



Dear Disability Salary Continuance Claimant:

The following Disability Salary Continuance information is for your review and action. We understand that being disabled does not cease your financial obligations and we hope that the Disability Salary Continuance benefits assist you during the time that you are unable to work and are off payroll. If you are unable to return to work at the end of your Disability Salary Continuance period, you may be eligible for Long Term Disability (LTD) benefits through Standard Insurance Company (The Standard).

This packet contains forms to apply for your Disability Salary Continuance benefits and the Plan Document that provides specific information about the plan. It is also intended to address common questions about Disability Salary Continuance claims and procedures. We recommend that you save this material for your future reference.

### **How To Apply for Disability Salary Continuance Benefits**

A Disability Salary Continuance application includes three forms that must be completed, 1) the claim form, 2) an Authorization to Obtain Information form and 3) IRS form W-4.

1. Complete the section of the claim form called "To be Completed by Employee".
2. Have your physician complete the section on the claim form called "Attending Physician's Statement".
3. Complete the section of the claim form called "Authorization to Obtain Information".
4. Complete the IRS form W-4.
5. Send all completed forms to:

**County of Orange/Employee Benefits  
10 Civic Center Plaza, 2nd Floor  
Santa Ana, CA 92701**

### **Important Notice: Incomplete forms will cause a delay in processing your disability claim form.**

Once all completed forms are received, Employee Benefits will:

1. Request written verification from your agency that all of your accrued sick time/annual leave that is required has been exhausted. *(For your information, subsequent payment of vacation or comp time will not affect your Disability Salary Continuance payments. Subsequent payment of Catastrophic Leave will affect your Disability Salary Continuance payments. Please contact the Employee Benefits Office as soon as you are awarded Catastrophic Leave.)*
2. The Employee Benefits Office will complete the "To Be Completed by Employer" section of the claim form.
3. Send all completed forms to The Standard.

Once The Standard receives your completed claim form, it will take approximately one week to make a claim decision. If a decision has not been reached within one week, you will be notified with the details. Once a decision (approval or denial) has been made on your claim, you will also be notified. The Standard will consider the applicable elimination period and issue payments each Wednesday as long as you are eligible for benefits.

### **Pregnancy Related Disabilities**

Soon after your baby is born, you must:

1. Notify The Standard at (800) 368-2859 to report the actual date and type of delivery.
2. It is your responsibility to report your life event to the County of Orange Benefits Center within 30 days from the date of birth to add the baby to your health plan. You can add your baby by logging on to the Benefits Center Web Site at [www.benefitsweb.com/countyoforange.html](http://www.benefitsweb.com/countyoforange.html) or call the Benefits Resource Line at the toll free number (866) 325-2345 and follow the instructions to speak with a Benefits Specialist.

**Other Benefits That May Reduce Your Disability Benefits**

Other benefits you receive may reduce the amount of Disability Salary Continuance benefits due you. The Disability Salary Continuance Plan Document and Long Term Disability group insurance certificates list these benefits, which may include, but are not limited to, sick leave, Workers' Compensation, Catastrophic Leave and Retirement.

Note: Any overpayments of Disability Salary Continuance benefits must be repaid in full.

**Extension of Disability**

In most cases, The Standard will cease benefit payments on the anticipated return to work date your physician indicates on your claim form. If your disability extends past this date, you must:

1. Notify your immediate supervisor.
2. Have your physician complete a new Attending Physician's Statement. An Attending Physician's Statement (APS) or the other medical questionnaire will be included with the correspondence you receive from The Standard. If you need an additional APS or medical questionnaire, you may request them directly from The Standard at their toll free number (800) 368-2859.
3. Once completed, send the new Attending Physician's Statement to The Standard.

To avoid a lapse in eligible benefit payments, the above steps should take place as soon as you are aware that additional time off work is required due to your disability.

**Federal Income Tax Withholding**

The Internal Revenue Service requires that Federal Income Tax be withheld from your Disability Salary Continuance Benefits. Therefore, you must complete an IRS Form W-4 and submit it with your disability claim. If you have questions on how you should complete the form, you should contact your tax advisor.

**Medicare Tax Withholding**

If you were hired by the County of Orange on or after April 1, 1986, the Medicare Tax will be withheld from your Disability Salary Continuance benefits.

**Return to Work**

If you return to work prior to the anticipated return to work date your physician indicates on your claim form, immediately notify The Standard. This will prevent overpayments of benefits. Any overpayments of Disability Salary Continuance benefits must be repaid in full.

