IMPORTANT NOTICE EMPLOYEE RESPONSIBILITIES

If you are using non-intermittent FMLA or Disability and under a doctor's care, before your return to work you must provide HR with a release from your physician indicating restrictions, if any. You will not be allowed to start your shift unless HR has received a release from your physician.

If you are not returning on the original date, you must notify HR prior to the start of your shift or follow proper call in procedures.

PREMIUM CO-PAYMENTS NOTICE

I understand that if I am no longer receiving County pay because of a leave, it is my responsibility to send in monthly medical insurance premium co-payments. The payment can be in the form of a personal check or money order made out to Genesee County Treasurer. HR should receive payment no later than the 15th day of each month.

I also understand, failure to make the required payments will result in the cancellation of the health care coverage. If the coverage is terminated due to non-payment, the cancellation will be the end of the month that the coverage was previously paid through. Employees will be re-enrolled into the insurance program the first day of the month following the return to work.

Personal and Vacation Time Allocation

☐ I am requesting to reserve the time allowed per my Collective Bargaining Agreement. I understand by doing so, I may experience unpaid time.

☐ I am requesting to reserve _____ hours of Personal Time and ____ hours of Vacation Time if allowed by my Collective Bargaining Agreement. I understand by doing so, I may experience unpaid time.

_____ _____

Print Name Employee's Signature

_____

Date

_____ _____ _____

Supervisor's Name Department Job Title

Disability Claim Form Instructions:

1. Complete Section II and III: EMPLOYEE'S SECTION (Page 1) and the AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION (Page 2) on the Lincoln disability claim form.

2. Have your physician complete the ATTENDING PHYSICIAN SECTION (Page 4) and the entire "Certification of Health Care Provider" (FMLA) form.

3. The disability claim form and the FMLA papers (Certification of Health Care Provider) must be returned to the Human Resources Office within ten (10) calendar days from the commencement date of your disability. Failure to return the forms within the specified ten (10) days may result in a delay of disability benefits.

Note:

- You must be disabled and under the continuous care of a physician to be eligible for disability benefits. Disability means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that you are (a) continuously unable to perform the *Material* and *Substantial Duties* of *Your Regular Occupation*; and (b) not *Gainfully Employed.* Acceptance of employment or working for another employer while on disability leave shall result in immediate termination of employment.
- For benefit amount and duration, please refer to your bargaining agreement.
- If your disability leave has to be extended beyond the original expected return-to-work date, **Human Resources must receive written notice from your doctor within two days of the extension date**. *It is your responsibility to submit additional medical information to Lincoln for continued benefits.*
- To have Federal income tax withheld from your disability benefits, you must submit a completed W-4 form, specifying the dollar amount to be withheld, and return it along with your disability claim form.
- Before you return to work, you must present a *Fitness for Duty* release from your physician to the Human Resources Office. Any work restrictions must be reviewed by HR and your department before you can return to work. Sheriff's department employees must also present the Fitness for Duty Statement to their department before returning to work.

The obtaining or receiving of a disability claim form from the Human Resources department does not fulfill the employee's contractual obligation to comply with the reporting of absence requirements. It is the employee's responsibility to notify his/her supervisor before disability leave begins and when the leave has to be extended.

Jennifer Draheim
1101 Beach St., Ste. 337
Flint, MI 48502
Tel: (810) 237-6120
FAX: (810) 768-7097

Lincoln Financial Group℠

The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

GROUP SHORT-TERM DISABILITY STATEMENT OF EMPLOYEE

1. Full Name (last, first, middle initial)	2. Social Security Number	3. Phone Number (include area code)

4. Street Address & Mailing Address	5. City	6. State	7. Zip Code

8. Please provide us with your e-mail address: May we contact you via e-mail? ☐Yes ☐No	9. Date of Birth

10. Date Last Worked: Date of Disability:	11. Gender ☐Male ☐Female	12. Hospital Confined ☐Yes ☐No Dates of confinement:

13. Have you ever had the same or similar condition in the past? ☐Yes ☐No If "Yes" provide dates:	14. Is your disability due to a: ☐Sickness ☐Injury ☐Other Date of Injury:

14a. Please describe your Sickness or how your Injury occurred:	Height:	Weight:

15. I returned to work part-time on:
I returned to work full-time on:

16. Is your disability due to your occupation? ☐Yes ☐No If "Yes" explain in 14a
Have you or do you intend to file a Workers Compensation Claim? ☐Yes ☐No

17. Treated by: (on another piece of paper, provide names & addresses of all doctors who have treated you for this disability).

Doctor: _____

Phone Number: _____ Specialty: _____

Address: _____

18. If approved, should Lincoln National Life Insurance Co withhold Federal Income Taxes from your Benefits? ☐Yes ☐No
If yes, how much should be withheld each week? (minimum is $20.00 per week) _____

19. Describe other income you are receiving, have applied for, or will be applying for (check all that apply):

	Amount	Date Began	Date Will Terminate	Date Applied For
☐ Social Security (Disability Retirement)	$_____	_____	_____	_____
☐ Salary Continuance or State Disability Benefits	$_____	_____	_____	_____
☐ Workers' Compensation	$_____	_____	_____	_____
☐ Other income related to your disability	$_____	_____	_____	_____

20. The above statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements. I have completed and attached the Authorization for Release of Information.

