Disability online claims submission
Employee Manual | County of Roanoke

‡The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

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Introduction

Standard Insurance Company's online claim submission site provides a convenient way for you to submit disability claims (short-term and long-term disability). It saves you time by not having to mail or fax your claim to us and can speed up the process because your claim gets sent directly to our system.

This manual offers step-by-step instructions on how to submit your claims online. If you have questions, you can call The Standard‡ at 1-844-404-2111 or your disability case manager.

You will see a different phone number online on the system screens — remember 1-844-404-2111 is the dedicated number for the County of Roanoke.

Notice of a claim must be given to The Standard within 30 days after a covered loss starts, or as soon as reasonably possible.

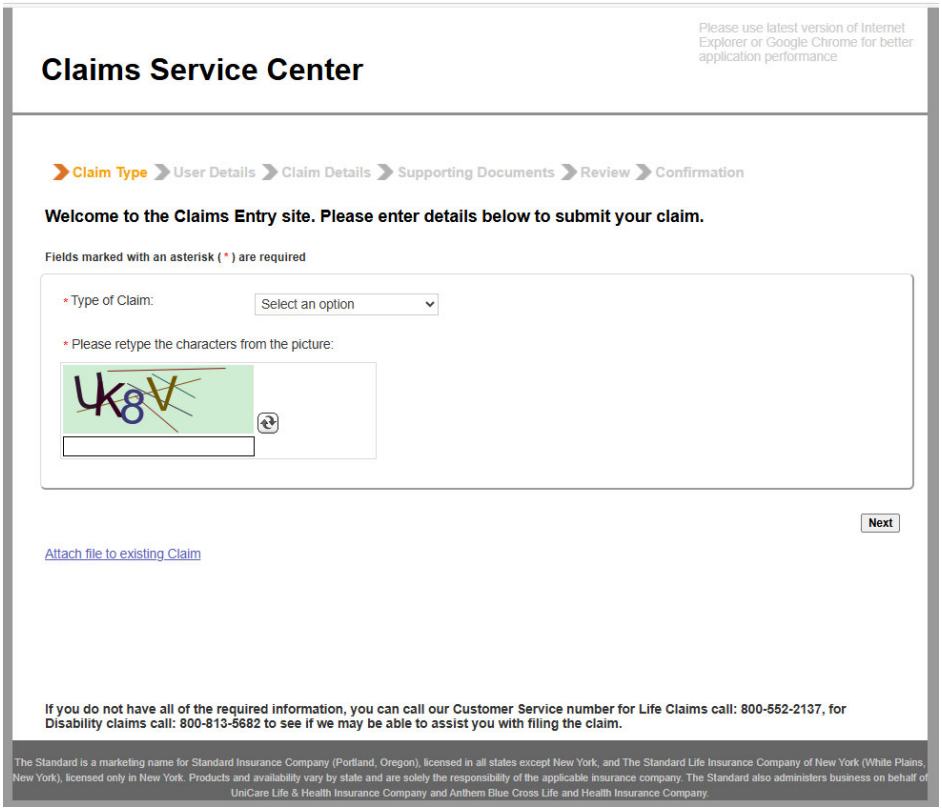
Due Written Proof of Disability must be given to The Standard within 90 days after such loss.

Getting started

To access online Disability Claims Submission, go to **https://app.standard.com/benefits/employee/soc/**.
You'll select the type of claim you want to submit on the *Welcome* screen. You'll see a list of claim types:

- Accidental dismemberment*
- Living benefit*
- Life waiver of premium*
- Short-term disability
- Long-term disability

* These coverages are not included in the County of Roanoke's plan. The County of Roanoke's coverage is for short-term disability or long-term disability. Select one of those options.



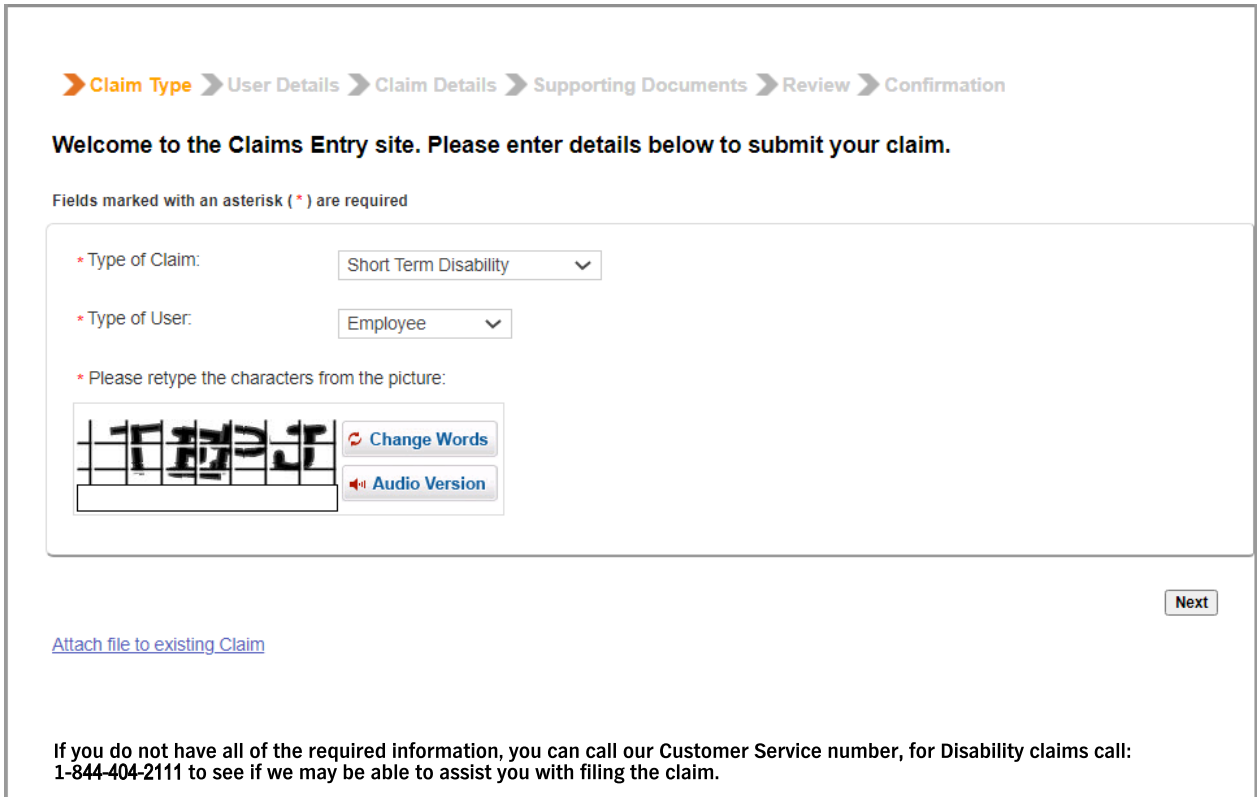
If you do not have all of the required information, you can call our Customer Service number, for Disability claims call: 1-844-404-2111 to see if we may be able to assist you with filing the claim.

Fields marked with an asterisk (*) are required.