**Need Additional Information**

We hope that this information addresses any questions you may have had regarding your Disability Salary Continuance plan. If not:

- You should contact The Standard at their toll free number (800) 368-2859 for general plan questions and/or specific details about your Disability Salary Continuance claim or determination.

Standard Insurance Company

Claims Administrator 800.368.2859 Tel 800.378.6053 Fax  
 PO Box 2800 Portland OR 97208-2800

County of Orange California  
**Disability Salary Continuance  
 Employer/Employee's Statement**

Submit Completed Form to: County of Orange, Employee Benefits, 2nd Floor, 10 Civic Center Plaza, Santa Ana, CA 92701

**TO BE COMPLETED BY EMPLOYEE**

Full Name:		Social Security Number:		Phone No.: (     )		Birthdate:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Mailing Address:				City:		State:		Zip Code:	
1. Is your disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No				2. Have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, do you intend to file? <input type="checkbox"/> Yes <input type="checkbox"/> No					
				3. Last active day at work:					
4. Date you became unable to work at your occupation because of disability:				5. Date you returned or expect to return to work:					
6. Is your disability due to: <input type="checkbox"/> Accident. When and where did it happen?				7. How does your disability prevent you from working?					
				8. Have you had a previous disability claim with The Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Illness. When did you first notice and what is the nature of your disability?				9. Pregnancy:     Expected delivery date: _____ Actual delivery date: _____ Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section					
<p><b>Acknowledgement</b>                  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 4 of this form.</p> <p>By signing this statement, you also agree to pay the County of Orange back any Disability Salary Continuance benefits that were paid to you for any period of time for which you also received income or benefits from other sources.</p> <p>Signature: _____ Date: _____</p>									
Have or will you be applying for: Disability Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No Catastrophic Leave <input type="checkbox"/> Yes <input type="checkbox"/> No				<p><b>Note to Employee: Complete top portion of Attending Physician's Statement on page 5.</b></p>					

**TO BE COMPLETED BY EMPLOYER**

Employee's Full Name:		Social Security Number:		Job Title:		1. Date Employed:	
2. Is employee insured for Short Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date: _____		3. Is disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined					
Is employee insured for Long Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date: _____		4. Has the employee filed for: Workers' Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No   Other: _____					
Is employee insured for Group Life Insurance through The Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No		5. Employee's weekly earnings: \$ _____					
6. Last active day at work: _____				7. Job status when disability began: <input type="checkbox"/> Full-time (____ hours/week) Rep Unit: _____ Agency: _____			
8. Date employee returned to work: _____		9. Last day through which sick leave benefits were paid: _____		10. Last day through which any compensation was paid by employer: _____ Type: _____			
11. Is employee subject to:     Social Security taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No					
12. Does the employee pay all or a portion of the premium for:     STD coverage? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		LTD coverage? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Employer: <b>The County of Orange</b>		Plan No.: <b>639024</b>		Phone No.: <b>( 714 ) 834-6282</b>			
Mailing Address: <b>10 Civic Center Drive, 2nd Floor</b>		City: <b>Santa Ana</b>		State: <b>CA</b>		Zip Code: <b>92701</b>	
<p><b>Acknowledgement</b>                  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 4 of this form.</p> <p>Signature: _____ Date: _____ Prepared By: _____</p>							

Some states require us to provide the following information to you:

**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**

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. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**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**

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA RESIDENTS**

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.

**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.

**TO BE COMPLETED BY EMPLOYEE**

Full Name:	Employer: <b>The County of Orange</b>	Plan No: <b>639024</b>
------------	--	---------------------------

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

*The following information is needed to document your patient's inability to work. The patient is responsible for completing this form without expense to the plan sponsor or The Standard.*

