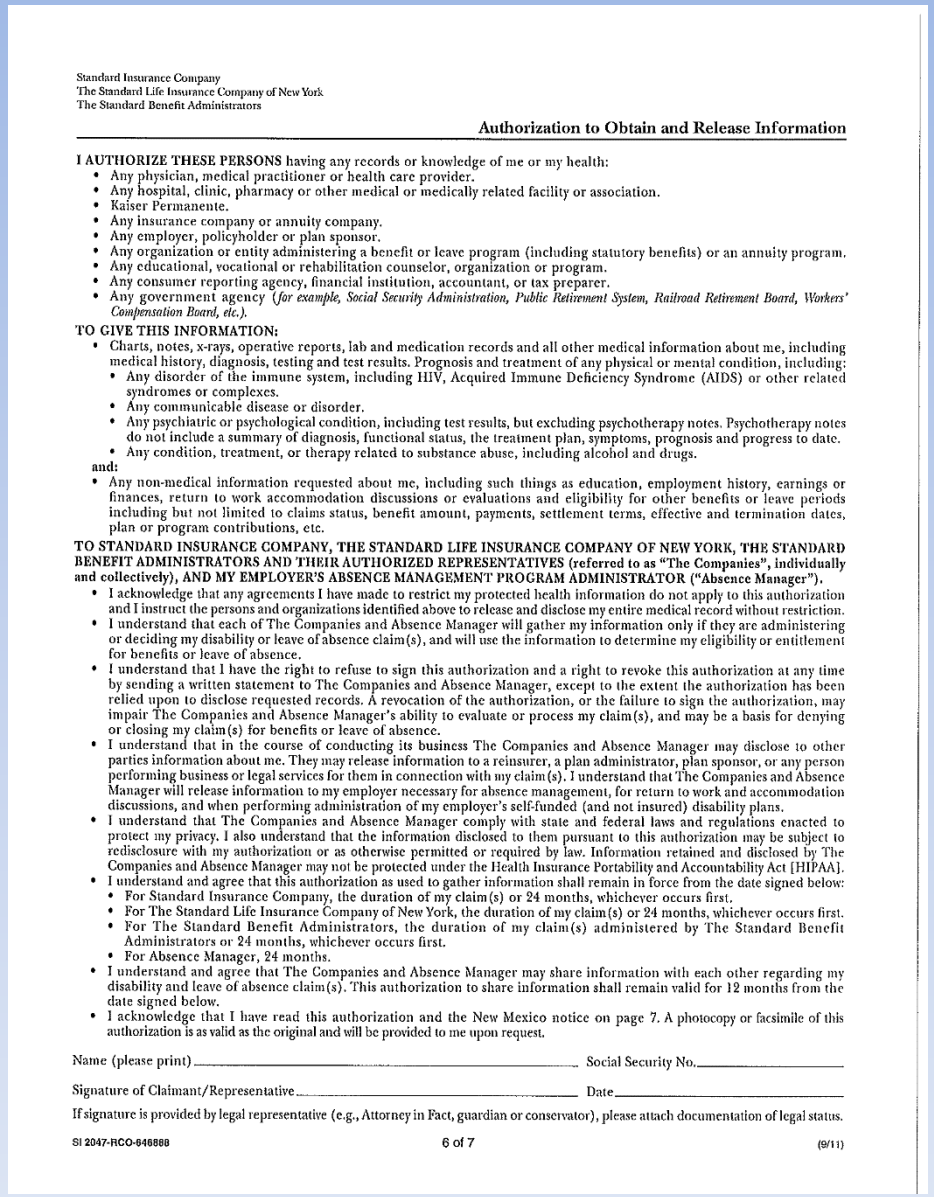
Authorization

- Authorization needs to be signed and dated by the employee and should be included with initial claim submission
- This form authorizes The Standard to obtain necessary medical documentation to assist in claim adjudication.



Standard Insurance Company
The Standard Life Insurance Company of New York
The Standard Benefit Administrators

Authorization to Obtain and Release Information

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 on page 7. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

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.

