HARVEY MUDD COLLEGE

Application for Disability (VDI) Benefits

Plan & Benefit Information

This application packet is for filing a claim for disability benefits through the Voluntary Disability Insurance (VDI) Plan of The Claremont Colleges. The VDI plan is intended as a wage loss replacement benefit for eligible employees (see below) and is not a leave entitlement. These forms must be fully completed by you and your treating doctor as indicated and returned to TCCS Disability Administration ***as soon as possible*** to determine your eligibility to receive disability pay benefits.

Eligibility: All employees are covered by the plan on the effective date of hire unless coverage is rejected in writing. If you do not participate in thevoluntary disability programs (VDI and PFL), you must participate in the state disability program.

Qualifying Reason: An employee with a serious health condition and unable to perform their job.

> Serious Health Condition Definition: An illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, or at home. This includes any period of incapacity (e.g., inability to work, attend school, or perform other regular daily activities) or any subsequent treatment in connection with such inpatient care, or continuing treatment by a physician or practitioner.

Maximum Benefit: Up to 52 weeks or the maximum benefit amount allowed for the claim, whichever comes first, and may be paid over a 12-month period. PFL benefits are paid on a 7-day calendar week per the California Employment Development Department (EDD). Note: VDI payments are not subject to federal or state taxes.

Waiting Period: There is a 7-day waiting period before pay benefits can be issued.

Base Period: The amount of the *basic weekly benefit* depends on the total wages paid to you during a 12-month base period. As shown below, the month in which your claim begins determines which 12-month period is used.

If your claim begins in:	The base period is the preceding:
January, February, or March	October 1 – September 30
April, May, or June	January 1 – December 31
July, August, or September	April 1 – March 31
October, November, or December	July 1 – June 30

HARVEY MUDD COLLEGE

Application for Disability (VDI) Benefits

Forms and Instructions

Notify Your Supervisor and Human Resources

As soon as possible, contact your supervisor and your Human Resources office to request a medical leave of absence and provide a note from your treating doctor placing you off work. Submit this request before you start your leave, or within 24 hours for emergency leaves.

VDI Benefits Application Forms

Employee Claim
Complete this form to provide information about your disability and to request ("claim") your benefits.

Authorization to Furnish Medical Information and Declaration of Disability
Complete this form to give us permission to receive your medical information from your healthcare provider on the *Medical Certification*. As required, on this form you will also declare you are disabled for the period of your claim.

Supplementation (Staff) **and Coverage of Benefits Deductions**
Complete this form to let us know if you want to supplement your VDI pay with your available vacation and/or personal hours IF you exhaust your balance of sick hours (for staff). On this form, you also state if you authorize your benefits deductions for your insurance plans to be taken from your VDI pay or if you will make payments directly to TCCS Benefits Administration.

Medical Certification (Completed by Your Doctor)
Give this form to your treating healthcare provider (doctor) for completion to certify your claim.

Important: All forms must be ***fully completed and received*** by the TCCS Disability Office before eligibility can be determined. Incomplete or late forms will delay your benefits. Once we determine your eligibility, we will send you a letter with your weekly benefit amount and will process payments in accordance with your institution's payroll schedule.

Questions or Need Assistance? Contact TCCS Disability Administration at disability@claremont.edu or (909) 621-8847. If you have any questions regarding your institution's leave of absence policies, please contact your Human Resources office.

Last Updated 02/03/2022

TCCS Disability Administration | 101 S Mills Avenue, Claremont, CA,91711
Email disability@claremont.edu | Phone (909) 621-8847 | Fax (909) 607-9688

HARVEY MUDD COLLEGE

Employee Claim Form

Important: To avoid delaying your VDI pay benefits, complete all the items on this form that apply to your claim.

1. First Name: _____ 2. Middle Initial(s): _____ 3. Last Name: _____

4. Home Address: _____ 5. Phone: _____

6. Email: _____ 7. Workday ID #: _____ 8. Last 4 of SSN: __ __ __ __

9. Date of Birth: _____ 10. Position Title: _____

11. TCC Institution: _____ 12. Department: _____

13. What date did your **disability start**? _____ 14. What was the last date you worked? _____

15. Have you recovered from your disability? ☐ Yes ☐ No

16. Describe what regular work duties (e.g., sitting, walking, typing, lifting, etc.) you cannot perform due to your disability:

_____

17. Was this disability caused by your work? ☐ Yes ☐ No (go to the *Acknowledgement and Certification* section)

18. Describe how your disability(ies) occurred from your work: _____

_____

19. Are you claiming Workers' Compensation benefits for any injuries or illnesses during any period covered by this claim?

