



Long-Term Disability Employer Statement

Prior to reviewing an LTD claim, the Standard Insurance Company requires an employer to provide the information requested below. Once you know an employee is filing a claim, complete and return this form to ltdmosers@standard.com. The claim will remain pending until this information is received.

PERSONAL INFORMATION

Employee's name	Job title		
Current medical condition is work-related	Yes	No	I don't know
Employee's job duties have been modified to accommodate any limitations and/or restrictions	Yes	No	
If yes, date accommodated			

EMPLOYEE WORK HISTORY

Hours scheduled per week	Last active day at work		
Employee has returned to work	Yes	No	I don't know
If yes, date returned to work			

EMPLOYEE COMPENSATION

Monthly salary on the last day worked			
Last date any compensation was or will be paid by employer			
Last date sick leave benefits were or will be paid by employer			
Type(s) of compensation that have or will be paid by the employer			
Employee has applied for Workers' Compensation	Yes	No	I don't know
Employee has applied for other compensation (e.g., Social Security, other insurance company)	Yes	No	I don't know
If yes, list other compensation			

EMPLOYER REPRESENTATIVE

Name	Email address
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