P.O. Box 7338 • Madison, WI 53707-7338
45 Nob Hill Road • Madison, WI 53713-3959
Voice/TDD: (608) 276-4000 / (800) 279-4000
Fax: (608) 276-9119 • Web site www.weatrust.com

Short Term Disability Claim Form

Instructions

This form or other similar written notice of claim must be submitted **within 90 days** of the onset of your claimed disability. If you have any questions, call the WEA Trust Disability Department at (608) 276-4000 or (800) 279-4000. Please **print** (use blue or black ink) or **type** and return the completed claim form ***with medical records*** to the WEA Trust.

This form consists of four sections. Each section must be completed. Return the entire form to the WEA Trust.

Section 1: Employer Information Section

The employer must:
- Complete this section in full.
- Sign and date this section.
- **Attach a copy of the current job description to this form.**

Section 2: Claimant Information Section

The claimant must:
- Complete this section in full.
- Sign and date this section and include a current address and telephone number.
- Have your employer and treating physician complete in full the appropriate sections of this form.
- Complete the authorization form as requested under Section 4.
- Review all four sections to make sure they are completed in full and that all questions are answered prior to returning the form to us.
- **Attach medical records to this form which document your condition. ***

Section 3: Attending Physician's Section

The attending physician must:
- Complete this section in full; each space must contain a response. A vague or incomplete response will result in additional correspondence and cause a delay in the processing of the claim.
- Sign and date this section. Note: Under the terms of the STD policy, this form can only be completed by one of the following health professionals: M.D., D.O., D.S.C., D.P.M., O.D., D.C., D.D.S., D.M.D.
- **Attach medical records to this form which document the patient's condition. ***

Section 4: Authorization for Use and Disclosure of Protected Health Information Between WEA Trust Plans

The claimant must:
- Complete this authorization in full.
- Sign and date this section.

Note: This authorization allows the Trust to share your health information, as needed, between Trust plans. By sharing information, we can more efficiently and effectively determine your eligibility for all benefits and coordinate your coverage, claims, and benefits.

*According to the express terms of the STD policy, we do not reimburse for the cost of medical records. Any charges for the release of this information are the responsibility of the claimant and should be billed directly to him or her.

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Short Term Disability Claim Form

Claimant Information Section

Name:	Home Phone No.:
Address:	Date of Birth:
	Marital Status: S M W D **(circle one)**

Social Security No.:	Occupation:	Male/Female **(circle one)**

1. Medical condition/diagnosis:

2. How does your condition limit your physical or mental ability to perform the specific requirements of your job? **(Attach separate sheet, if necessary)**

3. If due to pregnancy:
   - Date first seen by doctor:
   - First date of last menstrual period:
   - Estimated delivery date:
   - Actual delivery date:
   - Type of delivery:

4. Date of accident or date symptoms began:

5. First date treated:

6. Last date worked:

7. First date unable to work:

8. I returned, or will return, to work on a:
   ☐ Part-time basis on: _____
   ☐ Full-time basis on: _____

9. Are you or were you confined to a hospital for this condition? ☐ Yes ☐ No
   If yes, give name and address of hospital:
   Admission date: Discharge date:

10. Is the condition/injury the result of an accident? ☐ Yes ☐ No
    If yes, please provide information regarding how, when, and where accident occurred: **(Attach separate sheet, if necessary, and accident report, if applicable.)**

11. Did the condition/injury arise out of your employment? ☐ Yes ☐ No
    If yes, was your employer notified? ☐ Yes ☐ No
    Did you file a worker's compensation claim? ☐ Yes ☐ No
    Are you receiving worker's compensation benefits? ☐ Yes ☐ No

12. Have you applied for, or are you receiving, other disability benefits (e.g., long term disability, Veterans Administration, Wisconsin Retirement System, and/or Social Security Disability Insurance)? ☐ Yes ☐ No

13. Have you applied for, or are you receiving, retirement benefits? ☐ Yes ☐ No

14. Please list name, address, and telephone number of **all** physicians involved in your treatment: **(Attach separate sheet, if necessary.)**

I affirm the above information is true and complete to the best of my knowledge.

_____ _____

Claimant's Signature **Date**

(If claimant is unable to sign, state reason and specify signer's relationship to the claimant.)

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Short Term Disability Claim Form

Attending Physician's Section

Patient Name:	Patient I.D. No.:
Social Security No.:	Date of Birth:

1. Current diagnosis **(please attach medical records)**:
   - ICD-9 code(s):
   - Surgery performed:
   - Date(s) of surgery:

2. Patient's current symptoms:

3. If due to pregnancy:
   - Date first seen by doctor:
   - First date of last menstrual period:
   - Estimated delivery date:
   - Actual delivery date:
   - Type of delivery:

4. List all functional limitations caused by the patient's condition or symptoms:

5. Are the limitations temporary or permanent? ☐ Temporary ☐ Permanent
   Specify the date on which these limitations began: _____

6. Patient's prognosis:
   Do you expect full or partial recovery? ☐ Full ☐ Partial
   Date you expect a return to work: _____ (Date) Part-time _____ (Date) Full-time

7. When did the patient first consult you for this condition?

8. Is the patient still under your care for this condition?
   ☐ Yes ☐ No
   If no, indicate discharge date: _____

9. Please give date(s) of all hospitalization(s) related to this condition:
   From: To:

I affirm the above information is true and complete to the best of my knowledge.

Physician's name **(please print or type)**: _____

Degree: ☐ M.D. ☐ Other _____ Specialty: _____

Name of Clinic: _____ Address: _____

City: _____ State: _____ ZIP Code: _____ Phone number: _____

_____ _____

Attending Physician's Signature **Date**

(Must be signed by Attending Physician)

NOTE: Please attach all medical records documenting patient's condition.

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Short Term Disability Claim Form

Employer Information Section

Employee Name:	Social Security No.:
1. Does the employee pay 100% of the premium for short term disability coverage with post-tax dollars? ☐ Yes ☐ No	2. If no, who pays the premiums?
3. Employee's current occupation: **(Please attach copy of current job description)**	4. Date employment began:
5. Last date worked:	6. First date unable to work:
7. Type of employment: ☐ Part-time ☐ Full-time ☐ Year-round ☐ Other	8. Number of contract days for the employee's current or recent work year:_____
9. Current employment status (circle one): Active Terminated Resigned Retired	10. Effective date of this employment status:
11. Annual base salary:	12. Effective date of this salary:

13. Is sick leave available for this absence? ☐ Yes ☐ No
Indicate sick leave paid:
☐ Sick leave paid from _____ through _____. ☐ **This is an estimated end date.** ☐ **This is the actual end date.**
☐ No sick leave paid.

14. Has the employee received other paid leave for this absence? ☐ Yes ☐ No

15. Is leave paid at 100% of salary? ☐ Yes ☐ No

16. Employee returned, or is expected to return, to work on a: Part-time basis on:_____
Full-time basis on: _____

17. Please provide name and telephone number of employee's direct supervisor:

18. Do you provide long term disability coverage for this employee through another carrier? ☐ Yes ☐ No
- If yes, has a claim been filed? ☐ Yes ☐ No
- Indicate name and telephone number of the long term disability carrier:

19. Has a worker's compensation claim been filed? ☐ Yes ☐ No
If yes, indicate worker's compensation claim number and weekly benefit:

20. Indicate name, address, and telephone number of worker's compensation insurer:

I affirm the above information is true and complete to the best of my knowledge.

Employer's name and address: _____

Name of authorized representative **(please print or type)**: _____
Title: _____ Phone: _____ Ext.: _____ Fax: _____

_____ _____
Authorized Representative's Signature **Date**

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Short Term Disability Claim Form

Authorization for Use and Disclosure of Protected Health Information Between WEA Insurance Corporation Plans

Please print or type and use blue or black ink

I, _____, _____, _____, _____
Member Name | Birth Date | Social Security Number | Group Number

authorize the health, dental, long term care, short term disability, long term disability, and life plans of the WEA Insurance Corporation to share past, present, and future health information. This authorization, to share my health information, allows my insurer to more efficiently and effectively determine my eligibility for all benefits and to coordinate my coverage, claims, and benefits.

I understand that portions of my records may have extra protection under Wisconsin statutes or federal law, including information relating to mental health, alcohol and/or drug abuse, and developmental disabilities. However, if any such information is included in the information held by WEA Insurance Corporation, I understand that WEA Insurance Corporation will not attempt to separate out such information; thus, specially protected information may be disclosed from one plan to another pursuant to this authorization. I hereby authorize the use and/or disclosure of that information.

MY RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
I understand that I have the right to withdraw this authorization at any time by providing a written withdrawal to the entity/person(s) disclosing my information. I am aware that my withdrawal is not effective until it is received, and that it has no effect on uses or disclosures made prior to receipt of my withdrawal.

I understand that I am under no obligation to sign this form; however, if I do not sign, I understand that delays will occur in processing requests for coverage, eligibility determinations, and claims under the short term disability, long term disability, and life plans. I also understand that if I do not sign this authorization, I may incur additional expenses to provide required information that may have already been submitted to the Insurer under another plan. I further understand that I may make or request a copy of this authorization at any time.

Redisclosure Notice: I understand that the WEA Insurance Corporation is regulated by both state and federal law requiring it to maintain the confidentiality of my health information. The disability and life operations will not share my health information with a third party unless authorized or permitted by law to do so. When a third party is not directly regulated by state and federal privacy rules, there is a possibility that the information could be redisclosed.

Expiration Date: This authorization is valid until my claim related to either disability or functional impairment has ended, unless I substitute a specific date here: _____.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Member's Signature Date

If someone other than the member signs this authorization, please state reason why the member cannot sign and signer's relationship to the member:

_____