Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Short-Term Disability Application

HOW TO APPLY FOR BENEFITS:

The forms and documents contained in this application must be completed in their entirety and provided to Allegiant Care before any short-term disability benefits are paid. It is STRONGLY recommended that you retain a copy of all completed forms for your own records.

Checklist of documents required to submit a claim:
****INCOMPLETE OR UNSIGNED FORMS WILL NOT BE PROCESSED****

- ❑ Short-Term Disability Member Application
- ❑ Physician's Statement (must be completed by an MD)
- ❑ Memorandum of Understanding
- ❑ Authorization to Release Information
- ❑ Subrogation Agreement
- ❑ A copy of one current check stub (hours/wages must represent a typical pay period)
- ❑ FMLA approval or denial letter from your employer (must be received within 4 weeks)
- ❑ Direct Deposit Authorization Form
- ❑ Copy of voided check

WHAT IS FMLA?

FMLA refers to the Family and Medical Leave Act, which is a federal law that requires most employers (generally employers with 50 or more employees) to maintain the health benefits for eligible employees. **If your employer is subject to FMLA, you are required to apply for FMLA leave and send a copy of the FMLA approval or denial letter to Allegiant Care within four (4) weeks of date of disability.** Failure to do so will result in non-payment after four weeks.

HOW LONG DOES IT NORMALLY TAKE TO MAKE A CLAIM DECISION?

Once Allegiant Care receives all required paperwork (see checklist above), it will take approximately one week to make a claim decision. If we have not made a decision within one week, you will be notified with additional details.

IF MY CLAIM IS APPROVED, HOW OFTEN WILL I RECEIVE CHECKS?

Short-term disability benefits are paid on a weekly basis. In most cases, checks are mailed on Friday of each week. Periodically we will require a **Physician's Statement of Continuing Disability** which must be completed by your treating physician before additional benefits are paid. It is your responsibility to ensure that your physician completes the form by the due date specified; failure to do so will result in suspension of your weekly payments.

IS DISABILITY INCOME TAXABLE?

Short-term disability income is usually considered taxable income. Allegiant Care automatically withholds Medicare and Social Security tax, but does not automatically withhold Federal Income Tax. Disability income will be reported as taxable income by your employer on your W-2 Wage and Tax Statement at the end of the calendar year.

WHAT STEPS DO I TAKE IF I AM RETURNING TO WORK?

If you are returning to work, please notify us immediately and return the enclosed **Return to Work Notice** within 48 hours after you return to work. If you do not notify us, you will be responsible for reimbursing Allegiant Care for any days paid in error after your return to work date.

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Short-Term Disability Member Application

SECTION 1: MEMBER INFORMATION

Member's Full Name		Date of Birth	SSN (last 4 digits) XXX-XX-
Mailing Address	City	State	Zip Code
Marital Status	Employer		
Primary Phone	E-mail Address		

SECTION 2: EMPLOYER INFORMATION

Primary Employer		Job Title	Date Employed
Mailing Address	City	State	Zip Code
Employer Phone	Contact Person		Gross Weekly Wage (average)
Do you have other employment including self-employment? ❑ Yes ❑ No If yes, provide information below.			
Secondary Employer		Job Title	Date Employed
Mailing Address	City	State	Zip Code
Employer Phone	Contact Person		Gross Weekly Wage (average)

***** Enclose copies of current check stubs for each employer *****

SECTION 3: DISABILITY CLAIM INFORMATION

Disability due to:	What is the date you last worked:		
❑ **Illness**	Date Illness Began	Nature of Illness or Diagnosis	
❑ **Injury**	Date Injury Happened	Type of Injury ❑ Auto ❑ Worker' Compensation ❑ Home ❑ Other	
❑ **Pregnancy**	Expected Delivery Date	Actual Delivery Date	Type of Delivery ❑ Vaginal ❑ C-section
Date you returned to work:		**OR** Date you intend to return to work:	

Briefly describe injury or illness (if applicable): _____

_____

How and where did the injury occur (if applicable): _____

_____

Did you seek treatment at a hospital emergency room? ❑ Yes ❑ No If yes, indicate treatment date(s) and name and address: _____