Submitting a short-term disability claim

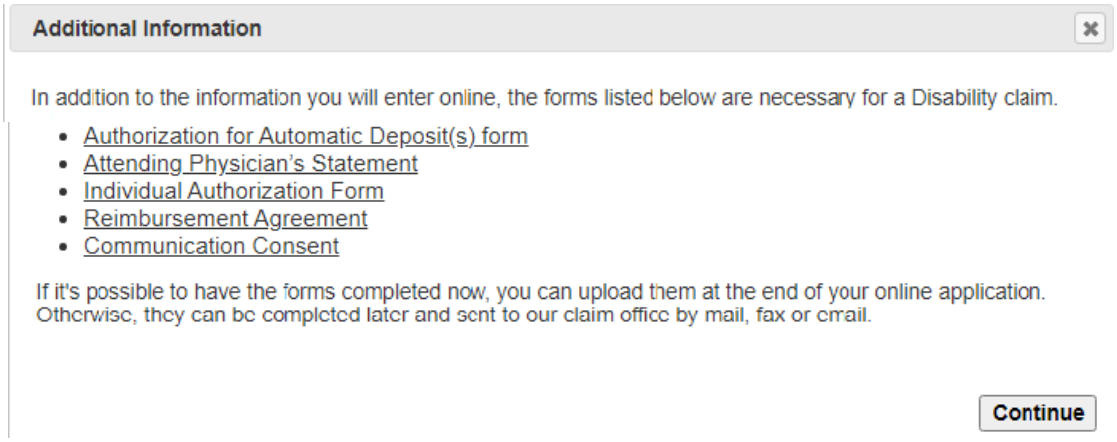
Select **Short-Term Disability** in the *Type of Claim* field and **Employee** in the *Type of User* field.

Enter the characters you see in the bottom box, then choose **Next**.



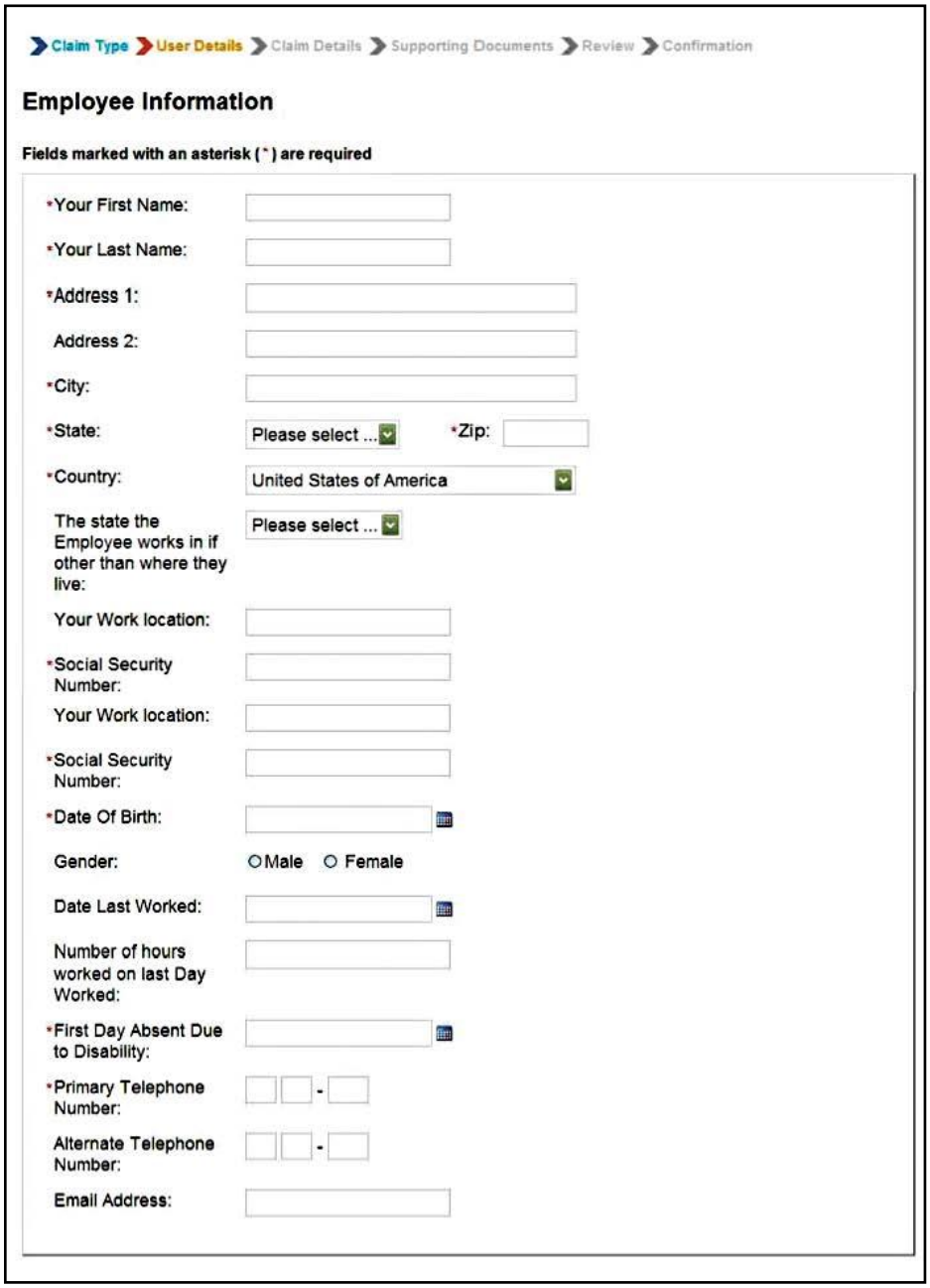
You can print the forms we need to process the short-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

- *Attending Physician's Statement*
- *Individual Authorization Form*
- *Reimbursement Agreement*
- *Communication Consent*

