ROBINS & MORTON

Request for Short Term Disability Benefits

TO BE COMPLETED BY EMPLOYEE:

Full Name: _____

Employee ID #: _____ Phone No: _____ DOB: _____

Please answer the following questions:

1. Is your disability work related? ☐ Yes ☐ No Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No
2. Last date at work before disability_____ Date you expect to return to work_____
3. Cause of Disability: ☐ Accident ☐ Illness Please explain: _____

_____

_____

I understand that my employer has integrated the claim services for disability benefits and request for leave under the Family and Medical Leave Act (FMLA), state leave laws, and/or my company's leave of absence policy ("Leave Request"). For purposes of determining my eligibility for disability benefits and/or my Leave Request, the administration of my employer's disability benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to my employer in its capacity as administrator of its disability benefit plan, and regarding my Leave Request, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on behalf of Robins & Morton, any and all information about my health, medical care, employment, and my claim for disability benefits and/or my Leave Request consistent with law.

2. **I permit:** Any insurance carrier or Third Party Administrator to disclose to my employer in its capacity as administrator of its benefit plans and to my employer regarding my Leave Request, any and all information about my health, medical care, employment, and claim for disability benefits or Leave Request. **This Authorization to Disclose Information About Me** specifically includes my permission to disclose my entire medical record, including medical information, records, test results, and data on: medical care, diagnosis or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.**

I understand that I may revoke this authorization at any time by writing to Robins & Morton at 400 Shades Creek Parkway, Birmingham AL 35209, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits and/or my Leave Request, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

_____ _____

Employee Signature Date

TO BE COMPLETED BY ATTENDING PHYSICIAN:

The following information is needed to document the patient's inability to work.

1. Diagnosis: _____ ICDA Classification: _____
2. History and Treatment:

   a. Date you recommended the patient stop work or limit work activities: _____
   b. When did symptoms appear or accident happen? _____
   c. Is this condition related to the patient's employment? ☐ Yes ☐ No If yes, did you complete a workers' compensation form? ☐ yes ☐ no
   d. Date of most recent related visit? _____ CPT Code Billed for Visit: _____
   e. Describe planned course and duration of treatment:
      _____
      _____
      _____
      _____
   f. Hospitalization? ☐Yes ☐ No If yes, date admitted: _____ discharged: _____
   g. Surgery? ☐ yes ☐ No If yes, date of surgery: _____

3. Level of Functional Impairment:

   a. Describe patient's limitations and restrictions (functional capacity): _____
      _____
      _____
      _____
   b. Factors delaying recovery (if applicable): _____
      _____
      _____
      _____
   c. How long do you expect these limitations and restrictions to impair your patient? ☐ Date: _____
      ☐ Unable to determine, follow up in ____ weeks ☐ Permanently

4. PHYSICIAN INFORMATION (please type or print)

   a. Name of Physician completing this form: _____
   b. Specialty: _____
   c. Phone Number: _____
   d. Address: _____
   e. City: _____ State: _____ Zip:_____
   f. Fax Number: _____

PHYSICIAN ACKNOWLEDGEMENT - I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

_____ _____

Signature Date