

CAPE MAY COUNTY
DEPARTMENT of HUMAN RESOURCES and TRAINING

LEONARD C. DESIDERIO
Freeholder Vice-Director
JEFFREY R. LINDSAY, ESQ.
Director

4 Moore Road, DN 122
Cape May Court House, N.J. 08210-1654
(609) 465-1060 ☐ Fax: (609) 465-3716



Leave of Absence Checklist

_____ “Request For Medical/Family Leave of Absence” form: To be signed and completed by the employee.

_____ “Certification of Health Care Provider” form: To be signed and completed by the treating health care provider.

All 4 pages must be completed and submitted.

_____ Sun Life: The County’s short term disability carrier.

This plan takes effect when the employee reaches 7 consecutive days of without pay status during his or her full time leave of absence.

Please complete the employee sections (pages 3, 4 & 9) and have your treating health care provider complete pages 5 & 6 if you choose to apply.

You may submit the Sun Life forms along with your Leave of Absence papers to the Human Resources Department.

Returning to Work

Returning to work early:

If your doctor clears you to return to work prior to the end date of your leave of absence, you are **required** to submit a note from your treating physician which clearly states the date that you are able to return to work “without restrictions.”
You **cannot** return to work without this documentation.

Returning to work on time:

In order to return to work after a leave of absence has been completed, you are **required** to present a note from your treating physician which clearly states the date that you are able to return to work “without restrictions.”
This documentation **must** be submitted in order to return to work.

*The only exception to the return to work rules are for those on a State Leave of Absence.

*This list serves as a guide for employees and does not include all information that may be required for a particular leave of absence. If additional information is required, the employee will be notified of such by Human Resources.

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REQUEST FOR MEDICAL/FAMILY LEAVE OF ABSENCE
(Must be completed for any employee who is out for
Medical/Family reasons for more than five consecutive days)

Employee Name _____

Department _____ Date of Hire _____

Employee Title _____

Length of Leave Requested _____ From _____ to _____

Reason for Leave _____

(Medical/Self, Medical/Family Member, or Birth/Adoption of a child)

Note: A Physician's certification is required if the reason for the leave of absence is medical. Please provide your doctor's name, address, and telephone number below and return this form to your Department Head or Supervisor.

Physician's Name _____

Address _____

Phone Number _____

By signing below, I hereby understand and acknowledge the following:

It is my responsibility to request an extension, as outlined in the County Leave of Absence Policy, if I cannot return to work on the expected date of return.

It is my responsibility to notify my Department Head, Supervisor and the Department of Human Resources and Training on the first day that I return from a leave of absence that I have returned to work.

I understand that in order to return to work, I am **required** to present a note from my doctor which clearly states the date that I am able to return to work "without restrictions."

I could be subject to disciplinary action for failing to notify all of the above that I have returned to work, and I will be responsible to repay the full amount of any monies that I collect from the Short Term Disability Carrier as a result of my failure to report my return to work.

Employee Signature

Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: () Fax: ()

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes.

Was medication, other than over-the-counter medication, prescribed? No Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ No ___ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ___ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___ No ___ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ___ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

POLICY 534-01

LEAVE OF ABSENCE POLICY

A. PURPOSE

The purpose of this policy is to provide employees with the rights and protections afforded by the Federal Family & Medical Leave Act and the New Jersey Family Leave Act.

B. DEFINITIONS

1. "Continuing treatment by a health care provider," means:
 - a. Two or more treatments for injury or illness.
 - b. Treatment on at least one occasion by a health care provider which results in a regimen in continuing treatment under the general supervision of the health care provider.
 - c. Treatment on at least two occasions by a physical therapist, nurse, or other professional under orders of a health care provider.
 - d. When an employee or family member is under the continuing supervision of a health care provider due to a serious long-term or chronic condition. Examples: Alzheimer's syndrome, serious stroke, and late stage cancer.
2. Family members with serious medical conditions include:
 - a. Spouses
 - b. Sons or daughters under the age of 18, including natural children, adopted children, stepchildren, and children of whom the employee is financially responsible if the child is "incapable of self care because of mental or physical disabilities".
 - c. Parents must be legal parents. (Step parents must have adopted a child)
Grandparents and In-laws are not considered parents unless they have legal custody of the child.
3. "Health Care Provider" encompasses medical doctors, doctors of osteopathy, dentists, and nurse practitioners.
4. "Serious health condition" is an illness, injury, impairment, or physical or mental condition involving:
 - a. In-patient care, or
 - b. Continuing treatment by a health care provider, or

- c. A period of incapacity of more than three days that requires health treatment. (The County will allow five days based on the certification requirements in the current bargaining agreement).

