Monterey County Office of Education

SHORT TERM DISABILITY INSURANCE

SUBMITTING A CLAIM FOR SHORT TERM DISABILITY (STD):

Keenan and Associates has been retained to process the claims for your STD. Enclosed is a packet of forms requiring completion by you and your physician. It is important that all forms are completed, signed, dated, and returned to MCOE/Human Resources in order to begin the STD review process.

FOR EMPLOYEE: Please complete the following documents:

- Employee Statement
- Employee Tax Notice – *If you want voluntary Federal Income Tax withheld from your disability benefit payments*
- Insurance Authorization *(If additional medical information is needed to review your claim, submitting this form now may reduce the time needed to reach a decision)*

FOR PHYSICIAN: Complete section titled "ATTENDING PHYSICIAN'S STATEMENT"

Your claim for STD benefits will be considered filed, when you meet **both** of these two criteria: 1) Keenan receives the Employee's Statement, Employer's Statement and Attending Physician's Statement 2) Your STD elimination period has started.

ABOUT THE PROCESS:

- There is a 10-day waiting period.
- All available leaves must be exhausted (sick leave, vacation hours, comp time) prior to disability benefits beginning.
- STD only pays for actual days worked (days that you are required to be at work.
- Expect to receive two checks: one from MCOE (for *sub-differential) and the other from Keenan and Associates (for your disability benefits). Between both checks, expect to receive UP TO 75% of your salary.

ADDITIONAL INFORMATION:

In order to return to work, HR must receive a note from your doctor stating that you are released to return to work. If your doctor does not release you to return to work for a period of more than 5 months or 100 days, you will be placed on a 39-month re-employment list. This means that at the end of your 5 months or 100 days, you will be placed on an unpaid leave and you will lose your medical benefits. You will have the right to purchase medical insurance through COBRA.

If you have any questions or would like to receive a copy of the MCOE Short Term Disability Coverage Plan document, please contact Human Resources at (831) 755-0381.

CALIFORNIA RESIDENTS – 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.

*Sub differential means the difference in hourly salary from what you receive and what is actually paid to a substitute in your place. All substitutes are paid at Level A of your current level. For classified employees, if no substitute is in place, you will receive full pay for each day that is not subbed.

(09/09)

Keenan

Short Term Disability Claim (STD) Services provided by:
Keenan & Associates Disability Department
P.O. Box 4328, Torrance, CA 90510
Tel: 800-444-9995 Fax: 310-320-3705

Employee Statement

1 Employer Information

Employer Name

Location/Division

2 Employee Information

First Name | MI | Last Name

Address 1 | Social Security Number

Address 2 | Telephone Number

City | State | Zip

Birth Date (MM DD YYYY) | Gender ☐ Male ☐ Female | Marital Status ☐ Unmarried ☐ Married ☐ Divorced ☐ Widowed

Email Address | Work Telephone Number

Date Last Worked (MM DD YYYY) | Date First Absent (MM DD YYYY) | Date First Treated for this Condition (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY) | Spouses Date of Birth (MM DD YYYY) | Is Spouse Employed? ☐ Yes ☐ No

Education Highest Grade Completed | Number of Children Under 18 | Age of Youngest Child

3 Job Information

Occupation

What Job Category best describes the claimant's essential job duties? (Please check the appropriate box.)

☐ Sedentary	☐ Light	☐ Medium	☐ Heavy	☐ Very Heavy
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and/or Frequent Walk/Stand and/or Constant Push/Pull	Up to 25 lbs. frequently Up to 50 lbs. occasionally	25 to 50 lbs. frequently 50 to 100 lbs. occasionally	More than 50 lbs frequently 100 lbs. occasionally

☐ Other (Please describe)

Keenan

Employee Social Security Number

4 Primary Care Physician

Physician First Name | MI | Physician Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | Zip Code

Specialty

5 Medical Information

All Other Physicians You Have Consulted for this Condition (Attach an additional sheet if necessary)

Physician First Name | MI | Physician Last Name

Specialty | Telephone Number

Physician First Name | MI | Physician Last Name

Specialty | Telephone Number

Physician First Name | MI | Physician Last Name

Specialty | Telephone Number

What medical condition is preventing you from working?

