GWINNETT COUNTY PUBLIC SCHOOLS

Short Term Disability Claim Form

Benefits & Leave Administration • 437 Old Peachtree Road, NW, Suwanee GA 30024-2978 • Fax 678-301-6111

Employee's Statement

Name:	Home Telephone:	
Employee ID #:	Date of Birth:	
Home Address:	City:	State, Zip:
Nature of disability:	Date first treated for this sickness or injury:	
Please indicate if you have filed a Workers' Compensation claim due to this event. ☐Yes ☐No		
Date last worked:	Actual or expected date you plan to return to work:	
Name(s) and address(s) of attending health care provider(s):		
Were you hospitalized? ☐Yes ☐No If "Yes," give name and address of hospital:	Hospital Confinement Dates:	

Authorization to Obtain and Disclose Information

I authorize you to give Gwinnett County Public School, its re-insurers, representatives, and/or its agents, all information you have as to illness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physical or mental condition of the patient, and other information you have about the patient which Gwinnett County Public Schools believes it needs to process leave request, job restrictions, accommodations, and/or disability benefits.

I also give my informed consent and authorize Gwinnett County Public Schools to release my private data and medical documents to any independent medical examiner and/or consultant retained by Gwinnett County Public Schools in the course of processing and evaluating any application for disability benefits or periodic review of my continued eligibility for disability benefits provided by Gwinnett County Public Schools. This release is effective for the duration of the leave period.

_____ _____

Signature of Employee **Date**

Health Care Provider Statement

To be completed by Health Care Provider Only

Please complete all that is appropriate to your patient's situation. After completing each section, please return to:

Gwinnett County Public Schools
Division of Human Resources and Talent Management
Benefits & Leave Administration
437 Old Peachtree Rd., NW
Suwanee, GA 30024-2978
Fax: 678-301-6111

It is the patient's responsibility to provide proof of disability. Any fee for the completion of this form is the patient's responsibility.

Please type or print

The purpose of this report is to assist Gwinnett County Public Schools in making a disability determination. In completing this report, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination.

Name of patient: _____ Date of birth: _____ SSN: _____

Beginning date of disability: _____

History

(a) When did symptoms first appear? Mo ___ Day ___ Yr ___
(b) Date patient last worked because of disability: Mo ___ Day ___ Yr ___
(c) Has patient ever had same or similar condition? ☐ Yes ☐ No
If "yes" state when and describe: _____
(d) Is condition due to injury or sickness arising out of patient's employment? ☐Yes ☐No
(e) Names and addresses of other treating health care provider(s): _____

Referral-Specialist: _____

Diagnosis

Diagnosis (including any complications):

(a) Subjective symptoms: _____
(b) Objective findings (including x-rays, EKG's, laboratory data, and any clinical findings that support the diagnosis):

Please provide copies of test results or office notes.

Dates of Treatment

(a) Date of first exam Mo ___ Day ___ Yr ___
(b) Date of last exam Mo ___ Day ___ Yr ___
(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) _____
(d) Date of Surgery Mo ___ Day ___ Yr ___
(e) If pregnancy related, est. date of delivery Mo ___ Day ___ Yr ___
(f) Actual date of delivery (if known) Mo ___ Day ___ Yr ___

Nature of Treatment

Nature of Treatment (including surgery, if any, expected recovery date or therapy duration):

Medications (name and dosage):

Progress

(a) Is patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
(b) Is patient ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined
(c) Has patient been hospital confined? ☐ Yes ☐ No Name of hospital _____

Confined from _____ to _____

Health Care Provider Statement (Continued)

Cardiac

(a) Functional capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood pressure _____

Prognosis

Is the employee currently capable of returning to work full duty? (circle one) Yes No

If no, and work restrictions are suggested, please provide them in measurable terms including anticipated date of full duty release:

Date of full duty release: _____

Mental / Nervous Impairment

If applicable, check one:

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 - Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations).
☐ Class 3 - Patient is able to function in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
☐ Class 4 -Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
☐ Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations).

Comments: _____

Mental Competency

Is the patient competent to endorse check and direct the use of the proceeds? ☐ Yes ☐ No

Rehabilitation

Is the patient a suitable candidate for vocational rehabilitation services to explore other employment opportunities? ☐ Yes ☐ No

Additional Comments

_____

Health Care Provider's Printed Name:_____ Contact Number: _____

Health Care Provider's Signature:_____

Address:_____

Signature:_____ Date:_____

Gwinnett County Public Schools
Short-Term Disability Plan Information

Short-Term Disability (STD) is a self-insured program through Gwinnett County Public Schools. The plan covers a period in which you are unable to perform the essential functions of your job. STD is for your personal disability only. The plan pays based on calendar days, not working days.

STD has three levels. Not to exceed the plan amount as described in the plan document.

- STD benefit checks are issued on the 15th of each month. The cut-off for processing applications is the 5th of each month.
- Benefits are paid beginning on the 15th day of a disability. All requests for benefits must be submitted within twelve (12) months of disability.
- An employee must have at least six (6) payroll deductions in order to receive benefit from the plan.
- Employee must be actively at work on the last workday before the disability begins in order to receive benefits from the plan. Employees drawing pay as a result of accumulated leave will be considered actively at work for purposes of STD.
- Participants may receive STD benefits and use accrued leave at the same time.

The claim will be paid or denied following a medical review. While a claim is pending, the Board, at its expense, has the right to request that you have one or more medical evaluations by independent physicians of its choice.

Benefit payments will end on:

- The date that a licensed health care provider indicates that the employee is no longer disabled;
- The date the employee fails to provide appropriate medical documentation;
- The date that an Independent Medical Evaluation finds the employee no longer disabled;
- The date that an employee refuses an Independent Medical Evaluation;
- The date that the employee is deceased;
- The date that the benefit is no longer active, due to job termination or discontinuation of the benefit enrollment during Open Enrollment; and/or,
- The date that the maximum benefit is paid.

Short-Term Disability Plan Document is available at www.gcpsk12.org/benefits.