Standard Insurance Company

Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Reset

Employee Request for an Accommodation
Workplace Possibilities Program

To be completed by employee

Employer			Employee Name	
Current Mailing Address				Job Title
Birthdate	Height Weight	Preferred Phone No.	Preferred Email	
Main Job Duties				
Physician's Name (please print)			Specialty	
Address	City		State	ZIP
Phone No.	Fax No.			

Describe the limitations that are currently preventing you from performing your job (or a part of your job).

Please describe what part(s) of your job are difficult to perform due to your limitations.

Is there anything that would help you to do your job at this time?

Have you had any accommodation for this limitation in the past? ☐ Yes ☐ No If yes, what were they?

Please provide any other information to help us understand your accommodation request, or what assistance you need in the workplace.

If you are currently out on leave, is there anything that would help you to return to work?

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 hereby certify that the information I have provided on this form is both true and complete to the best of my knowledge and belief.

Employee Signature	Date

Please fax completed form to: 971-321-5727

Print (6/20)