CLAREMONT UNIVERSITY CONSORTIUM

Voluntary Disability Benefits

Enclosed you will find a disability packet that will provide information to assist you in filing for disability benefits through The Claremont Colleges' Voluntary Disability Insurance (VDI) Plan that is available to all qualified employees.

These documents must be completed by you and your treating physician and returned to Disability Administration ***as soon as possible*** to determine your eligibility to receive disability benefits.

Employee Responsibility (Instructions)

Employee Claim Form
Complete the Employee Claim Statement

Doctor's Certificate
Give the Doctor Certification to your treating physician for completion—this document must be completed and returned to our office as soon as possible. Failure to complete the certification form may delay your benefits.

Authorization to Furnish Medical Information
Complete the Authorization to Furnish Medical Information—this document must be completed and returned to our office as soon as possible. Failure to complete the authorization form may delay your benefits.

Salary Continuation Form
Complete and sign the Salary Continuation form—this will allow us to supplement your medical leave in the event that you exhaust accrued sick leave, please elect whether to use Vacation and Personal Holidays.

Redirect Form
Complete the Redirect form, which allows for your benefit deductions to be taken from your VDI pay if or when your supplemental leave has been exhausted.

Notify your Supervisor and HR
Notify your supervisor of your medical leave and provide written notification (off-work note). Contact your Human Resource Officer prior to starting your medical leave or within 24 hours for emergency leaves.

Please note that all forms must be received ***completed*** by our office before eligibility can be determined. Once we have determined eligibility we will send you an acceptance letter with your weekly benefit amount and will process payments in accordance with the payroll schedule.

If you have any questions or concerns, please feel free to contact Disability Administration at (909) 607-7946.

THE CLAREMONT COLLEGES Pomona College 1887 Claremont Graduate University 1925 Claremont University Consortium 1925
Scripps College 1926 Claremont McKenna College 1946 Harvey Mudd College 1955 Pitzer College 1963 Keck Graduate Institute 1997

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Employee Claim Form

SHORT TERM DISABILITY INSURANCE

PLEASE COMPLETE ALL APPLICABLE ITEMS. IF INCOMPLETE, THIS FORM WILL BE RETURNED, CAUSING A DELAY IN BENEFITS.

1. First Name _____ Middle Name _____ Last Name _____

2. Street Address _____ City _____ State _____ ZIP _____

3. Phone Number _____ 4. Social Security Number _____ 5. Date of Birth _____ 6. Gender ☐ Male ☐ Female

7. College _____ 8. Department _____ 9. Occupation _____

10. On what date did your disability begin? _____ 10A. Give the last day worked before you became disabled. _____

11. Are you employed, full- or part-time, by another employer? ☐ Yes ☐ No 12. If "Yes," are you disabled from this job? ☐ Yes ☐ No

13. Does this employer have a voluntary disability plan? ☐ Yes ☐ No

14. What disability (or disabilities) prevent you from work? *(describe below)*

15. What normal duties *(e.g. walking, sitting, lifting, climbing, driving, reading, filing, etc.)* are you unable to perform due to your disability? *(describe below)*

16. Was this disability caused by your work? ☐ Yes ☐ No 17. If "Yes," describe how your disability occurred. *(describe below)*

18. Are you claiming or receiving Workers' Comp Benefits for any injuries of illnesses during any period covered by this claim? ☐ Yes ☐ No

19. Have you recovered from your disability? ☐ Yes ☐ No 20. If "Yes," on what date did you return to work _____

21. Have you returned to work for any day, full- or part-time, after the date in item 10 above? ☐ Yes ☐ No

I hereby claim benefits and certify that for the period covered by this claim I was disabled and therefore unable to work, that the foregoing statements including any accompanying statements are to the best of my knowledge and believe true, correct and complete. I hereby authorize my attending physician, practitioner or hospital to furnish and disclose all facts concerning my disability that are within their knowledge, and allow inspection of and provide copies of any hospital records concerning my disability that are under their control.

Signature _____ Date _____

If your signature is made by mark (X), it must be attested by one witness with address:

Signature *(Witness)* _____ Address _____

Under Section 2101 of California Unemployment Insurance Code, it is a misdemeanor to willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits, such misdemeanor being punishable by imprisonment not exceeding six months or by a fine not exceeding $500 or both.

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Doctor's Certificate

Certification shall be made by a licensed physician and surgeon, osteopath, chiropractor, dentist, podiatrist, optometrist, designated psychologist, licensed nurse, mid-wife, nurse practitioner, or an authorized medical officer of a United States Government facility.
ALL ITEMS ON THIS FORM MUST BE COMPLETED, OR BENEFITS WILL BE DELAYED.

Patient Name

22. This patient has been under my care and treatment for this medical problem from:

23. At intervals of:

24. History *(State the nature, severity and the bodily extent of the incapacitating disease or injury):*

25. ICD Code

26. Diagnosis:

27. Objective Findings:

28. Is this a pregnancy-related disability? ☐ Yes ☐ No

29. If "Yes," please provide date pregnancy terminated or future EDC:

30. If you are certifying for a pre-partum period, what complication, impairment, or disabling factor prevents this patient from working prior to delivery?

31. Type of surgery:

32. ICD Code

33. Date performed or to be performed

34. Date and time admitted:

Date and time discharged:

35. Has the patient at any time during your attendance for this medical problem been incapable of performing his or her regular work? ☐ Yes ☐ No

36. If "Yes," this disability commenced

37. Approximate date, in your opinion, this disability should end or has ended sufficiently to permit the patient to resume regular or customary work. This is a requirement of the Code, and the claim will be delayed if such date is not entered.