NOTE: Voluntary or cosmetic treatments, which are not medically necessary, are not serious health conditions unless in-patient care is required. Outpatient dental care is also not covered.

C. STATEMENT OF POLICY

1. The County will grant leaves of absence in accordance with the provisions of the Federal Family & Medical Leave Act ("FMLA") and the New Jersey Family Leave Act ("NJFLA") (collectively herein, "Acts").
2. The County will grant a leave of absence under the Acts based on a "rolling year." The year will be measured from the date that the first leave of absence commenced.
3. The County requires all accrued vacation and sick days to be used as a part of the leave of absence. The only exception is that sick days cannot be used for care of a newly born or newly adopted child.
4. There will be no accrual of vacation, sick, personal or holiday time during the time period covered by an unpaid leave of absence.
5. During the time of leave of absence, health benefits and life insurance benefits will be maintained at the same level and under the same conditions as would apply to employees who are not on leave.
6. Time off for a "workers comp" injury will be counted as Family Leave time used.

D. ELIGIBILITY REQUIREMENTS

1. In order to be eligible for FMLA, an employee must:
 - a. Have one (1) year of service with the County;
 - b. Have worked 1,250 hours during the last twelve (12) months prior to the commencement of the leave; and
 - c. Seeking leave for:
 - i. the birth of a child and to care for the newborn child within one year of birth;

- ii. the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- iii. to care for the employee's spouse, child, or parent who has a serious health condition;
- iv. a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
- v. any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;"

Note: The condition must be documented by the physician or health care provider on the form which is provided. No other form or "note" will be accepted. The County will require that this form be updated by your physician or health care provider every four (4) weeks and turned in to the Human Resources Department.

2. In order to be eligible for NJFLA, an employee must:

- a. Have one (1) year of service with the County;
- b. Have worked 1000 hours during the last twelve (12) months prior to the commencement of the leave; and
- c. Seeking leave for:
 - i. Birth or adoption of a child within one year of the child's birth or adoption. If both parents work for the County this type of leave is aggregate, which means a total of 12 weeks can be taken between both of the parents.
 - ii. The care of a parent, child under 18, spouse, or civil union partner who has a serious health condition requiring in-patient care, continuing medical treatment or medical supervision.

Note: The condition of the family member must be documented by their physician or health care provider on the form provided. This is the only form to be used for certification by your physician. No other form or "note" will be accepted. The County will require that this form be updated by your physician or health care provider and turned in to the Human Resources Department every four (4) weeks.

E. ADDITIONAL LEAVE

1. If an employee has a medical condition, which requires more than twelve (12) weeks covered by the "Federal Family Medical Leave Act," the following shall apply:
 - a. An employee who has been employed by the County for more than one (1) year but less than five (5) years may apply for an "extended" County leave for up to two (2) months for their own serious health condition. These additional months will be either paid or unpaid, depending on if the employee has any accrued sick or vacation time remaining. Documentation will be required from their "Health Care Provider" and the same form must be used. During this "extended" additional leave, employees will be required to pay for their own benefits. This will apply to the Health Benefits policy in effect at the time of the leave for each employee. The employee will reimburse the County the amount of the premium paid for that policy.
 - b. An employee who has been employed by the County of Cape May for five (5) years or more may request an additional twelve (12) weeks for medical purposes only. These additional weeks would be paid or unpaid depending on if the employee has any accrued sick or vacation time remaining. Documentation will be required from their "Health Care Provider" every four (4) weeks as stated for the "Family Medical Leave Act" and the same form must be used. If at the end of the twelve (12) week period, the employee is still not able to return to work, they may apply for an additional "extended" County Leave for up to four (4) months. During this "extended" additional leave, the employee will be required to pay for their own health benefits. This will apply to the health benefits policy in effect at the time of the leave for that employee. The employee will reimburse the County the amount of the premium paid for the policy.
 - c. Employees with ten (10) years or more of County employment would be eligible for up to an additional 24 weeks if needed for their own serious medical condition. If at the end of this 24 week period, the employee is still not able to return to work, they may apply for an additional six (6) months of "extended" County Leave. During this "extended" additional leave the employee will be required to pay for their own health benefits. This will apply to the Health Benefits policy in effect at the time of the leave for that employee. The employee will reimburse the County the amount of the premium paid for that policy.

