MEDICAL LEAVE OF ABSENCE

Updated 07-06-2023

YOU MUST FOLLOW THESE PROCEDURES WHEN GOING ON A LEAVE OF ABSENCE YOU MUST OBTAIN AND SUBMIT THESE FORMS (**Within 20 Days**) FAILURE TO DO SO WILL RESULT IN YOUR CLAIMS NOT BEING PAID.

1. RAILROAD RETIREMENT SICKNESS BENEFITS - UB-11 FORM For COVID Pages 1 & 2 And G-93 Form

U.S. RAILROAD RETIREMENT BOARD **US RRB-RUIA** **PO Box 541186** **Houston, TX 77254-1186** **(RRB.GOV)** **HELPLINE: 1-877-772-5772**	***FOR COVOID-19 CLAIMS FAX PAPERS TO RRB** ***(On UP Property Add "91" To Fax Number)*** **Fax #: *713-405-2078***

YOU NEED TO MAIL RRB FORMS CERTIFIED RETURN RECEIPT
TO ASSURE THAT FORMS HAVE BEEN RECEIVED.
ALSO SEND A VOIDED CHECK FOR DIRECT DEPOSIT.

2. The Hartford Supplemental Sickness- Members MUST file a claim for supplemental

PHONE (800)205-7651

Online via the internet registered members have 24X7 access to The Hartford Ability Advantage, The Hartford's online disability system.

The website is: http://abilityadvantage.thehartford.com

- **Live reps are available M-F, 8 AM to 8 PM EST.**
- **The Customer Care rep will walk through the disability form with you over the phone to ensure an accurate completion of the request.**
- **Immediately after completion, a claim reference # will be provided, which is proof a claim has been filed and the prime locator for the claim in the future.**

After the member has reported a claim to the Hartford, they will receive a package of information in the mail which includes an Authorization for Release of Medical Information and a W-4 form. They should sign all forms and mail or fax to Hartford. The Claim Specialist assigned to the member's claim will use those forms to contact the treating provider to obtain the proof of loss directly from their office. The W-4 form is provided to complete as we do not receive information regarding your withholding status from your employer. Failure to complete the W-4 form, including the number of exemptions you are claiming for tax filing purposes, will result in an automatic Federal withholding at single rate with zero exemptions. Please make the member completes their full name, address, social security number and number of exemptions they want taken while out on disability. A separate W-4 form will be provided at the beginning of each calendar year.

Things to remember:

- Omaha Automated help line #1 (877) 275- 8747 Omaha fitness for duty/return to work Nurse #1 (402) 544-7011
- Not all unions are covered by The Hartford's supplemental sickness benefit plan. Please contact your local representative if you are unsure of your union's eligibility for this benefit.
- Claims must be filed with and approved by the RRB to be eligible for Supplemental Sickness Benefits.
- RRB does not have to approve disability benefits prior to you filing your SSB claim with The Hartford. File your SSB claim right away.
- Claims must also be separately filed with The Hartford to determine eligibility for SSB, and amount/duration of benefits.
- Maximum length of benefit payments is 12 months.

Supplemental Sickness Benefit claims must be filed with The Hartford within 60 days of Date of Disability

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Application for Sickness Benefits

Section A Identifying Information

1. Employee's Name (First, Middle Initial, and Last)

2. Social Security Number

			–			–				

3. Employee's Street Address, City, State and ZIP Code (Including Apartment Number)

4. Date of Birth

Month		Day		Year	

5. Sex
- ☐ Male
- ☐ Female

6. Telephone Number (Include Area Code)
( )

Section B Infirmity and Employment Information

7. Date You Became Sick or Injured _____

8. Date You Last Worked for a Railroad _____

9. Last Railroad Employer (Name of Company) _____

10. Location of Last Railroad Employment (City/State) _____

11. Last Railroad Occupation _____

12. Department _____

13. If you worked for a nonrailroad employer after the date shown in Item 8, complete Items A, B, and C, below. Otherwise, **go to Item 14.**

