



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 after your last day worked due to the onset of your alleged disability. Return the entire form and medical records to WEA Trust, P.O. Box 7338, Madison, WI 53707-7338.

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 that document your condition. ***

Section 3: Attending Physician's Section

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. 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.
- **Attach medical records to this form that 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.



Short Term Disability Claim Form

(To be completed and signed **after** the last day worked due to the onset of alleged disability.)

Employer Information Section

Employee Name:		Social Security No.:	
		Subscriber No.:	
1. Does the employee pay 100% of the premium for short term disability coverage with post-tax dollars? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Full-time <input type="checkbox"/> Year-round <input type="checkbox"/> Other <input type="checkbox"/> Part time: _____ hours per day		8. Current employment status (circle one): Active Terminated Resigned Retired	
9. Effective date of this employment status:		10. Annual base salary on last day worked: Effective date of this salary:	
11. Is sick leave available for this absence? <input type="checkbox"/> Yes <input type="checkbox"/> No Indicate sick leave paid: <input type="checkbox"/> Sick leave paid from _____ through _____. <input type="checkbox"/> This is an estimated end date. <input type="checkbox"/> This is the actual end date. <input type="checkbox"/> No sick leave paid.			
12. Has the employee received other paid leave for this absence? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Is leave paid at 100% of salary? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Employee returned, or is expected to return, to work on a: Part-time basis on: _____ Full-time basis on: _____			
15. Please provide name and telephone number of employee's direct supervisor:			
16. Do you provide long term disability coverage for this employee through another carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No • If yes, has a claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No • Indicate name and telephone number of the long term disability carrier:			
17. Has a worker's compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate worker's compensation claim number and weekly benefit:			
18. 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



Short Term Disability Claim Form

(To be completed and signed **after** your last day worked due to the onset of alleged disability. Any incomplete answers may delay the processing of your claim.)

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)
Subscriber No.:		

- Medical condition/diagnosis: *(If this claim is for postpartum recovery **only**, please skip to questions 3 through 9.)*

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

3. Date of accident or date symptoms began:	4. First date treated:
5. Last date worked:	6. First date unable to work:

7. I returned, or will return, to work on a:	<input type="checkbox"/> Part-time basis on: _____
	<input type="checkbox"/> Full-time basis on: _____

8. If due to pregnancy:	• Date of positive pregnancy test:	• Estimated delivery date:
	• Date first seen in clinic (including laboratory tests):	• Actual delivery date:
	• First date of last menstrual period:	• Type of delivery:

9. Are you or were you confined to a hospital for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give name and address of hospital:	
Admission date:	Discharge date:

10. Is the condition/injury the result of an accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide information regarding how, when, and where accident occurred: (Attach separate sheet if necessary and/or accident report if applicable)	

11. Did the condition/injury arise out of your employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, was your employer notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you file a worker's compensation claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you receiving worker's compensation benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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13. Have you applied for, or are you receiving, retirement benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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.)



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 Subscriber 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:
