



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 and Redirection of Benefits Form

Complete and sign the 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. The form 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.



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
		XXX-XX-		
3. Phone Number	4. Social Security Number	5. Date of Birth	6. Gender <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. If "Yes," are you disabled from this job? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Does this employer have a voluntary disability plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. What disability (or disabilities) prevent you from work? (<i>describe below</i>)				

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 Workers' Comp Benefits for any injuries or illnesses during any period covered by this claim? Yes No

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

20. Have you recovered from your disability? Yes No

21. If "Yes," on what date did you return to work _____

22. 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 unemployed and disabled, 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.



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 _____ Date of Birth _____

22. This patient has been under my care and treatment for this medical problem from: _____ 23. At intervals of (Frequency and Duration): _____

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 _____ licensed 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 _____ Fax Number _____



Authorization to Furnish Medical Information

READ THIS FORM CAREFULLY.

FILL IT OUT COMPLETELY. IF INCOMPLETE, PROCESSING OF YOUR CLAIM WILL BE DELAYED.

Name	Date
XXX-XX- Social Security Number	Date of Disability
Date of Birth	College

Health Insurance Portability and Accountability Act Authorization

I authorize any physician, practitioner, hospital, vocational rehabilitation or counselor, carrier to furnish and disclose to the Office of Worker's Compensation & Disability.

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

Signature (<i>Witness</i>)	Address
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Salary Continuation and Redirection of Benefits Form

SHORT-TERM DISABILITY LEAVE (VDI)

Employee Name

College

Claim Effective Date

Authorization

During your short-term disability (VDI) period, you may receive disability benefits. The benefit payments are not equal to your regular pay but provide approximately 60% or 70% based on 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 your 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 supplemental 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 Disability Administration office for authorization form).

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 the Disability Administration office 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 benefit payment.

If you wish to stop a current benefit deduction while receiving VDI benefits, 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 VDI 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 VDI benefit 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