- d. If an employee with ten (10) years or more of service has exhausted all leave and “extended” leave time and is still medically unfit to return to work, they may request an additional leave of absence from the County. At this time, the leave could be denied based on the recommendation of a committee which will review the needs of the individual department. Any employee with 10 years of paid service into the State of New Jersey Pension System would be eligible to apply for a “disability retirement”.
- e. These additional leaves SHALL NOT apply for the serious health condition of anyone other than the employee.

F. DISABILITY

- 1. In the case of an approved “Disability Retirement” by the State of New Jersey, if an employee has any accrued sick days remaining, they will be paid according to the applicable bargaining agreement.

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet



Instructions

Send in ALL signed statements, which we require to properly review the claim. **Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.**

- Employer Statement
- Attending Physician Statement
- Employee Statement
- Authorization Statements

An STD claim should be submitted for a disability absence that may extend beyond the required elimination period.

Prefill the Group STD policy number and Employer name on the Employee and Physician Statements.

Employer is required to include the following (as applicable):

- Enrollment Form
- Worker Compensation Report
- W2
- Job Description
- Return-to-Work slip
- Payroll Ledger

Physician must completely fill out and sign the Physician Statement.

Have all the physicians keep a copy of your signed authorization for their files.

To file a Disability Claim or check on a status online go to www.sunlife.com/us.

- Click on "Submit a Disability Claim"

- OR Fax to: 781-304-5599

Employer's Statement

Group STD policy number

1 General Information

Please print clearly.

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875

Fax: 781-304-5599

www.sunlife.com/us

Name of employer (parent company name)		Employer phone number			
Employer street address (employee's location)	City	State	Zip code		
Name of employee (first, middle initial, last)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number		
Employee street address	City	State	Zip code		
Employee phone number	Preferred form of contact		Date of birth		
Home	<input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Mail				
Work					

2 Employment and Claim Information

Is condition due to injury/sickness caused by patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date hired	Start date of insurance	Date last worked before disability	Hours worked last day
Employee job title (Attach employee's formal job description)			
List employee's major job duties			
How would you classify the employee's occupation? <input type="checkbox"/> Sedentary (1-10 lbs) <input type="checkbox"/> Light (11-20 lbs) <input type="checkbox"/> Medium (21-50 lbs) <input type="checkbox"/> Heavy (51+ lbs)			
Indicate days per week the employee regularly works? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7			
Indicate daily hours the employee regularly works. <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Other:			
Has employee terminated employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, termination date:			
Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, return date: If yes, did employee return: <input type="checkbox"/> Full-Time (full-capacity) <input type="checkbox"/> Full-Time (partial capacity) <input type="checkbox"/> Part-Time (attach payroll ledger)			
Has Worker's Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Worker's Compensation carrier			Phone number

Attach Return-to-Work slip from physician.

Attach Worker's Compensation Report and Reward/Denial notice.

3 Salary and Benefits Information

How was the employee paid? (check one)	Other work related income:			
<input type="checkbox"/> Hourly	<input type="checkbox"/> Salaried	Commissions	Bonuses	Overtime
\$ per hour:	\$ per week:	\$	\$	\$
How does employee contribute toward the STD premium?				
<input type="checkbox"/> PRE-tax <input type="checkbox"/> POST-tax <input type="checkbox"/> Employee does not contribute				
If employee contributes, please provide percentage. %				

If employee contributes to STD premium, attach a copy of employee enrollment form

4 Information About Other Income

Source of income	Payment Amount	Weekly or monthly?		Payment Coverage (M/D/Y)	
		<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Sick pay	\$	<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Salary continuance	\$	<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> State Disability	\$	<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Worker's Compensation	\$	<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Unemployment	\$	<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Social Security Disability	\$	<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Other:	\$	<input type="checkbox"/> Wkly	<input type="checkbox"/> Mthly	From:	To:

Indicate whether the employee is currently receiving, or entitled to receive, benefits from any of these sources.

Check all that apply.

