



Employee Benefits has been advised of your absence from the workplace due to illness or injury. The County provides short term disability benefits which can replace a portion of your lost income. The enclosed brochure addresses many common questions about your Disability plan.

Standard Insurance Company administers the disability plan for Pinellas County employees. The Standard claims representatives will review the claim forms you submit, request additional information needed and approve or deny your claim for benefits.

- **Steps To Follow In Submitting Your Disability Claim**

For your claim to be processed and benefits paid, **you must** follow the instructions below:

1. Complete the **Disability Insurance Employee Statement**
2. Read, sign and date the **Disability Insurance Authorization to Obtain Information.**
3. Have your medical provider complete the **Disability Claim Attending Physicians Statement.** If more than one physician is treating you for your disabling condition, each should complete a form. Any cost for having the forms completed will be your responsibility.
4. **Return all forms to Employee Benefits.** They must be received no later than 30 days from the end of your Elimination (waiting) Period.

**Pinellas County  
Employee Benefits**  
400 S. Ft. Harrison Ave.  
Clearwater, FL 33756

(727) 464-4570 Ext 1  
(727) 464-5291 Fax  
Email Address:  
Employee.Benefits@  
co.pinellas.fl.us

Please remember that your claim may not be processed or benefits paid until Standard Insurance Company approves your claim. When Employee Benefits receives your forms, they will be immediately forwarded to The Standard via fax.

*Please see important information on the next page.*

- Once The Standard receives your claim forms, it will take approximately one week to make a claim decision. If a decision cannot be made within a week, you will be notified of the details. Employee Benefits will submit a payment request to payroll only after receiving notice from The Standard that your claim is approved.

- **Other Factors  
Affecting Your STD  
Benefits**

**It may be necessary to use annual leave if your claim forms are not completed and submitted prior to your absence, or if approval is not obtained prior to the normal payroll deadlines.** Should that occur and your claim is approved, a payroll correction can be processed restoring any leave time for which short term disability benefits are approved and paid.

- Other income you receive may reduce the amount of disability benefits that are due you. Your short term disability benefits plan booklet lists these. They include, but are not limited to, outside employment income, workers compensation, social security and auto insurance PIP wage loss benefits.

- To avoid any overpayment on your claim, please inform The Standard if you receive any of these benefits. Any benefit overpayments must be repaid in full.

- Standard Insurance Company may contact you by phone or letter to request additional information in order to approve or extend your claim. It will be your responsibility to provide the requested information or to work with your medical providers in doing so.

- **Visit Our Website  
For Additional  
Information**

[www.co.pinellas.fl.us/persnl/](http://www.co.pinellas.fl.us/persnl/)  
Unified Personnel System  
via internet

<http://intraweb.co.pinellas.fl.us>  
Unified Personnel System  
via intranet

- It is your responsibility to follow your departments policy for reporting your absence and updating your return to work status.

- For specific information about your Disability insurance coverage, refer to the **Pinellas County Unified Personnel System Short Term Disability Benefits Plan** booklet. This booklet is available on the Pinellas County Unified Personnel System website address noted in the margin. If you do not have access to the internet or County Intranet, you may request a copy of the booklet from Employee Benefits.



Some states require us to provide the following information to you:

**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.

**COLORADO RESIDENTS**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FLORIDA RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**NEW JERSEY RESIDENTS**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW YORK RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA RESIDENTS**

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**ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

**TO BE COMPLETED BY EMPLOYEE**

Full Name:	Employer: <b>Pinellas County Government</b>	Plan No: <b>642230</b>
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**TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

*The following information is needed to document your patient's inability to work. The patient is responsible for completing this form without expense to the plan sponsor or The Standard.*

<b>1. Diagnosis</b>			
A. Diagnosis:		ICDA Classification:	
B. Symptoms:		C. Objective Findings: Height: _____ Weight: _____ B/P: _____ / _____	
<b>2. Pregnancy (if applicable)</b>			
A. Expected date of delivery:		B. Actual date of delivery:	C. Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section
D. Significant complications, if any:			
<b>3. History</b>			
A. Date you recommended the patient stop work:		B. When did symptoms appear or accident happen?	
C. Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when? _____	
D. Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		E. Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4. Treatment</b>			
A. Date of first visit:	B. Date(s) of subsequent visits:		C. Date of most recent visit:
D. Planned course and duration of treatment (include surgery and medications, if any):			
<b>5. Level of Functional Impairment</b>			
A. Describe the patient's physical, mental and cognitive limitations, if any.		B. In a work day given two breaks and a meal break, your patient can:	
		Lift (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+	
		Carry (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+	
		Total Hours	
		With positional change	
		Sit 8 7 6 5 4 3 2 1 (hrs) _____	
		Stand 8 7 6 5 4 3 2 1 (hrs) _____	
		Walk 8 7 6 5 4 3 2 1 (hrs) _____	
		Alternately sit/stand 8 7 6 5 4 3 2 1 (hrs) _____	
		Bend/stoop: <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently	
C. Is the patient competent to manage insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is the patient competent to appoint someone to help manage the insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>6. Hospitalization (if applicable)</b>			
A. Date admitted:	B. Date discharged:	C. Reason:	
D. Name and location of hospital (city/state):			
<b>7. Prognosis</b>			
A. Since onset of symptoms, the patient's condition has: <input type="checkbox"/> Improved <input type="checkbox"/> Not changed <input type="checkbox"/> Retrogressed			
B. When do you anticipate the patient can return to work? <input type="checkbox"/> Date: _____ <input type="checkbox"/> Unable to determine, follow up in _____ weeks <input type="checkbox"/> Never			
<b>8. Physician Information (Please type or print)</b>			
Name of physician completing this form:			Phone Number: ( )
Specialty:	Tax ID#:	Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:
<b>Acknowledgement</b>			
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.			
Signature: _____			Date: _____

Send to The Standard at the address listed above.

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**I AUTHORIZE THESE PERSONS** having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, etc.*).

**TO GIVE THIS INFORMATION:**

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

**and:**

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, or eligibility for other benefits (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.*).

**TO PINELLAS COUNTY GOVERNMENT AS PLAN SPONSOR AND STANDARD INSURANCE COMPANY ACTING AS ITS CLAIMS ADMINISTRATOR.**

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction. I understand that Pinellas County Government and The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with Pinellas County Government and The Standard. I understand that I have the right to refuse to sign this authorization and the right to revoke this authorization at any time by sending a written statement to Pinellas County Government or The Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair Pinellas County Government and The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, Pinellas County Government and The Standard may disclose to other parties information it has about me. Pinellas County Government and/or The Standard may release this information about me to a reinsurer, a plan administrator, the plan sponsor and the policyholder, or any person performing business or legal services for Pinellas County Government and The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (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 The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations (*if applicable*) on the page 8. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

\_\_\_\_\_  
Name (*please print*)

\_\_\_\_\_  
Social Security No.

\_\_\_\_\_  
Signature of Claimant/Representative

\_\_\_\_\_  
Date

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

*This Authorization is a two-page document. Please see page 8 for additional terms and information. Both pages are part of the Authorization.*

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

**FOR RESIDENTS OF MINNESOTA**

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

**FOR RESIDENTS OF NEW MEXICO**

The state of New Mexico requires us to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The accompanying Authorization to Obtain Information allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by The Standard, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The Standard is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by The Standard. Within 30 business days of receiving the request, The Standard will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. The Standard will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.