Signature of Employee _____ Date _____

21. Payment Method
☐Direct Deposit
Financial Institution's Name: _____
Type of Account ☐Checking
Bank/Routing Number: _____
Checking Account Number:

(BENEFITS MAY BE DELAYED IF CLAIM FORM IS NOT FULLY COMPLETED)

Please sign this page and the authorization on page two of this form to avoid delays in processing

(PLEASE see FRAUD NOTICES attached)

Lincoln Financial Group℠

The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

AUTHORIZATION FOR RELEASE OF INFORMATION

1. **I (the undersigned) authorize** any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

   Date of Birth: _____ Social Security Number: _____

2. Information to be released:
   - data or records regarding my medical history, treatment, prescriptions, consultations [including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition I may now have or have had];
   - any information regarding insurance coverage; and
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, Retirement Income, financial, earnings and employment history).

3. Information to be released to: The Lincoln National Life Insurance Company
   PO Box 2609
   Omaha, NE 68103-2609

4. I understand the information obtained by use of this Authorization will be used by The Lincoln National Life Insurance Company ("Company") to evaluate my claim for disability benefits. The Company will only release such information:
   - to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
   - to a vendor, approved by the company, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing the claimant with wellness, disability or leave related services as part of an employer sponsored benefit plan
   - to the employer for self-insured disability plans; or
   - as otherwise may be required by law or as I may further authorize.

   I further understand that refusal to sign this Authorization may result in the denial of benefits.

5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent:
   1. the Company has taken action in reliance on this Authorization; or
   2. the Company is using this Authorization in connection with a contestable claim.

   If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

7. A photocopy of this Authorization is to be considered as valid as the original.

8. I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: _____ **DATE:** _____
Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient: _____

ADDRESS: _____ PHONE NO: _____
(Street)

_____
(City) (State) (Zip Code)

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EMPLOYER'S REPORT OF CLAIM (TO BE COMPLETED BY EMPLOYER)

Please submit a copy of this employee's complete Job Description with this claim form.
Please submit a copy of this employee's enrollment statement with this claim.
(PLEASE see FRAUD NOTICES attached)

1. Full Name (last, first, middle initial)		2. Social Security Number
3. Occupation of Employee/Claimant	4. Insurance Class	5. Employee Date of Hire
6. Date Insured	7. Date Employee was last present at work On that day, did employee work a full day? ☐Yes ☐No	
8. Employee's Basic Weekly Earnings	9. Returned to Work? ☐Full-time ☐Part-time Date:	
10. Information needed for withholding and reporting taxes Does employee contribute post-tax dollars toward the premium? ☐Yes ☐No If yes, what percent is paid by the employee? _____% If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.		
11. What was the employee's regular scheduled work week? _____ hours per week _____ hours per day		
12. Is the claim due to your employee's occupation: ☐Yes ☐No		
13. Has a claim been filed with Workers' Compensation? ☐Yes ☐No If yes, send initial report of illness or injury and award/denial notice. Name, address and telephone number of your compensation carrier _____ Name, address and telephone number of your medical insurance carrier _____		
14. Is the employee receiving or has he/she received continued pay? ☐ Yes ☐ No If yes, complete the following: Pay Period: Amount: Source of Income:		
15. Can job be modified to fit accommodations?		
16. Physical Requirements (Include Job Description)		
Employer's Name & Address (or name of policyholder, if other) Genesee County, 1101 Beach St	Telephone Number (Include Area Code and Extension) 810-237-6120	Group Policy Number & Division Number 01-0189319
E-mail address jdraheim@co.genesee.mi.us	Fax Number (Include Area Code) 810-768-7097	
The above Statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements.		
Signature of Person Completing this form and Title		Date
Jennifer Draheim, HR Representative Print Name of Person Completing this form and Title		jdraheim@co.genesee.mi.us E-mail address

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ATTENDING PHYSICIAN'S STATEMENT

1. Name of Patient	2. Social Security Number	3. Employer Name
4. When did symptoms first appear or accident happen?	5. Date you believe patient was unable to work?	
6. Diagnosis (including complications)	7. Subjective symptoms	
8. Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)	Height Weight	
9. List of Restrictions & Limitations		
10. Nature of treatment (Including surgery and medications prescribed, if any).		
11. Has patient ever had same or similar condition? ☐Yes ☐No If "Yes" provide dates.		
12. Do you consider this condition to be due to your patient's employment? ☐Yes ☐No		
13. If pregnancy, estimated date of delivery: Actual date of delivery:	14. Date first treated	15. Date of last visit/treatment
16. Has patient been hospital confined? ☐Yes ☐No Confined from: to If "Yes" give name of hospital.		
17. Has surgery been scheduled or performed? ☐Yes ☐No If "Yes" date of surgery: Type of surgery scheduled:		
18. Prognosis and Rehabilitation: a. When do you think your patient will be able to return to work in their occupation? b. When could trial employment commence? ☐Full-time ☐Part-time Please submit clinical documentation to support your decision.		
Print Name (Attending Physician)	Specialty	Telephone (Include Area Code)
Street Address/City or Town/State or Providence/Zip Code		
The above Statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements.		
Signature (Attending Physician) No stamps please	Date	Fax Number (Include Area Code)

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY IS NOT RESPONSIBLE FOR CHARGES INCURRED DUE TO COMPLETION OF THIS FORM. THE PATIENT IS RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH FORM COMPLETION.

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Genesee County

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ☐ No ☐ Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes.

   Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ☐ No ☐ Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ☐ No ☐ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ☐ No ☐ Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ☐ No ☐ Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**