Continued on reverse side ➲

SECTION 4: THIRD PARTY COMPENSATION

Is disability work related? ❑ Yes ❑ No **OR** Is disability related to a motor vehicle accident?* ❑ Yes ❑ No			
Workers' Compensation or Auto Insurance Carrier		Phone Number	
Mailing Address	City	State	Zip Code
Are you seeking legal representation for settlement purposes?			
❑ **Yes**	Legal Counsel Name	Phone Number	
	Address	City	State	Zip
❑ **No**, I am not seeking legal counsel and I will not be receiving any type of settlement relative to this claim.			
Are you currently or will you be receiving wage-replacement from any other insurer? ❑ Yes ❑ No			
If yes, Name of Other Insurance Carrier		Phone Number	
Mailing Address	City	State	Zip Code

***** Please attach the police report from the motor vehicle accident. *****

SECTION 5: LIST ALL ATTENDING PHYSICIANS

1. Physician's Full Name		Phone Number	
Mailing Address	City	State	Zip Code
2. Physician's Full Name		Phone Number	
Mailing Address	City	State	Zip Code
3. Physician's Full Name		Phone Number	
Mailing Address	City	State	Zip Code
4. Physician's Full Name		Phone Number	
Mailing Address	City	State	Zip Code

***** Please attach any hospital discharge papers or any physician's notes relative to this claim. *****

SECTION 6: CERTIFICATION & AUTHORIZATION

I certify that the above information is complete and accurate and that I am totally disabled, unable to perform my job or any other job. I also authorize the release of any medical information necessary to process this claim.

Member Signature: _____ **Date:** _____

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Short-Term Disability Physician's Statement

Disability Income Claims are reviewed in reference to the member's level of impairment (disability). To qualify for disability income, the member must be **unable to work** for wages or profit at **any** job for which the member is reasonably qualified by education, training or experience.

ASSESSMENT & PROGNOSIS (Must be completed by the treating physician)

Patient Name: _____ Date of Birth: _____

Diagnosis with Diagnosis Code: (MUST include ICD-10 code to be accepted)_____

_____

Dates of first visit: _____ Most recent visit: _____ Next follow-up visit: _____

Condition is related to: ❑ Work injury ❑ Auto accident ❑ Pregnancy (expected delivery date): _____

Date physician put patient out of work due to injury or illness: _____

Describe the patient's current physical and mental limitation and work activity restrictions: _____

_____

_____

For how long will the described limitations impair the patient? _____

Describe current treatment: _____

_____

_____

Will the patient require surgery? ❑ Yes ❑ No If yes, date of surgery: _____

When do you expect a fundamental or marked change in the patient's condition? _____

_____

_____

When do you anticipate the patient can return to work? _____

_____

PHYSICIAN INFORMATION & CERTIFICATION

Name of Physician completing this form			Phone Number	
Specialty	Tax ID Number		Fax Number	
Mailing Address	City		State	Zip Code

I certify that the above statement relative to the patient named on this form is both true and complete to the best of my knowledge and belief.

Healthcare Provider Signature: **Date:**

Please indicate your patient's level of impairment or inability to perform the tasks listed on Page 2 ➲

MEDICAL FOCUS	TASK	Indicate ability to perform tasks			
		Poor/None	Fair	Good	Very Good
Neurological and Mental:	Decision Making				
	Concentrate on and attend to work tasks				
	Understand and/or remember				
	Interact with other people				
	Respond to changes in work setting				
Medication:	Causes _____% of Impairment				
Lifting Restrictions:	Up to 10 Pounds				
	Up to 25 Pounds				
	Up to 50 Pounds				
	Up to 100 Pounds				
	More than 100 Pounds				
Use of Equipment:	Keyboard				
	Telephone				
Job Activities:	Ambulating				
	Weight Bearing				
	With Wheelchair				
	With Crutches				
	Driving				
	Sitting				
	Standing				
Ears:	Hearing				
Eye Sight:	To Read Fine Print				
	To Use Computer				
	To Read Large Print				
Mouth:	Speech				
Neck:	Rotate				
Shoulders:	Reach Above				
Forearm:	Rotational Movement				
Hands:	Simple Grasping				
	Fine Manipulation				
	Medium Dexterity				
	Power Grip				
	Pushing/Pulling				
Back:	Bend				
	Stoop				
	Squat				
Lower Extremities:	Sit				
	Stand				
	Walk				
	Climb Stairs				
Foot:	Operate Foot Controls				

Healthcare Provider Signature: _____ **Date:** _____

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Short-Term Disability Memorandum of Understanding

Instructions: Please read this document carefully and sign in the space provided.