How does this condition interfere with your ability to perform your job?

Have you ever been hospitalized for this condition? ☐ Yes ☐ No ☐ Inpatient ☐ Outpatient

If Hospitalized Give Dates (MM DD YYYY)

From

Return to Work Target Date (MM DD YYYY)

To

If You are Pregnant:

Estimated Delivery Date (MM DD YYYY)

Actual Delivery Date (MM DD YYYY)

Name of Your Health Insurance Company | Telephone Number

Keenan

Employee Social Security Number

6 Other Income and Workers' Compensation Information

What other income are you entitled to receive as a result of your disability? (Examples: Social Security Disability or Retirement Benefits, Workers' Compensation, State Disability, Pension Disability or Retirement, No-Fault Auto Insurance, Salary Continuance, Group Life or Disability Plan, Health or Welfare Plan, Individual Disability Benefits.)

Please send copies of any letters or notices approving or denying benefits.

Source	Applied for Yes	Applied for No	Amount	Frequency Weekly	Frequency Monthly	Date Benefit Begins (MM DD YYYY)	Date Benefit Ends (MM DD YYYY)
Salary Continuance	☐	☐	.	☐	☐		
State Disability Benefits	☐	☐	.	☐	☐		
Social Security	☐	☐	.	☐	☐		
Workers' Compensation	☐	☐	.	☐	☐		
Medical Deduction	☐	☐	.	☐	☐		
Dental Deduction	☐	☐	.	☐	☐		
Vision Deduction	☐	☐	.	☐	☐		
Life Deduction	☐	☐	.	☐	☐		
Other	☐	☐	.	☐	☐		

Is this condition work related? ☐ Yes ☐ No If Yes, do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

7 Fraud Notice

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.

Claimant Signature X _____

Date (MM DD YYYY)

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Attending Physician Statement

1 Employee Information

Employer's Name

Employee First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature X _____ Date (MM DD YYYY)

The Employee is responsible for the completion of this form without expense to the Employer or Keenan.

2 To Be Completed by Attending Physician

Clinical Diagnosis | ICD-9 Code is Required | Pregnancy EDC (MM DD YYYY) | Actual Delivery Date (MM DD YYYY)

Primary:

Secondary:

Secondary:

Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY)

Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital:

From (MM DD YYYY)

To (MM DD YYYY)

Check all that apply to this disability:

Work Related	Accident	Sickness	Maternity	Motor Vehicle Accident	If MVA, in what State did it occur?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Other Treating Physicians or Consultants:

First Name | Last Name

Specialty | Telephone Number

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2 **Attending Physician Information (Cont'd.)**

Other Treating Physicians or Consultants

First Name | Last Name

Specialty | Telephone Number

First Name | Last Name

Specialty | Telephone Number

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Date when significant loss of function occurred (MM DD YYYY)

Return to Work Target Date (MM DD YYYY)

Full-Time ☐
Part-Time ☐
With Limitations (Functions lost) ☐

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have significant impact on Functional Abilities (i.e., interpersonal, financial, family)?

3 **Physician Information**

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | Zip Code

Specialty

4 **Fraud Notice**

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Physician's Signature X

Date (MM DD YYYY)

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Insurance Authorization

1 Claimant's Information

First Name | MI | Last Name

Social Security Number | Employee Phone Number

2 Authorization for Release of Information to Keenan & Associates

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to Keenan & Associates. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities, or employment history to Keenan & Associates.

Unless limits* are shown below, this form pertains to all of the records listed above.

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 My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that Keenan & Associates may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for.

This authorization shall remain in force for 1 year following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to: Keenan's Disability Dept. P.O. Box 4328, Torrance, CA 90510. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Keenan & Associates has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to Keenan is not protected under the Act.

Keenan & Associates is the Administrator of your Employer's Disability program

I understand that if I refuse to sign this authorization to release the entire medical record, Keenan & Associates may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization.

*Limits, if any:

Date (MM DD YYYY)

X

Employee Signature (indicate how related if signed by other than claimant.)