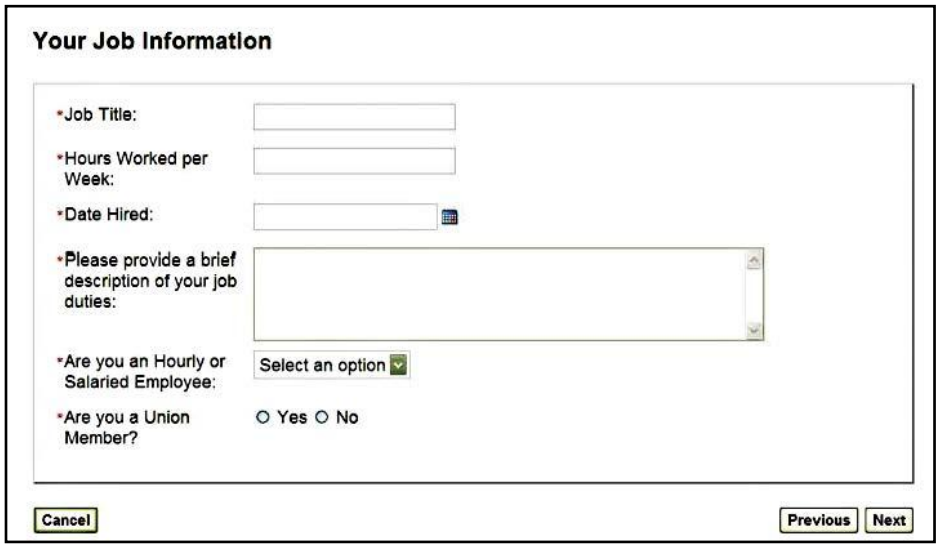


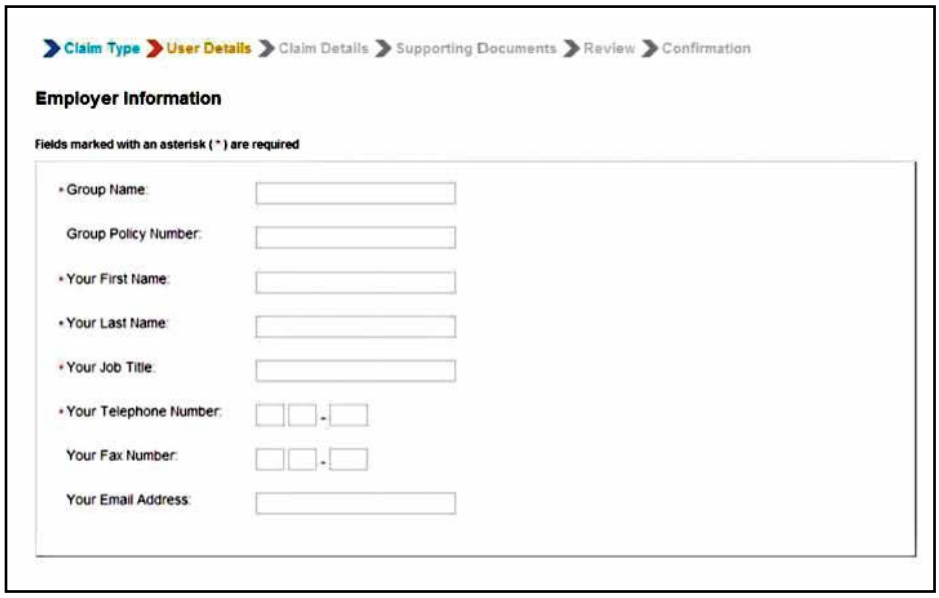
Do not complete Authorization for Automatic Deposit(s) form.

Enter your contact information and all the information you have about your disabling condition on the *Employee Information* screen. Be sure to give us as much detail as you have, to help us process your claim.



Next, enter your employer's contact information and information about your job.

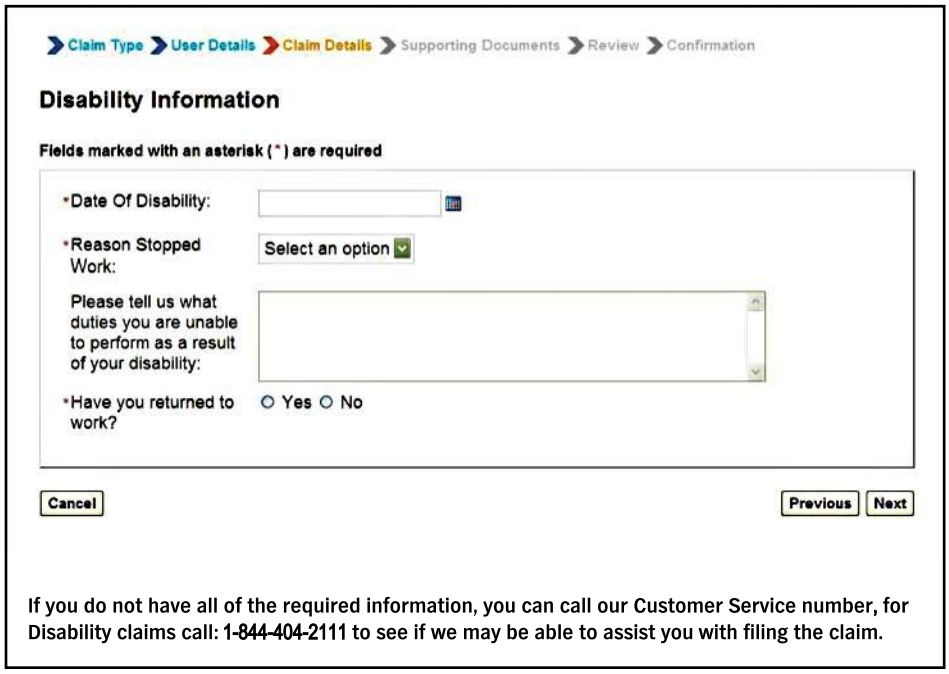




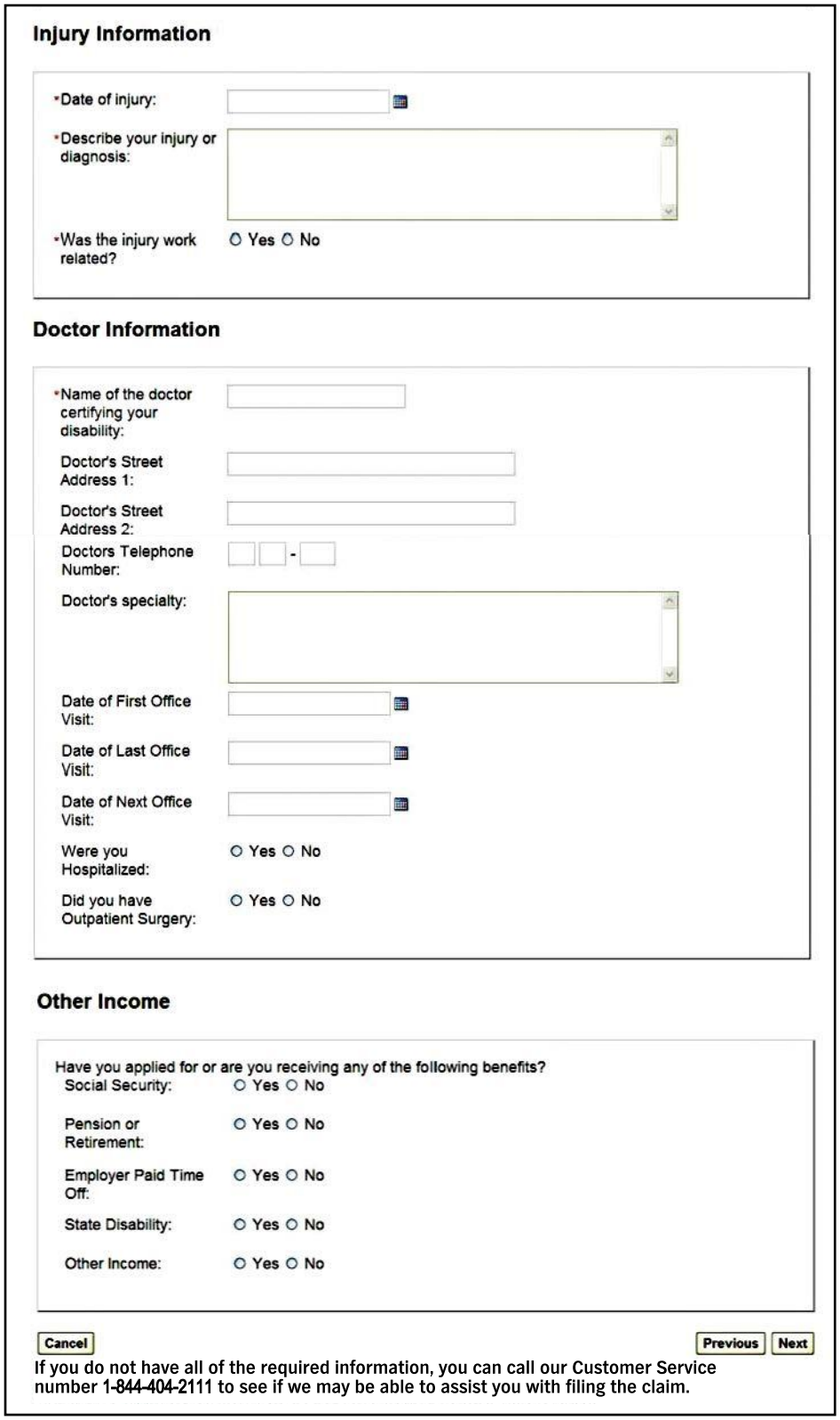
Group Policy Number:

- If you are a Hybrid employee, enter AL00006723
- If you are a Legacy (Plan 1 or Plan 2) employee, enter CM10002158

Next, you'll give us information about your disabling condition. Be sure to provide as much detailed information as you can.



Be sure to provide as much detail as you can to help us in processing your claim.



Injury Information

*Date of injury:

*Describe your injury or diagnosis:

*Was the injury work related? Yes No

Doctor Information

*Name of the doctor certifying your disability:

Doctor's Street Address 1:

Doctor's Street Address 2:

Doctors Telephone Number: -

Doctor's specialty:

Date of First Office Visit:

Date of Last Office Visit:

Date of Next Office Visit:

Were you Hospitalized: Yes No

Did you have Outpatient Surgery: Yes No

Other Income

Have you applied for or are you receiving any of the following benefits?

Social Security: Yes No

Pension or Retirement: Yes No

Employer Paid Time Off: Yes No

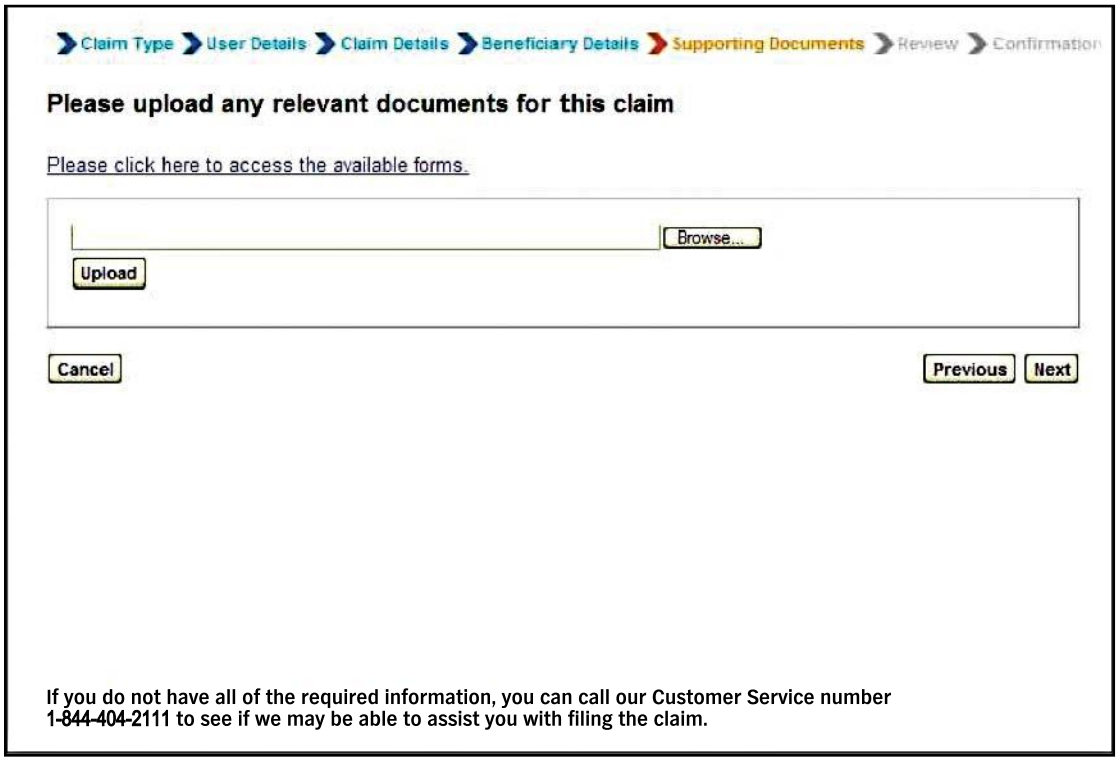
State Disability: Yes No

Other Income: Yes No

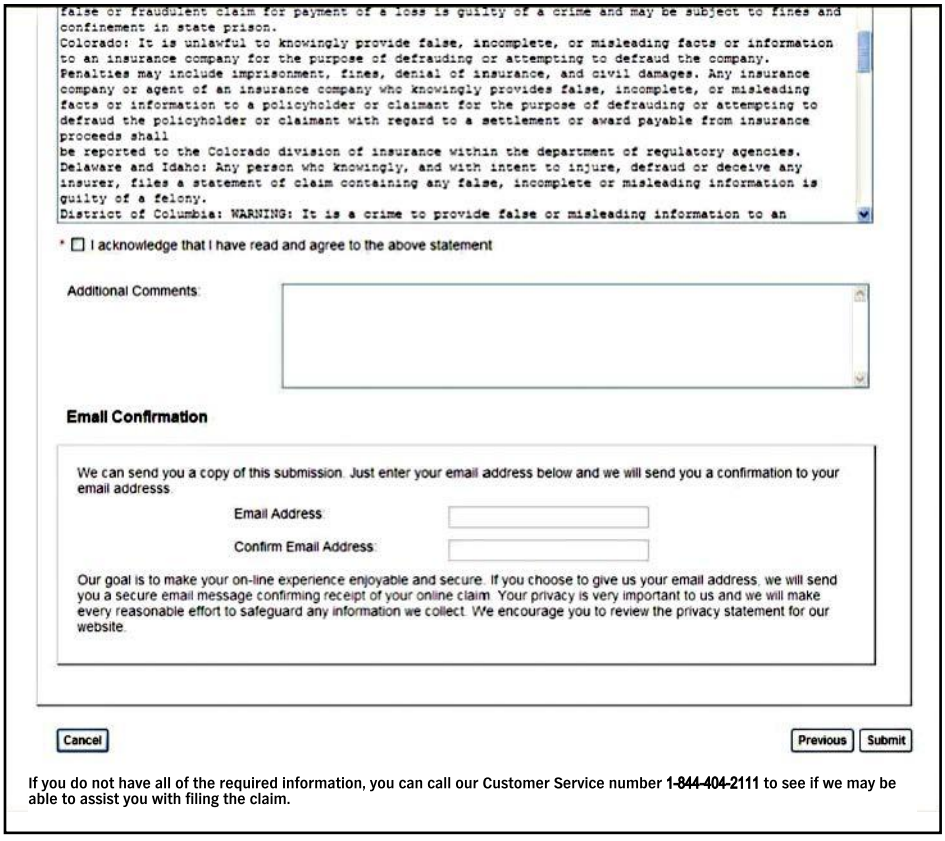
Cancel Previous Next

If you do not have all of the required information, you can call our Customer Service number 1-844-404-2111 to see if we may be able to assist you with filing the claim.