☐ Yes ☐ No

20. Are you receiving Workers' Compensation benefits for any injuries or illnesses during any period covered by this claim?

☐ Yes ☐ No

Acknowledgement and Certification

I hereby claim benefits and certify that for the period covered by this claim I was unemployed and disabled, that the foregoing statements including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize my attending physician, practitioner, or hospital to furnish and disclose all facts concerning my disability that are within their knowledge and allow inspection of and provide copies of any medical records concerning my disability that are under their control.

I understand and acknowledge that under Section 2101 of the California Unemployment Insurance Code, it is a misdemeanor to willfully make a false statement or knowingly conceal a material fact to obtain the payment of any benefits, such misdemeanor being punishable by imprisonment not exceeding six (6) months or by a fine not exceeding $500 or both.

Employee Signature: _____ **Date**: _____

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

TCCS Disability Administration | 101 S Mills Avenue, Claremont, CA,91711
Email disability@claremont.edu | Phone (909) 621-8847 | Fax (909) 607-9688

HARVEY MUDD COLLEGE

Authorization to Furnish Medical Information and Declaration of Disability

Important: Read this form carefully. To avoid delaying your VDI pay benefits, complete all the items on this form.

First Name: _____ Last Name: _____
Last 4 of your SSN: __ __ __ __ Date of Birth: _____ Date Disability Begins: _____
TCC Institution (Employer): _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or carrier to furnish and disclose to *The Claremont Colleges Services Disability Administration Office* all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control. I understand that *The Claremont Colleges Services Disability Administration Office* may disclose information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected by this rule. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for five (5) years from the date received by *The Claremont Colleges Services Disability Administration Office* or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent recovery of monies to which it is legally entitled.

Employee Signature: _____ Date: _____
If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

Declaration of Disability

By my signature on this claim statement, I claim disability benefits and certify that for the period covered by this claim I was disabled and unable to work. I understand that willfully making a false statement or concealing a material fact to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to then best of my knowledge and belief true, correct, and complete.

By my signature on this claim statement, I authorized *The Claremont Colleges Services Disability Administration Office* and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the *Health Insurance Portability and Accountability Act (HIPAA) Authorization* portion of this form. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of five (5) years from the date of my signature or the effective date of the claim, whichever is later.

Employee Signature: _____ Date: _____
If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

TCCS Disability Administration | 101 S Mills Avenue, Claremont, CA,91711
Email disability@claremont.edu | Phone (909) 621-8847 | Fax (909) 607-9688

HARVEY MUDD COLLEGE

Supplementation (Staff) and Coverage of Benefits Premiums

First Name: _____ Last Name: _____

Date Disability Begins: _____ TCC Institution: _____

Staff: Authorization of Supplementation (not applicable to Faculty)

If you are eligible for voluntary disability insurance (VDI) payments, they will provide approximately 60% or 70% of your base wages. Your accrued sick leave (hours) will automatically be used to supplement your VDI pay up to 90% of your base salary. If your sick hours exhaust, you can allow the use of your available vacation and/or personal hours to supplement your VDI pay during your leave.

☐ I authorize the use of my accrued time off ("accruals") as follows:

(Indicate if you wish to allow the use of "all" or a specific number of hours.)

Vacation hours: _____ Personal hours: _____

I understand that while I receive sufficient pay from my accruals, payroll deductions for my insurance benefits (i.e., medical, dental, vision, retirement, etc.) will continue. If my accruals exhaust or are not sufficient to cover my deductions, I must either allow the use of my VDI pay to cover benefit premiums (see below) OR I must make premium payments directly to TCCS Benefits Administration.

OR

☐ I choose NOT to supplement my VDI pay with my available vacation and/or personal hours ("accruals").