<b>1. Diagnosis</b>																																															
A. Diagnosis:		ICDA Classification:																																													
B. Symptoms:		C. Objective Findings: Height: _____ Weight: _____ B/P: _____ / _____																																													
<b>2. Pregnancy (if applicable)</b>																																															
A. Expected date of delivery:		B. Actual date of delivery:	C. Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section																																												
D. Significant complications, if any:																																															
<b>3. History</b>																																															
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when? _____																																													
D. Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		E. Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No																																													
<b>4. Treatment</b>																																															
A. Date of first visit:	B. Date(s) of subsequent visits:		C. Date of most recent visit:																																												
D. Planned course and duration of treatment (include surgery and medications, if any):																																															
<b>5. Level of Functional Impairment</b>																																															
A. Describe the patient's physical, mental and cognitive limitations, if any.		B. In a work day given two breaks and a meal break, your patient can:																																													
		Lift (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+																																													
		Carry (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+																																													
		Total Hours <span style="float: right;">With positional change</span>																																													
		<table style="width:100%; border: none;"> <tr> <td style="text-align: right;">Sit</td> <td style="text-align: center;">8</td> <td style="text-align: center;">7</td> <td style="text-align: center;">6</td> <td style="text-align: center;">5</td> <td style="text-align: center;">4</td> <td style="text-align: center;">3</td> <td style="text-align: center;">2</td> <td style="text-align: center;">1</td> <td style="text-align: right;">(hrs)</td> <td>_____</td> </tr> <tr> <td style="text-align: right;">Stand</td> <td style="text-align: center;">8</td> <td style="text-align: center;">7</td> <td style="text-align: center;">6</td> <td style="text-align: center;">5</td> <td style="text-align: center;">4</td> <td style="text-align: center;">3</td> <td style="text-align: center;">2</td> <td style="text-align: center;">1</td> <td style="text-align: right;">(hrs)</td> <td>_____</td> </tr> <tr> <td style="text-align: right;">Walk</td> <td style="text-align: center;">8</td> <td style="text-align: center;">7</td> <td style="text-align: center;">6</td> <td style="text-align: center;">5</td> <td style="text-align: center;">4</td> <td style="text-align: center;">3</td> <td style="text-align: center;">2</td> <td style="text-align: center;">1</td> <td style="text-align: right;">(hrs)</td> <td>_____</td> </tr> <tr> <td style="text-align: right;">Alternately sit/stand</td> <td style="text-align: center;">8</td> <td style="text-align: center;">7</td> <td style="text-align: center;">6</td> <td style="text-align: center;">5</td> <td style="text-align: center;">4</td> <td style="text-align: center;">3</td> <td style="text-align: center;">2</td> <td style="text-align: center;">1</td> <td style="text-align: right;">(hrs)</td> <td>_____</td> </tr> </table>		Sit	8	7	6	5	4	3	2	1	(hrs)	_____	Stand	8	7	6	5	4	3	2	1	(hrs)	_____	Walk	8	7	6	5	4	3	2	1	(hrs)	_____	Alternately sit/stand	8	7	6	5	4	3	2	1	(hrs)	_____
Sit	8	7	6	5	4	3	2	1	(hrs)	_____																																					
Stand	8	7	6	5	4	3	2	1	(hrs)	_____																																					
Walk	8	7	6	5	4	3	2	1	(hrs)	_____																																					
Alternately sit/stand	8	7	6	5	4	3	2	1	(hrs)	_____																																					
		Bend/stoop: <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently																																													
C. Is the patient competent to manage insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is the patient competent to appoint someone to help manage the insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No																																															
<b>6. Hospitalization (if applicable)</b>																																															
A. Date admitted:	Date discharged:	B. Reason:																																													
C. Name and location of hospital (city/state):																																															
<b>7. Prognosis</b>																																															
A. Since onset of symptoms, the patient's condition has: <input type="checkbox"/> Improved <input type="checkbox"/> Not changed <input type="checkbox"/> Retrogressed																																															
B. When do you anticipate the patient can return to work? <input type="checkbox"/> Date: _____ <input type="checkbox"/> Unable to determine, follow up in _____ weeks <input type="checkbox"/> Never																																															
<b>8. Physician Information (Please type or print)</b>																																															
Name of physician completing this form:			Phone Number: ( )																																												
Specialty:		Tax ID#:	Fax Number: ( )																																												
Mailing Address:	City:	State:	Zip Code:																																												
<b>Acknowledgement</b> 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 6 of this form.																																															
Signature: _____			Date: _____																																												

Some states require us to provide the following information to you:

**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**

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. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**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**

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA RESIDENTS**

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.

**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.

**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.
- 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 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, 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 THE COUNTY OF ORANGE AS PLAN SPONSOR AND STANDARD INSURANCE COMPANY (THE STANDARD) ACTING AS ITS CLAIMS ADMINISTRATOR.**

- 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 The County of Orange California and The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The County of Orange California and 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 County of Orange California and 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 County of Orange California and The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The County of Orange California and The Standard may disclose to other parties information it has about me. The County of Orange California and/or The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The County of Orange California and The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my 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. (Disability 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 8. 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.