1. Weekly disability income benefits are provided to eligible members who are "totally disabled," which means that you are unable to perform your job or any other job to which you have access under the terms of your collective bargaining agreement. You must be totally disabled as a result of a "medically determinable physical or mental impairment," which means an impairment that results from anatomical, physiological or abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques and not only by your statement of symptoms. You must be totally disabled as a result of an illness or injury that is not work-related. You must be actively receiving treatment by a doctor for the disabling medical condition or, in the case of mental health related disability, be actively receiving treatment from a licensed mental health professional. You must not be performing any work or service of any kind, for wages or profit.
2. Once your application and signed Memorandum are received by Allegiant Care, your claim will be reviewed. If you meet the eligibility requirements, you will begin to receive your benefit on a weekly basis. Physician update forms will be included periodically with your benefit check. It is your responsibility to ensure that your physician or mental health professional responds to these requests in a timely manner. Weekly benefit payments will be suspended if Allegiant Care does not have sufficient updated information to determine your disability status.
3. If your employer is covered by the Family and Medical Leave Act (FMLA) and you are eligible for leave under the FMLA, you must apply for FMLA leave, if your employer is not obligated under your collective bargaining agreement to make contributions to Allegiant Care on your behalf while you are out of work. You must send a copy of the approval or denial letter to Allegiant Care to receive or to continue to receive weekly benefits if/when your employer does not have an obligation to make contributions to Allegiant Care under the terms of your collective bargaining agreement.
4. It is your responsibility to keep Allegiant Care informed regarding any changes to your disability status (*e.g.*, return to work, physician extends return to work date etc.). It is your responsibility to notify Allegiant Care when you return to work. If, for any reason, you receive a check for a pay period during which you worked or were able to work, you must return the check or refund the payment to Allegiant Care immediately.
5. If your injury or illness is work-related, you must file a worker's compensation claim with your employer. If the worker's compensation claim is disputed by your employer, additional forms will be provided to you and must be completed and returned to Allegiant Care before your weekly disability income benefit claim will be considered by Allegiant Care. It is your responsibility to notify Allegiant Care if, at any time during the course of your disability leave, your claim is turned over to worker's compensation.
6. If you receive, at any time, worker's compensation benefits or receive an award or settlement from a third party related to your illness or injury, you must reimburse Allegiant Care in full for any weekly disability income benefits you have received from Allegiant Care. For a further description of your obligation to reimburse Allegiant Care, please refer to the Subrogation provision of your Plan document.

Member's Full Name	Date of Birth	SSN (last 4 digits) XXX-XX-
I acknowledge that this authorization is subject to the terms set forth above, all of which I have read and understand.		
Member Signature:	**Date:**	

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Short-Term Disability Authorization to Release Information

Instructions: Employee must complete, sign and date this release and must provide a copy to any physician and/or mental health professional involved with this claim.

I authorize my medical care provider(s) to disclose to Allegiant Care, any information relating to my current medical and/or mental health condition necessary to process my claim for disability income benefits under the Allegiant Care Short-Term Disability Plan.

With respect to my authorization to release my medical information, I understand and acknowledge that:

- I may revoke this authorization at any time by giving my written revocation to my physician, other medical care provider or mental health professional.
- My healthcare treatment by my physician, other medical care provider or mental health professional will not be affected if I refuse to sign this form.
- I am authorizing disclosure of information protected under federal privacy law and that the information, once disclosed, could be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.
- If I do not revoke it, this authorization will expire 18 (eighteen) months from the date on this form.
- I am entitled to receive a signed copy of this authorization and a copy will serve as an original.

Member's Full Name		Date of Birth	SSN (last 4 digits) XXX-XX-
Mailing Address	City	State	Zip Code
Marital Status	Employer		
Primary Phone	E-mail Address		

I acknowledge that this authorization is subject to the terms set forth above, all of which I have read and understand.