If you have forms completed at the time you enter the claim, such as the *Attending Physician's Statement*, *Individual Authorization Form, Reimbursement Agreement*, *or Communication Consent*, you can scan and attach them here.



Next, you'll get confirmation of the information you entered and you'll give your certification to us so that we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered.

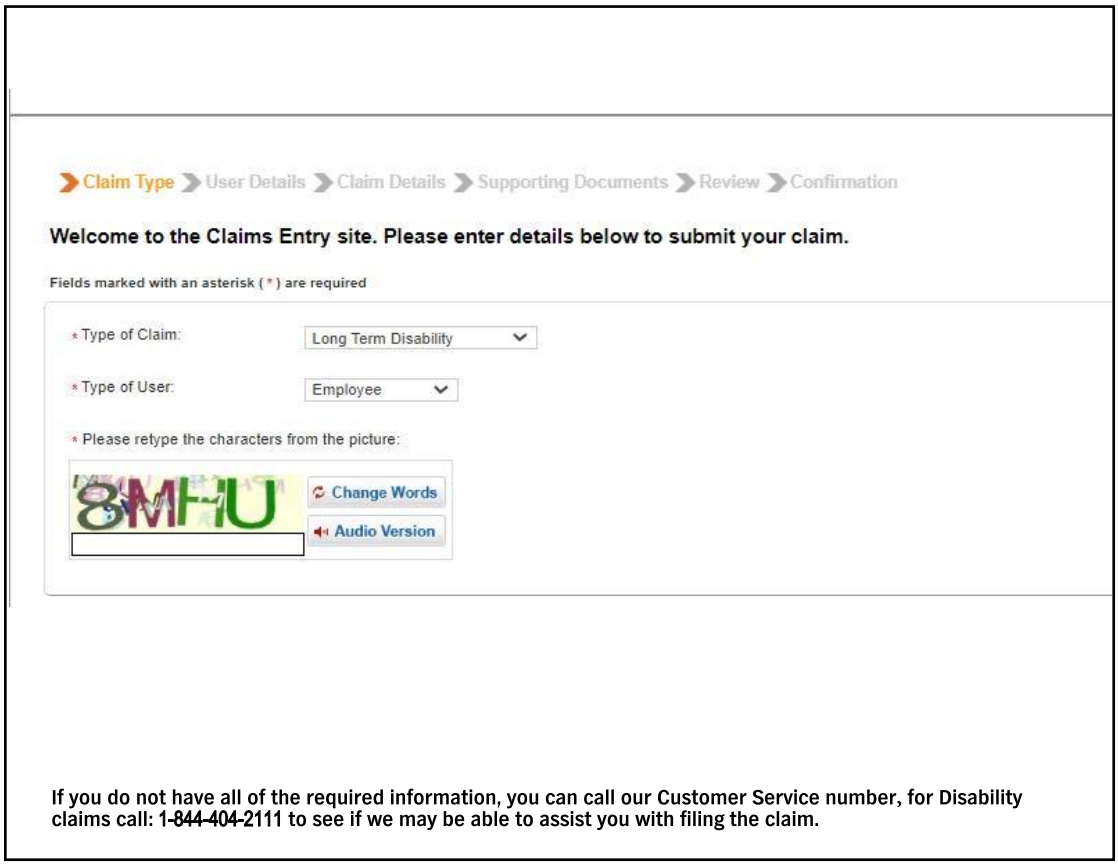


Once the claim is complete, you'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen you'll also get a confirmation summary by email.

Submitting a long-term disability claim

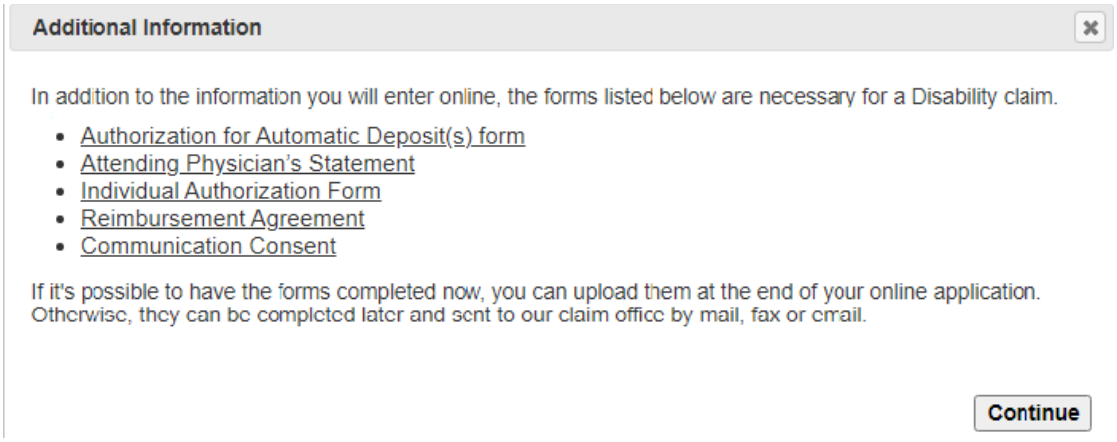
Select **Long-Term Disability** in the *Type of Claim* field and **Employee** in the *Type of User* field.

Enter the characters you see in the bottom box, then choose **Next**.