*This Authorization is a two-page document. Please see page 8 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.

# Form W-4 (2007)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners/Multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

**Nonresident alien.** If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_

**B** Enter "1" if:   
 { • You are single and have only one job; or   
 • You are married, have only one job, and your spouse does not work; or   
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. } . . . . . **B** \_\_\_\_\_

**C** Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** \_\_\_\_\_

**D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** \_\_\_\_\_

**E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . . . . **E** \_\_\_\_\_

**F** Enter "1" if you have at least \$1,500 of **child or dependent care expenses** for which you plan to claim a credit . . . . . **F** \_\_\_\_\_  
 (Note. Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**G Child Tax Credit** (including additional child tax credit). See Pub 972, Child Tax Credit, for more information.  
 • If your total income will be less than \$57,000 (\$85,000 if married), enter "2" for each eligible child.  
 • If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children. **G** \_\_\_\_\_

**H** Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► **H** \_\_\_\_\_

For accuracy, **complete all worksheets that apply.**   
 { • If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.  
 • If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.  
 • If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b> <small>Department of the Treasury Internal Revenue Service</small>	<b>Employee's Withholding Allowance Certificate</b>  ► <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>	<small>OMB No. 1545-0074</small> <b>2007</b>
---	---	---

<b>1</b> Type or print your first name and middle initial.	Last name	<b>2</b> Your social security number
Home address (number and street or rural route)		<b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
City or town, state, and ZIP code		<b>4</b> If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>
<b>5</b> Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	<b>5</b> _____	
<b>6</b> Additional amount, if any, you want withheld from each paycheck	<b>6</b> \$ _____	
<b>7</b> I claim exemption from withholding for 2007, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . . ► <b>7</b> _____		

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

**Employee's signature**  
 (Form is not valid unless you sign it.) ► \_\_\_\_\_ **Date** ► \_\_\_\_\_

<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	<b>9</b> Office code (optional)	<b>10</b> Employer identification number (EIN)
--	---------------------------------	--

### Deductions and Adjustments Worksheet

**Note.** Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2007 tax return.

- 1** Enter an estimate of your 2007 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2007, you may have to reduce your itemized deductions if your income is over \$156,400 (\$78,200 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ \_\_\_\_\_
- 2** Enter:  $\left\{ \begin{array}{l} \$10,700 \text{ if married filing jointly or qualifying widow(er)} \\ \$ 7,850 \text{ if head of household} \\ \$ 5,350 \text{ if single or married filing separately} \end{array} \right\}$  2 \$ \_\_\_\_\_
- 3** **Subtract** line 2 from line 1. If zero or less, enter "-0-" 3 \$ \_\_\_\_\_
- 4** Enter an estimate of your 2007 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$ \_\_\_\_\_
- 5** **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) 5 \$ \_\_\_\_\_
- 6** Enter an estimate of your 2007 nonwage income (such as dividends or interest) 6 \$ \_\_\_\_\_
- 7** **Subtract** line 6 from line 5. If zero or less, enter "-0-" 7 \$ \_\_\_\_\_
- 8** **Divide** the amount on line 7 by \$3,400 and enter the result here. Drop any fraction 8 \_\_\_\_\_
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 \_\_\_\_\_
- 10** **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 \_\_\_\_\_

### Two-Earners/Multiple Jobs Worksheet (See *Two earners/multiple jobs* on page 1.)

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1** Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 \_\_\_\_\_
- 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3." 2 \_\_\_\_\_
- 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 \_\_\_\_\_

**Note.** If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

- 4** Enter the number from line 2 of this worksheet 4 \_\_\_\_\_
- 5** Enter the number from line 1 of this worksheet 5 \_\_\_\_\_
- 6** **Subtract** line 5 from line 4 6 \_\_\_\_\_
- 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ \_\_\_\_\_
- 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ \_\_\_\_\_
- 9** Divide line 8 by the number of pay periods remaining in 2007. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2006. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ \_\_\_\_\_

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$510	\$0 - \$35,000	\$510
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	850	35,001 - 80,000	850
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 170,000	950	80,001 - 150,000	950
18,001 - 22,000	3	19,001 - 26,000	3	170,001 - 300,000	1,120	150,001 - 340,000	1,120
22,001 - 26,000	4	26,001 - 35,000	4	300,001 and over	1,190	340,001 and over	1,190
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.