Member Signature: **Date:**

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Subrogation Agreement

This Agreement is made between Allegiant Care (hereinafter, the "Plan") and _____
(member's full name – please print)

(hereinafter, "Participant"), who resides at: _____

1. Subject to the terms and provisions of the Eligibility Rules and the Plan of Benefits provided by the Plan, the Plan will pay on the behalf of Participant medical, hospital and related expenses for the treatment and care of the injury or illness and, if applicable, pay to Participant weekly disability income benefits.

2. In certain instances, a "third party" may be responsible for the cost of treating an illness or injury incurred by participant. A "third party" means someone other than Allegiant Care. It can be a person, a legal entity or some other insurance or benefit Plan (*e.g.,* Workers' Compensation, uninsured motorists' pool). If participant is entitled to reimbursement from a third party for expenses for an illness or injury, this Plan has the right to recover all amounts paid by this Plan. As a condition to receiving medical or disability benefits under this Plan, participant must agree to transfer to the Plan their rights to make claim, sue and recover medical or disability expenses against any person, an insurance company or business entity from any funds which are paid or payable as a result of a personal injury claim or any reimbursement of medical/disability expenses.

3. Participant is required to cooperate fully with the Plan and provide any information requested by the Plan within five (5) days. No settlement of Participant's claim may be made prior to notifying the Plan, in writing, at least thirty (30) days in advance. Participant will not settle or compromise any claim without written approval from the Plan.

4. From any and all monies payable or received as Worker's Compensation payments, including but not limited to weekly indemnity and medical, hospital, nursing and related expenses, or from any monies received by way of any recovery, by judgment, settlement, compromise or otherwise, by or from any third party whose conduct is claimed to have caused the injury or illness, Participant agrees to first reimburse the Plan to the extent of all payments made by the Plan hereunder without reduction for attorney's fees or costs. Participant agrees and understands that the Plan is to be reimbursed at 100% for all disbursements for weekly indemnity, medical, hospital, nursing and related expenses. The monies so paid will be credited by the Plan first to reimbursement for any weekly indemnity payments, and second for any other medical, hospital, nursing and related expenses.

5. By signing below, participant acknowledges this is a legal binding contract and agrees to cooperate fully with the Plan. Participant understands that failure to comply with the terms and conditions of this contract will result in the termination of health and welfare benefits.

Participant Signature: _____ **Date:** _____

Allegiant Care Signature: _____ **Date:** _____

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Return to Work Notice

Instructions: This form must be signed and dated by the member and his/her employer when returning to work at the conclusion of a short-term disability absence and then mailed to Allegiant Care immediately.

To be completed by the employee

Member's Full Name		Date of Birth	SSN (last 4 digits) XXX-XX-
Mailing Address	City	State	Zip Code
Primary Phone	E-mail Address		

Member Signature: **Date:**

To be completed by the employer

Employer Name	Primary Phone
Signed by (please print)	Official Title

The employee named above returned to work on _____ following an absence due to disability.

Employer Signature: **Date:**

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Authorization for Direct Deposit (via ACH) Form

Complete and sign this form to authorize Direct Deposit between Allegiant Care and your bank. You must include a copy of a voided check with this authorization form.

You may securely upload the completed form with a copy of a voided check at https://myallegiantcare.com/std or mail to Allegiant Care, Disability Dept., P.O. Box 4604, Manchester, NH 03108.

Member Information

Member's Full Name:			
Mailing Address:	**City**	**State**	**Zip Code**
Daytime Phone:	**Email Address:**		

Certification and Authorization

I hereby authorize Northern New England Benefit Trust, d.b.a. Allegiant Care to electronically credit my account (and, if necessary, to electronically debit my account to correct erroneous credits).

This authorization is to remain in full force and effect until Allegiant Care has received my written notification of its termination in such time and in such manner (at least 10 days) as to afford Allegiant Care and Financial Institution a reasonable opportunity to act on it.

Allegiant Care shall not be held liable for any charges or fees incurred by my financial institution.

Account Holder's Name	**Signature**	Date

Office Use Only	**Received Date Stamp:**
Bank Information Entered By: _____ **Date:** _____ **Verified By:** _____ **Date:** _____	