I understand that by not authorizing the use of my accruals, I will only receive disability pay, if I am eligible. To continue my coverage for my elected insurance benefits (e.g., medical, dental, vision, retirement, etc.) I must allow deductions for my benefit premiums from my VDI pay (see below) OR I must make cash payments directly to TCCS Benefits Administration.

Authorization of Coverage of Benefit Premiums

California regulations allow you to use a portion of your voluntary disability insurance (VDI) payment to cover all or part of the employee portion of the premiums for the benefit insurance plans in which you are currently enrolled (e.g., medical, dental, vision, retirement, etc.). To allow the use of your VDI payments to cover your benefit premiums, you must provide a written authorization.

☐ YES, I authorize deducting my benefit premiums from my VDI payments.

I understand these premium deductions will continue until I terminate them, reach my maximum VDI benefit amount or leave of absence time, or until I return to work, for a maximum of up to 12 months. I understand I can terminate or change these deductions at any time while receiving VDI payments (see Stopping Benefit Deductions below). I understand that benefits deductions from VDI payments can only be taken after taxes.

☐ NO, I do NOT authorize deducting my benefit premiums from my VDI payments and understand I must make timely payments by personal check, cashier's check, or money order for my premiums to TCCS Benefits Administration. Please contact Benefits Administration for detailed instructions: BenReps@claremont.edu or (909) 621-8151.

Stopping Benefits: If you wish to stop coverage on an after-tax benefit plan (e.g., life insurance) or would like to inquire if special approval is available to stop coverage on a current pre-tax benefit plan while on a leave of absence, submit your request in writing to TCCS Benefits Administration at BenReps@claremont.edu, or by mail, fax, or in person.

Legally Incompetent VDI Recipients: If the disability benefit recipient has been declared legally incompetent, the spouse of the recipient, in the absence of any other legally authorized representative, shall have the right to continue or cancel the authorization to use VDI payments for benefits premiums coverage.

Employee Signature: _____ Date: _____

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

HARVEY MUDD COLLEGE

Medical Certification

Important: To avoid delaying benefits, complete all the items on this form that apply to the claim.

Employee (Patient) Completes This Section

First Name: _____ Last Name: _____ Date of Birth: _____

Licensed Healthcare Provider Completes This Section

Certification must be by a licensed physician, surgeon, osteopath, chiropractor, dentist, podiatrist, optometrist, designated psychologist, licensed nurse, mid-wife, nurse practitioner, or an authorized medical officer of a United States Government facility.

1. As of what date has this patient been under your care and treatment for this medical problem? _____

2. At what intervals? (frequency and duration): _____

3. Provide the nature, severity, and the bodily extent of the incapacitating disease or injury:

_____

4. ICD Code: _____ 5. Diagnosis: _____ 6. Objective Findings: _____

7. Pregnancy-related disability? ☐ Yes ☐ No (go to #10) 8. Date the pregnancy terminated or future EDC? _____

9. If you are certifying for a pre-partum period, what complication, impairment, or disabling factor prevents this patient from working before delivery? _____

10. Type of surgery: _____ 11. ICD Code: _____ 12. Date of surgery: _____

13. Date & time admitted: _____ 14. Date & time discharged: _____

15. At any time while attending this medical problem, has the patient been incapable of performing their regular work?

☐ Yes* ☐ No 16. *Provide the **Date the Disability Began**: _____

17. In your opinion, what date should this disability end or end sufficiently to permit the patient to resume regular and customary work? (This date is required by California Unemployment Insurance Code and the patient's claim will be delayed if not provided):

Date to Return to Work: _____

18. In your opinion, is the disability a result of "occupation" either as an "industrial accident" or as an "occupational disease"?

☐ Yes ☐ No

19. Have you reported this or a concurrent disability to any insurance carrier as a Workers' Compensation Claim? ☐ Yes ☐ No

I certify under penalty of perjury that, based on my examination, the foregoing Medical Certification truly describes the patient's disability (if any) and the estimated duration thereof.

I certify that I am a _____ licensed to practice in the State of _____
(Type of Doctor)

Doctor's Name: _____

State License Number: _____ Medical Group (if any): _____

Signature of Attending Doctor: _____ Date: _____

Address: _____

Phone: _____ Email: _____ FAX: _____