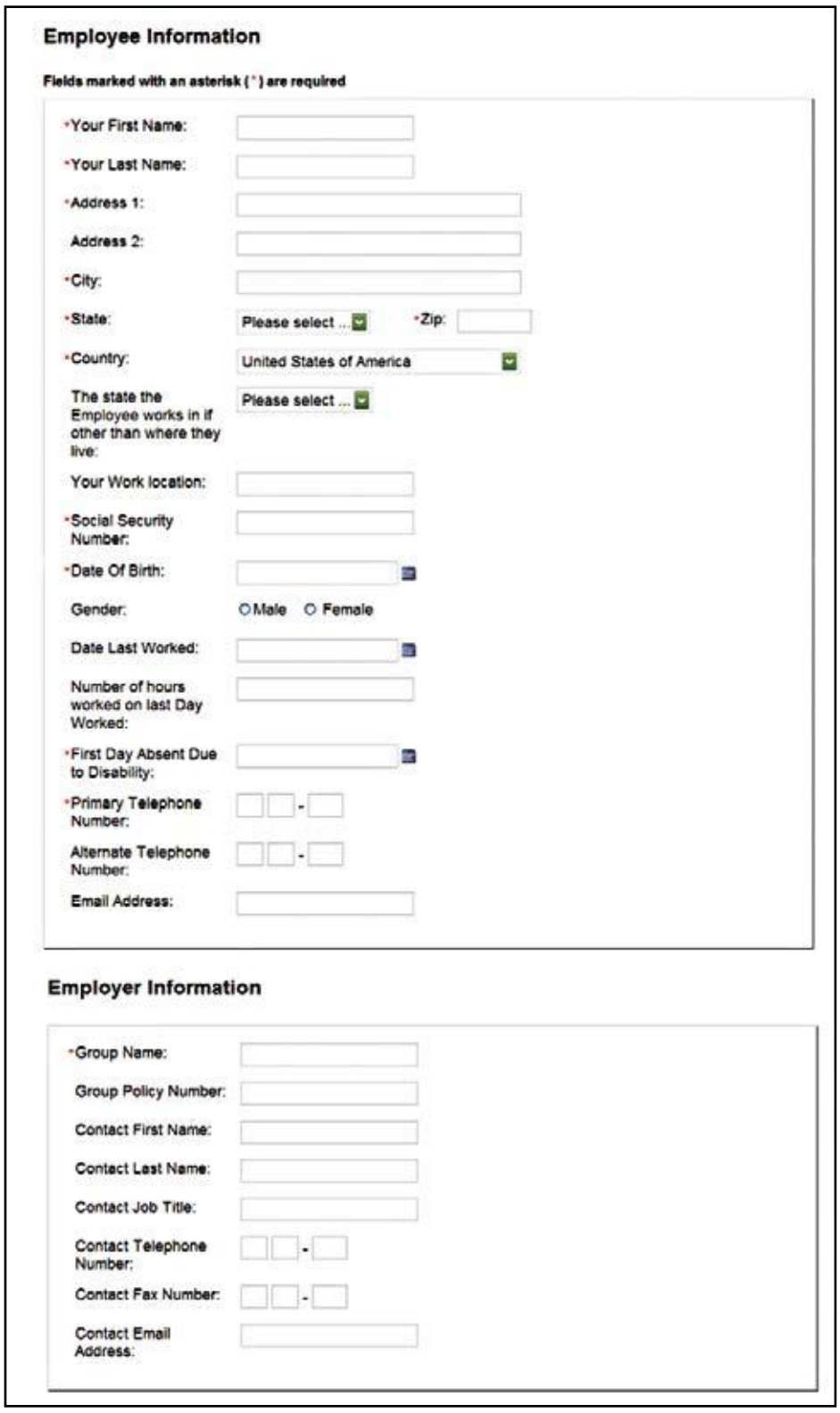
You can print the forms we need to process the long-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

- *Attending Physician's Statement*
- *Individual Authorization Form*
- *Reimbursement Agreement*
- *Communication Consent*



Do not complete Authorization for Automatic Deposit(s) form.

Enter your contact information and your employer's contact information on this screen.



Employee Information

Fields marked with an asterisk (*) are required

*Your First Name:
*Your Last Name:
*Address 1:
Address 2:
*City:
*State: Please select ... *Zip:
*Country: United States of America
The state the Employee works in if other than where they live: Please select ...
Your Work location:
*Social Security Number:
*Date Of Birth:
Gender: Male Female
Date Last Worked:
Number of hours worked on last Day Worked:
*First Day Absent Due to Disability:
*Primary Telephone Number:
Alternate Telephone Number:
Email Address:

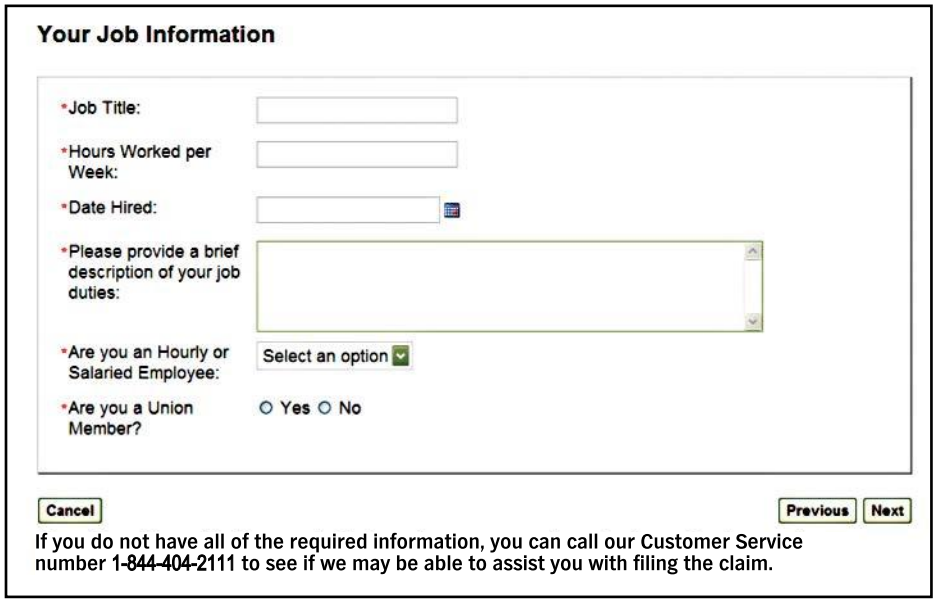
Employer Information

*Group Name:
Group Policy Number:
Contact First Name:
Contact Last Name:
Contact Job Title:
Contact Telephone Number:
Contact Fax Number:
Contact Email Address:

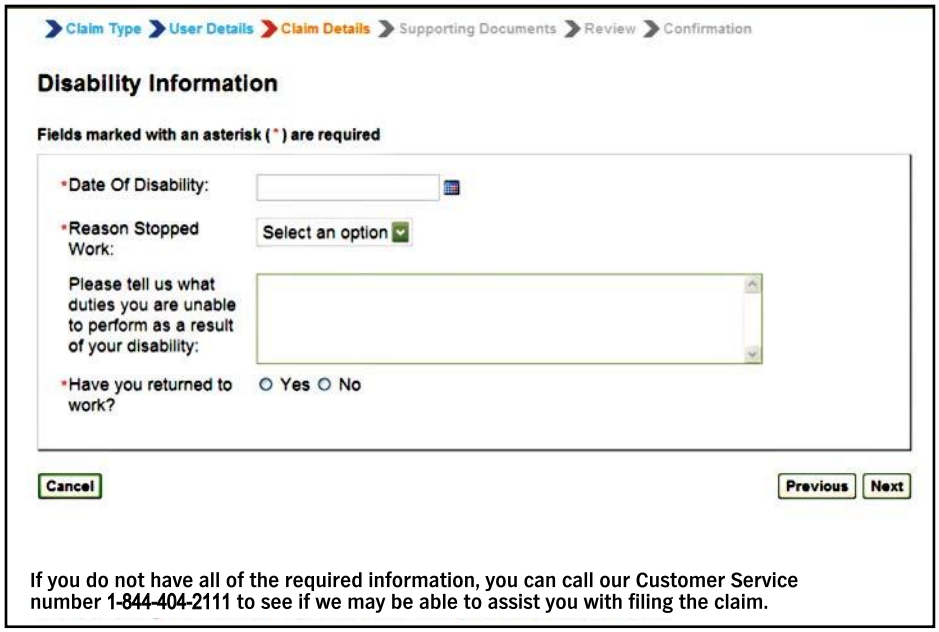
Group Policy Number:

- If you are a Hybrid employee, enter AL00006723
- If you are a Legacy (Plan 1 or Plan 2) employee, enter CM10002158

Be sure to give us as much information about your job as you can.