5 Certification and Signature

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Name of person completing this form	E-mail address
Title	Phone number
Signature (original signature required) X	Date signed

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet



Employee's Statement

Group STD policy number

1 General Information

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

Name of employee (first, middle initial, last)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)
Employee street address	City	State	Zip code
Home phone: Cell phone: Work phone:	Preferred form of contact: <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Work phone <input type="checkbox"/> Mail		
Name of employer (parent company name)			

2 Information About the Condition Causing Your Disability

Last day worked before disability	Date first treated by Physician	Date expected to return to work <input type="checkbox"/> FT <input type="checkbox"/> PT
Did you require Emergency Room care for your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, Hospital name: Date: _____ Phone: _____		
Were you confined to a hospital for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, include the hospital name		Hospital phone
Date(s) of confinement: From: _____ To: _____		

Select the appropriate type of condition, and provide details:

<input type="checkbox"/> Pregnancy Expected due date: _____ Actual due date: _____ Delivery type: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section Complications:
<input type="checkbox"/> Work-related injury/sickness Date of first symptom/injury: Where occurred: Cause of injury/sickness: Do you intend to file for Workers Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the status: <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Appealed
<input type="checkbox"/> Sickness First date of symptom: _____ Type of sickness: Have you experienced a symptom in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____

2 Information About the Condition Causing Your Disability continued

<input type="checkbox"/> Motor vehicle accident - complete only if applicable	
Date occurred:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Was a citation issued to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, type of citation:	
How injury occurred:	
Where injury occurred:	
Name of your car insurance carrier:	
Phone number:	
Are you receiving compensation from a car insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Date: From:	To:
<input type="checkbox"/> Other injury	
Date occurred:	Where occurred:
How occurred:	
Describe type of injury:	

3 Information About Other Income

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

<input type="checkbox"/> Sick pay/Salary continuance	<input type="checkbox"/> State Disability	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Other:		

4 Physician Information

Indicate physicians you are seeing or have seen for this condition.

Name of physician:	Phone:
Specialty:	Fax:
Name of physician:	Phone:
Specialty:	Fax:

5 Signature

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Employee's signature X	Date signed
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Sun Life Assurance Company of Canada

Short Term Disability Claim Packet



Attending Physician's Statement

Group STD policy number

1 Information About the Patient

Patient is responsible for any costs associated with the completion of this form.

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875
Fax: 781-304-5599

www.sunlife.com/us

Name of patient (first, middle initial, last)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)	
Name of employer (parent company name)				
Patient home street address		City	State	Zip code
Patient home phone number		Patient work phone number		

2 Physician Information

- Complete all sections – any missing information may result in a delay to your patient
- Print clearly
- Fax this form to 781-304-5599 or as instructed by patient

Name of attending physician (first, middle initial, last)	Specialty	Tax ID#		
Street address		City	State	Zip code
Phone number		Fax number		

List other physicians treating for this condition

Name of physician: Specialty:	Phone: Fax:
Name of physician: Specialty:	Phone: Fax:

3 Diagnosis and History

Your response is required and affects the patient's benefit. Failure to complete this information may cause the patient financial hardship due to lack of benefit payments.

Primary Diagnosis (include any complications)	ICD-9 Code
Secondary Diagnosis (if applicable)	ICD-9 Code
Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date occurred:	
If pregnancy, provide the following: Expected delivery date: Actual delivery date:	Delivery type: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section
List any complications pre or post delivery that would extend this disability longer than a normal pregnancy.	
Is condition due to injury/sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Describe objective or abnormal findings and date.

If you need more room, check here and attach a separate sheet.

<input type="checkbox"/> X-ray <input type="checkbox"/> EKG <input type="checkbox"/> MRI <input type="checkbox"/> PFT <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other data (e.g. Labs)
Date(s):
Findings:

4 Treatment Details

Start date of disability	Date of first office visit	Date of last office visit	Date of next office visit
Was Emergency Room care required for condition?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of hospital	Date	Phone number	

Check all that apply and describe type, frequency and treatment

<input type="checkbox"/> Surgery	<input type="checkbox"/> Medications prescribed	<input type="checkbox"/> Therapy	<input type="checkbox"/> Behavioral intervention	<input type="checkbox"/> Other
Date(s):				
Procedure/Treatment:				
Is patient:	<input type="checkbox"/> Hospital confined	Date from:	Date to:	
	<input type="checkbox"/> House confined	<input type="checkbox"/> Bed confined	<input type="checkbox"/> Ambulatory	
Hospital name:			Phone:	

5 Restrictions and Limitations

Describe what the patient can do .	From: To:
Describe what the patient should not do .	From: To:
Is patient capable of working with these restrictions/limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Full-Time: 8+ hours/day	<input type="checkbox"/> Part-Time: _____ hours/day

Indicate class of impairment - As defined in federal dictionary of occupation titles