DATE OF RETURN TO WORK

38. In your opinion, is this disability the result of "occupation" either as an "industrial accident" or as an "occupational disease"? ☐ Yes ☐ No

39. Have you reported this or a concurrent disability to any insurance carrier as a Worker's Compensation Claim? ☐ Yes ☐ No

40. If "Yes," to whom? *(Name of carrier or firm)*

41. Would the disclosure of this information be medically or psychologically detrimental to your patient? ☐ Yes ☐ No

I certify under penalty of perjury that, based on my examination, the foregoing Doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.

I further certify that I am a _____ licenced to practice in the State of _____
Type of Doctor

Doctor's Name

Name of Medical Group *(if any)*

Signature of Attending Doctor

Street Address

State License Number

City, State, ZIP

Date

Phone Number

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Authorization to Furnish Medical Information

READ THIS FORM CAREFULLY.
FILL IT OUT COMPLETELY. IF INCOMPLETE, PROCESSING OF YOUR CLAIM WILL BE DELAYED.

Health Insurance Portability and Accountability Act Authorization

I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or workers' compensation insurance carrier to furnish and disclose to the Office of Worker's Compensation & Disability for *(check employer)*:

☐ Claremont University Consortium

☐ Claremont McKenna College
☐ Harvey Mudd College
☐ Keck Graduate Institute
☐ Pitzer College
☐ Pomona College
☐ Scripps College

all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control. I understand that the Office of Worker's Compensation & Disability for the above designated institution may disclose information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected by this rule. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for five years from the date received by Worker's Compensation & Disability for the above designated institution or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent recovery of monies to which it is legally entitled.

Employee's Signature _____ Date Signed _____

Declaration and Signature

By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was disabled and therefore unable to work. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to then best of my knowledge and belief true, correct, and complete. By my signature on this claim statement, I authorized Worker's Compensation & Disability Administration and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of five years from the date of my signature or the effective date of the claim, whichever is later.

Employee's Signature _____ Date Signed _____

If your signature is made by mark (X), it must be attested by one witness with address:

Signature *(Witness)* _____ Address _____

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Salary Continuation Form

SHORT-TERM DISABILITY LEAVE (VDI)

Name _____ Date _____

Social Security Number _____ Date of Disability _____

College/Location _____ Job Title _____

Authorization

During your short-term disability (VDI) period, you may receive disability benefits. These payments are not equal to your regular salary but rather 55% of your regular wages. Your accrued sick leave will automatically be used to supplement your leave up to 90% of your regular salary. After your sick leave has been exhausted, you have the option to use available vacation hours and/or personal time to supplement disability payments during your VDI leave. Please review the following options carefully and designate your choice(s).

1. ☐ I authorize the use of the following paid time off. *(If you select "all," write "all".)*

Vacation hours _____ Personal hours _____

I understand that while I receive supplemental paid time off, the normal payroll deduction(s) for my elected benefit(s) will continue (i.e., health, dental, life, etc.).

When I no longer receive paid time off, in order to continue elected benefit(s) coverage, I will be required to make cash payments to Benefits Administration or approve the redirection of benefits from my VDI pay.

Or

2. ☐ I choose not to use any paid time off.

I understand that by not authorizing the use of supplemented paid time off, I may only receive disability payments. In order to continue my normal elected benefit(s) coverage I will be required to make cash payments to Benefits Administration or I may choose to have a portion of my VDI benefits directed to cover payments (contact the VDI Office for authorization form).

Employee Signature _____ Date Signed

FOR OFFICE USE ONLY

SALARY INFORMATION	HOURS WORKED	AVAILABLE TIME OFF
Hourly		Sick days/Hours
Biweekly/Semi-monthly		Vacation days/Hours
Monthly		Personal days/Hours

First day of disability leave _____ Estimated date of return _____

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Authorization to Redirect Voluntary Plan Benefits

Employee Name _____ College _____

Employee ID Number _____ Claim Effective Date _____

Section 1345 of the California Unemployment Insurance Code (CUIC) allows an individual to redirect a portion of his/her Voluntary Plan benefit payment to cover all or part of the cost of any employee-paid benefits in which the individual is currently enrolled. In order to allow Disability Administration to redirect a portion of the Voluntary Plan benefit payment, the individual must provide a written authorization for the redirection to begin.

If the Voluntary Plan benefit payment recipient has been declared legally incompetent, the spouse of the individual, in the absence of any other legally authorized representative, shall have the right to continue or cancel the authorization for the redirection of Voluntary Plan benefit payments. Benefit redirections are taken after taxes and deducted evenly from each paycheck.

If you wish to stop a current benefit deduction while on disability leave, please provide a request in writing to Benefits Administration. Your benefit deductions will begin on the first payment cycle after your supplemental pay has been exhausted.

☐ **YES, I wish to redirect my Voluntary Disability benefit payments to pay for my benefit premiums.**

☐ **NO, I do not wish to redirect my benefits and understand I will need to cash-pay for my premiums.**

I understand that these deductions from my Voluntary Plan benefit payments will continue until I terminate them, reach my maximum disability amount or leave time, or until I return to work. I understand that I can terminate or change these deductions at any time while receiving Voluntary Plan benefit payments and that these deductions will be taken after-tax.

Employee Signature _____ Date Signed _____

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