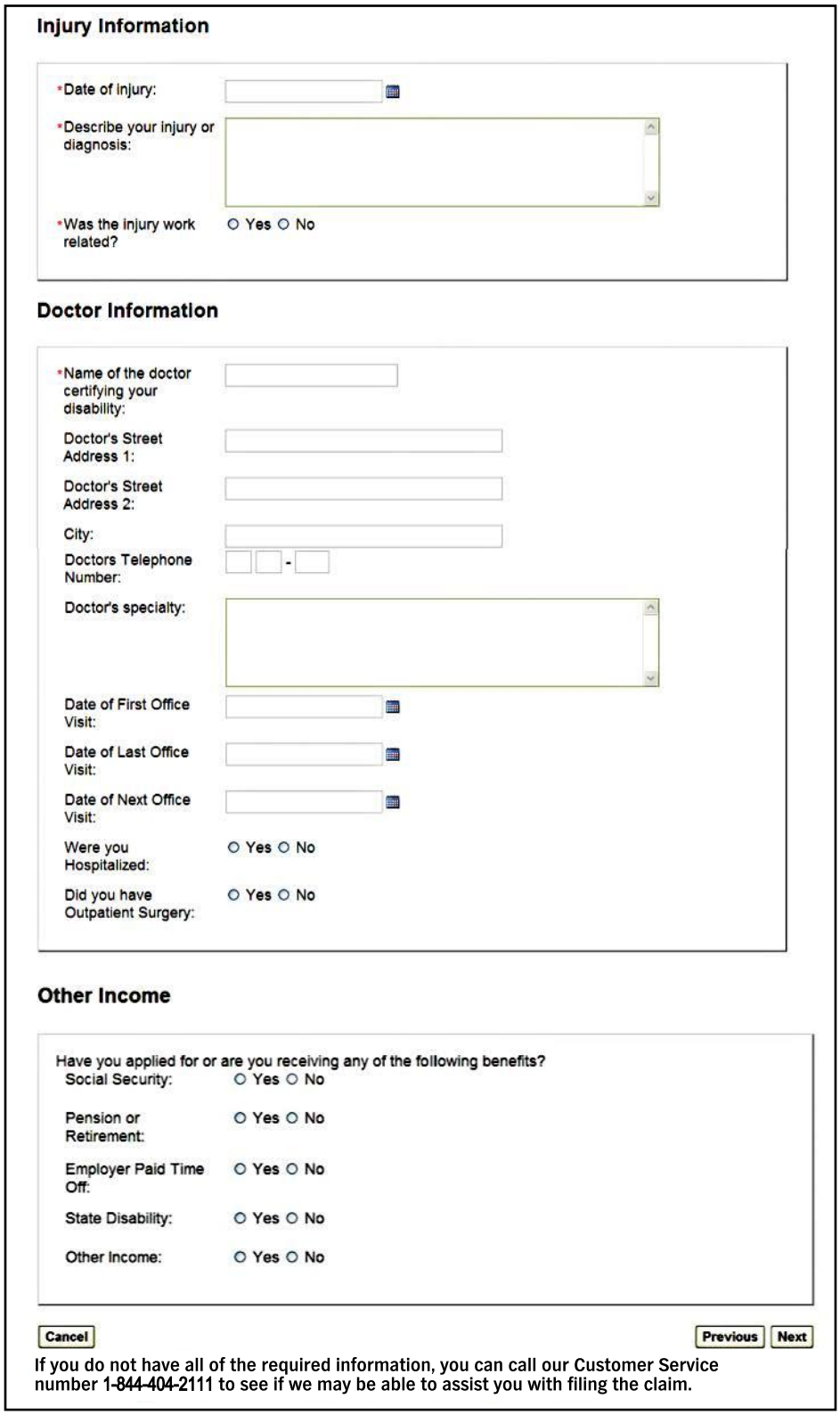
On the *Disability Information* screen, enter information about the disabling condition.



The questions will vary based on the reason you stopped work:

- Illness
- Injury
- Maternity

Regardless of the reason, you'll need to give as much information about your doctor and your other income as possible.



Injury Information

*Date of injury:

*Describe your injury or diagnosis:

*Was the injury work related? ○ Yes ○ No

Doctor Information

*Name of the doctor certifying your disability:

Doctor's Street Address 1:

Doctor's Street Address 2:

City:

Doctors Telephone Number: -

Doctor's specialty:

Date of First Office Visit:

Date of Last Office Visit:

Date of Next Office Visit:

Were you Hospitalized: ○ Yes ○ No

Did you have Outpatient Surgery: ○ Yes ○ No

Other Income

Have you applied for or are you receiving any of the following benefits?

Social Security: ○ Yes ○ No

Pension or Retirement: ○ Yes ○ No

Employer Paid Time Off: ○ Yes ○ No

State Disability: ○ Yes ○ No

Other Income: ○ Yes ○ No

Cancel Previous Next

If you do not have all of the required information, you can call our Customer Service number 1-844-404-2111 to see if we may be able to assist you with filing the claim.

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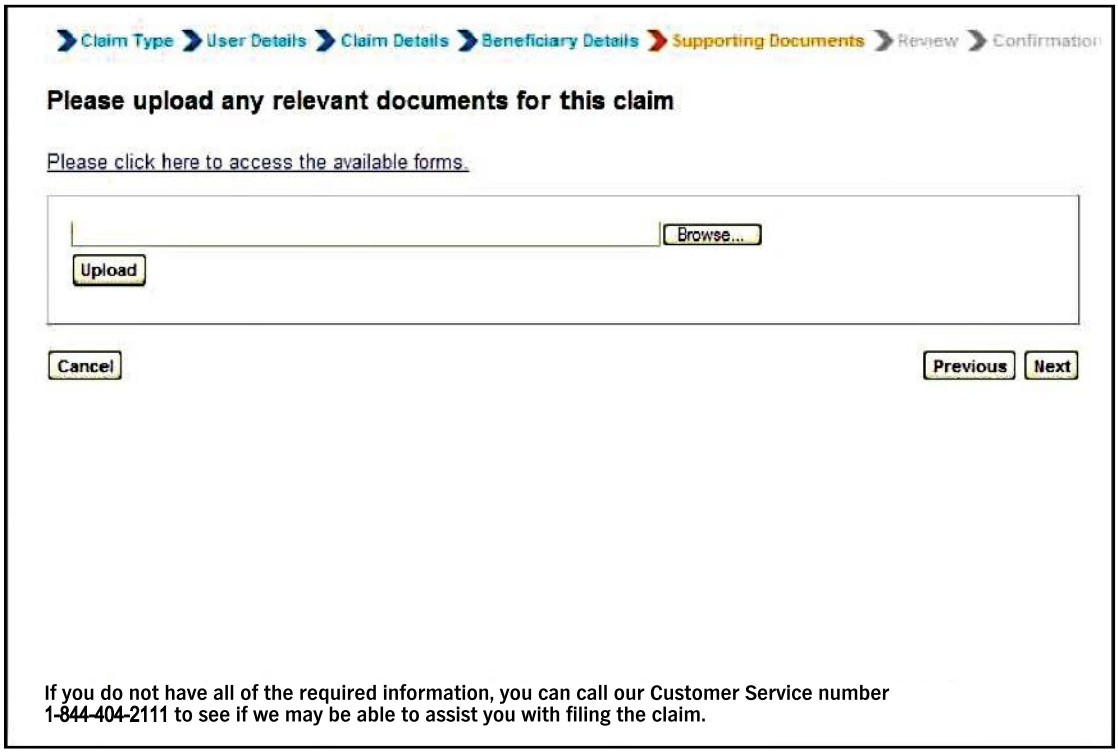


Next, you'll get confirmation of the information you entered and you'll give your certification to us so we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered.