Physical Impairment

<input type="checkbox"/> Class 1 – No limitation	<input type="checkbox"/> Class 4 – Moderate limitation
<input type="checkbox"/> Class 2 – Slight limitation	<input type="checkbox"/> Class 5 – Severe limitation
<input type="checkbox"/> Class 3 – Medium limitation	

Mental Impairment (if applicable)

Current DSM-IV-R diagnosis

<input type="checkbox"/> Class 1 – No limitation	Axis I:
<input type="checkbox"/> Class 2 – Slight limitation	Axis II:
<input type="checkbox"/> Class 3 – Moderate limitation	Axis III:
<input type="checkbox"/> Class 4 – Marked limitation	Axis IV:
<input type="checkbox"/> Class 5 – Severe limitation	Axis V:
Do you believe this patient is competent to endorse/direct the use of proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> No	

6 Return-to-Work

Indicate the specific date or recovery period for when the patient will recover sufficiently to perform duties.

<ul style="list-style-type: none"> Return to patient's occupation full-time: Date: _____ -or- <ul style="list-style-type: none"> <input type="checkbox"/> 1-2 wks <input type="checkbox"/> 2-3 wks <input type="checkbox"/> 3-4 wks <input type="checkbox"/> 4-5 wks <input type="checkbox"/> 5-6 wks <input type="checkbox"/> 6-7 wks <input type="checkbox"/> 7-8 wks <input type="checkbox"/> 2 months or more <input type="checkbox"/> Other: _____ <input type="checkbox"/> Never Return to patient's occupation part-time: Date: _____ -or- <ul style="list-style-type: none"> <input type="checkbox"/> 1-2 wks <input type="checkbox"/> 2-3 wks <input type="checkbox"/> 3-4 wks <input type="checkbox"/> 4-5 wks <input type="checkbox"/> 5-6 wks <input type="checkbox"/> 6-7 wks <input type="checkbox"/> 7-8 wks <input type="checkbox"/> 2 months or more <input type="checkbox"/> Other: _____ <input type="checkbox"/> Never
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7 Certification and Signature

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Attending Physician Signature (original signature required) X	Date
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Sun Life Assurance Company of Canada

Short Term Disability Claim Packet



Fraud Warnings

State law requires that we notify you of the following:

Fraud warning: 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.

Fraud warning—AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Fraud warning—AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Fraud warning—AR, LA, MA, MN, NM, RI, TX, and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Fraud warning—CA: 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.

Fraud warning—CO: 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 a 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.

Fraud warning—DC: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—DE, ID, and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Fraud warning—FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud warning—KS: 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 may be guilty of insurance fraud as determined by a court of law.

Fraud warning—KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Fraud warning—MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—ME, TN, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Fraud warning—NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Fraud warning—NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud warning—OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud warning—OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud warning—OR and VA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud warning—PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Fraud warning—VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Fax: 781-304-5599

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada (“the Company”), its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records relating to my physical or mental condition, such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that The Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Short Term Disability Claims, SC3212, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the authorization upon request.

A copy of this authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: 781-304-5599

I HEREBY AUTHORIZE any: physician, health care provider, health plan, medical professional, hospital, clinic, or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada (“the Company”) its subsidiaries, affiliates, third party administrators and reinsurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose all psychotherapy notes relating to me without restriction.

I understand that The Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice Sun Life Financial, Group Short Term Disability Claims, SC3212, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada (“the Company”) collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances, and activities.

We also may collect information about you from other sources. By signing the authorization for release and disclosure of health-related information and/or the authorization for release and disclosure of psychotherapy notes, you authorize us to obtain medical information about you that we need to underwrite your application. Depending on your particular circumstances, we may collect additional information about you from the following sources:

- physicians, health care providers, medical professionals, hospitals, clinics, or other medical or health-care-related facilities
- other insurance companies you have applied to for insurance
- public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the authorization for release and disclosure of health-related information and/or the authorization for release and disclosure of psychotherapy notes, you authorize us to disclose information we have about you:

- to our reinsurers and
- as required or permitted by law.

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- companies that help us conduct our business or perform services on our behalf,
- your physician or treating medical professional, and
- comply with federal, state or local laws, respond to a subpoena or comply with an injury by a government agency or regulator.

ACCESS, CORRECTION, AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information),
- request that we correct, amend, or delete any recorded personal information about you in our possession, and
- file your own statement of facts if you believe that the recorded personal information we have about you is incorrect.

To take any of these actions, please contact us at the following address for further instructions:

Sun Life Assurance Company of Canada
Group Short Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481