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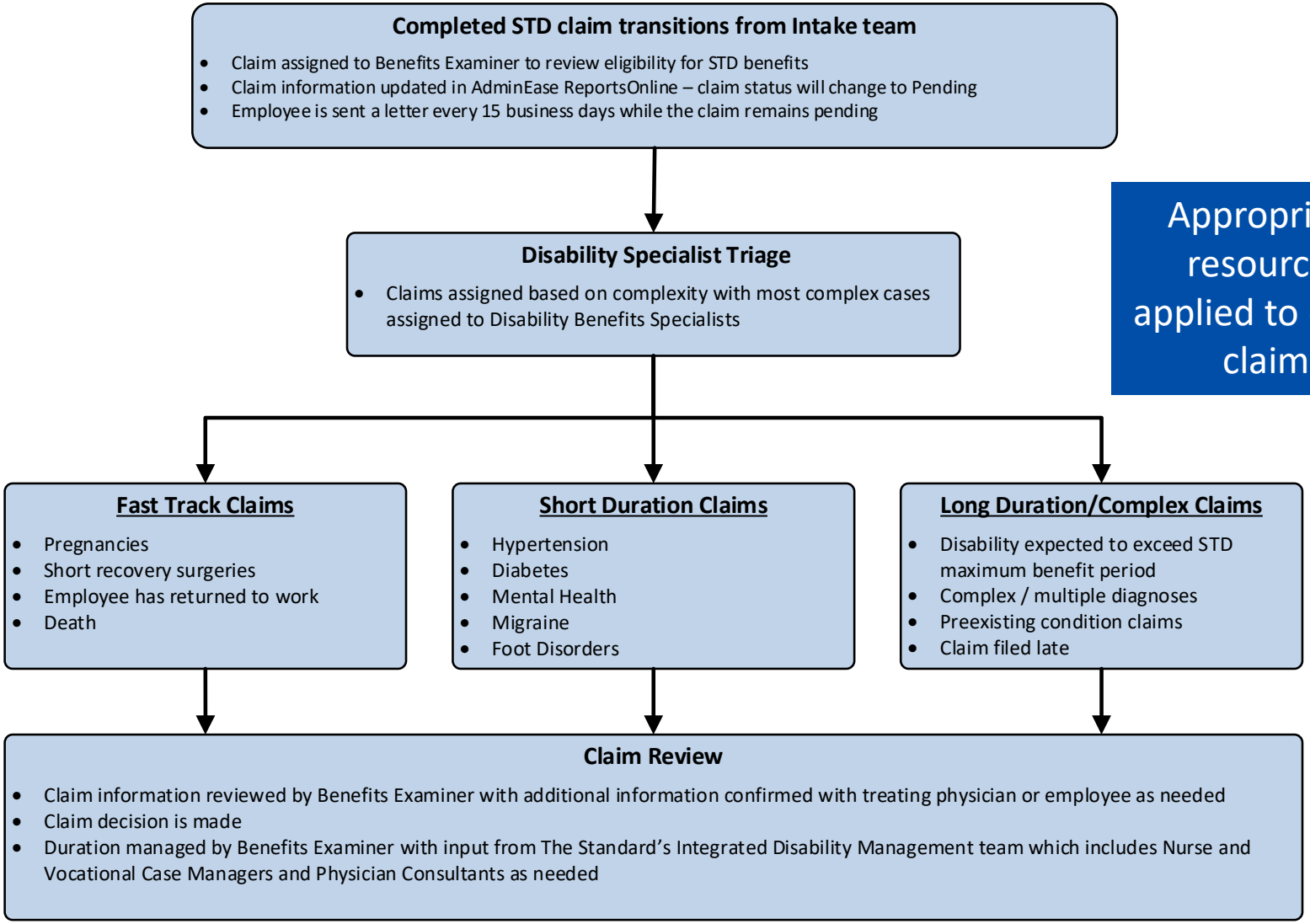
STD Claim Review



STD Claims Experience

Short Term Disability			
	6/1/2015 – 5/31/2016		6/1/2016 – 5/31/2017
Earned Premium	**1,088,576**		**1,114,700**
Paid Claims	1,028,972		1,068,387
FICA	-		-
Change in IBNR Reserves	162		3,306
Total Incurred Claims	**1,042,708**		**1,078,909**
Loss Ratio	**96%**		**97%**
Approved Claim Count	**129**		**117**
Claims Incidence (per 1000)	**35.3**		**31.0**

Wrap Up

Questions/Comments?

Thank you for having us!

We value your business and look forward to a successful 2018!