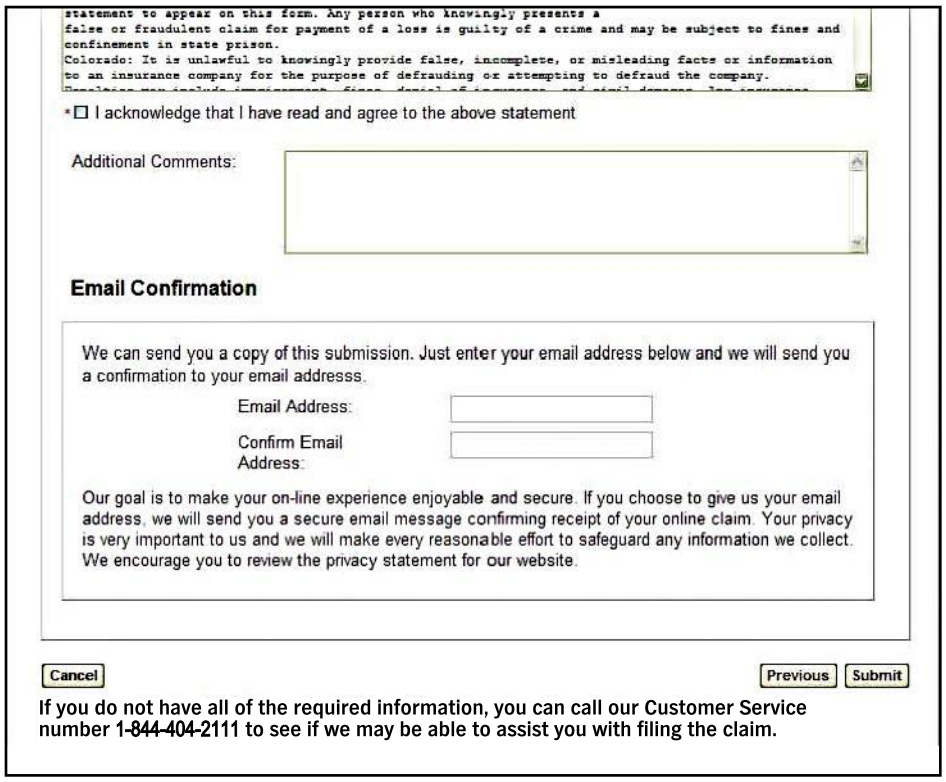
Employee Information

Your First Name:	t
Your Last Name:	t
Address 1:	t
City:	t
State:	NH
Zip:	44444
Country:	United States of America
Social Security Number:	444-33-3222
Date Of Birth:	11/11/1960
First Day Absent Due to Disability:	06/01/2013
Primary Telephone Number:	111-222-3333

Employer Information

Group Name:	t

Your Job Information



statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company.

* ☐ I acknowledge that I have read and agree to the above statement

Additional Comments:

Email Confirmation

We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email addresss.

Email Address:

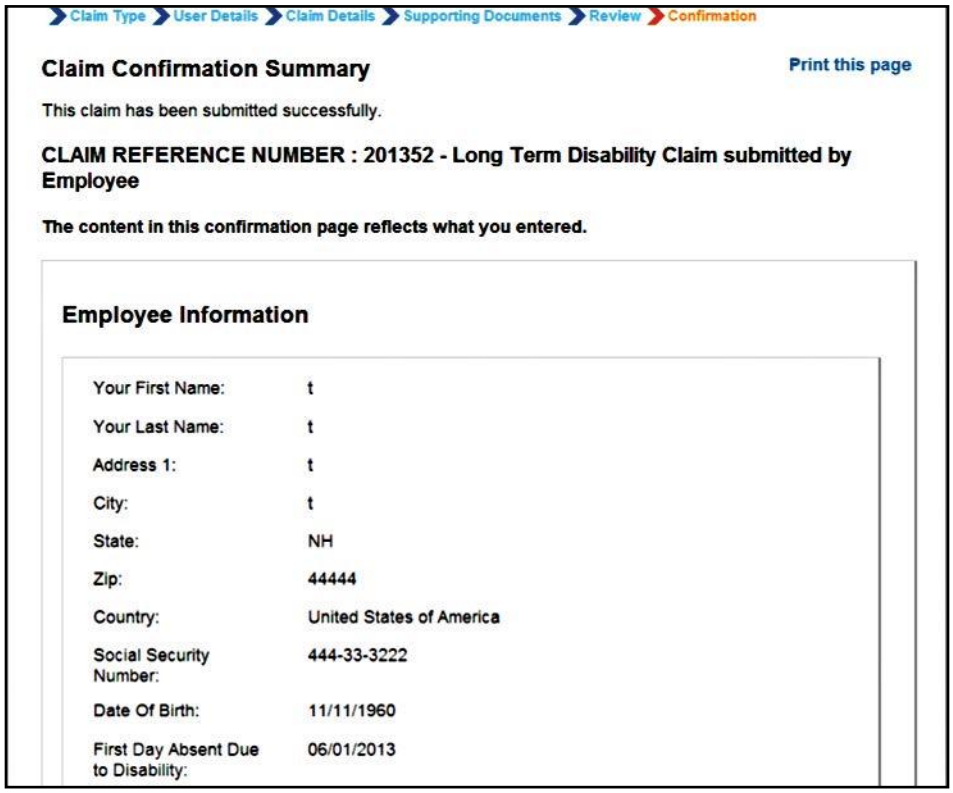
Confirm Email Address:

Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure email message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard any information we collect. We encourage you to review the privacy statement for our website.

Cancel Previous Submit

If you do not have all of the required information, you can call our Customer Service number 1-844-404-2111 to see if we may be able to assist you with filing the claim.

Once the claim is complete, you'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen, you'll also get a confirmation summary by email.



Claim Type › User Details › Claim Details › Supporting Documents › Review › Confirmation

Claim Confirmation Summary Print this page

This claim has been submitted successfully.

CLAIM REFERENCE NUMBER : 201352 - Long Term Disability Claim submitted by Employee

The content in this confirmation page reflects what you entered.

Employee Information

Your First Name:	t
Your Last Name:	t
Address 1:	t
City:	t
State:	NH
Zip:	44444
Country:	United States of America
Social Security Number:	444-33-3222
Date Of Birth:	11/11/1960
First Day Absent Due to Disability:	06/01/2013

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