A. Last Nonrailroad Employer (Name of Company) _____

B. Last Occupation After Railroad Work _____

C. Date Last Worked After Railroad Work _____

Section C Accident and Insurance Information

14. Are you applying for sickness benefits because you were injured at work or have a work-related illness? ☐ Yes ☐ No

15. Have you filed or do you expect to file a lawsuit or claim against any person or company for personal injury?

☐ Yes - **Complete Items A-D, below** ☐ No - **Go to Item 16**

A. Furnish the name and complete address of the person or company.

Name _____

Address _____

City, State, ZIP Code _____

B. Give the place where the injury occurred. _____

C. Were you injured in an automobile accident? ☐ Yes ☐ No - **Go to Item 16**

D. If you were injured in an automobile accident, provide information about all the vehicles, ***other than your own,*** that were involved in the accident that caused your injury. Information about your vehicle and insurance company is not needed. If you need more space attach a separate sheet of paper.

Owner of Car (other vehicle)	**Driver (other vehicle)**
Name	Name
Address	Address
City, State, ZIP Code	City, State, ZIP Code
Insurance Company (other vehicle)	**Policy Information (other vehicle)**
Name	Policy Number
Address	Claim Number
City, State, ZIP Code	

Continued on Next Page

Section D Claim for Sickness Benefits Information

16. Enter the earliest date you wish to claim sickness benefits. _____

17. Are you claiming all the days of sickness beginning with the date you entered in Item 16? (**Note:** You may claim rest days if you were unable to work and did not receive pay from your employer.) ❑ Yes - **Go to Item 19** ❑ No - **Go to Item 18**

18. Enter any dates that you do not wish to claim. _____

19. Enter the date you returned to work (if applicable). _____

20. **You must complete all boxes** to indicate if you have received or will receive any of the following payments for your days of sickness. If you check "YES" for any item, be sure to provide the requested information.

A. WAGES (Include Railroad and Nonrailroad Wages)

YES	NO	If "YES," show the dates for which you were paid in Month/Day/Year format below.
❑	❑	Regular Wages. . . . . _____
❑	❑	Vacation Pay . . . . . _____
❑	❑	Holiday Pay . . . . . _____
❑	❑	Military Reservist Pay . . . . . _____
❑	❑	Wage Continuation Pay . . . . . _____
❑	❑	Earnings from Self-Employment . . _____
❑	❑	Sick Pay from Your Employer . . . . _____

(but not payments supplementing Railroad Retirement Board (RRB) benefits. See Booklet UB-11)

B. GOVERNMENTAL PAYMENTS (Not RRB Sickness Benefits)

YES	NO	If "YES," enclose copy of award letter and complete Items 1 - 3 below.
❑	❑	Sickness or Unemployment Benefits Under Any Other Law
❑	❑	Social Security Benefits
❑	❑	Railroad Retirement or Disability Annuity
❑	❑	Military Retirement Pay
❑	❑	Worker's Compensation
❑	❑	Retirement Payments Under Another Law

1. Beginning Date of Payment _____
2. Gross Amount of Payment $ _____
3. How often do you receive the payment?
   ❑ Weekly ❑ Monthly ❑ Yearly
   ❑ Other: _____

C. OTHER PAYMENTS

YES	NO	If "YES," complete Items 1 and 2.
❑	❑	Settlement, Judgment or Damages for Personal Injury
❑	❑	Advances
❑	❑	Separation Allowance (Buyout, Severance Pay)

1. Date of Payment _____
2. Paid By: _____

21. If the date you are submitting this form is **more than 30 days** after the date you entered in Item 16, answer the following:

A. Why did it take more than 30 days to submit this form? If more space is needed, attach a separate sheet of paper.

_____

B. How did you obtain this form? _____

C. Who provided this form to you? _____

D. On what date did you obtain the form? _____

E. Furnish the name and title of any person from whom you asked for help in completing and filing the forms.

NAME_____ TITLE _____

Section E Direct Deposit Information

22. Benefits are normally paid by Direct Deposit to your bank, savings and loan, credit union, or other financial institution. To provide the information we need to correctly deposit your payments, **attach a voided personal check and go to Item 23**, or call your financial institution for the information you need to complete Items A-E.

A. Routing Transit Number | | | | | | | | | | B. Account No. _____

C. Account Type:
❑ Checking ❑ Saving

D. Name of Financial Institution: _____

E. Telephone No. (Include Area Code) (_____)_____

Section F Certification and Signature

23. I waive any "doctor-patient privilege" I may have with respect to the disclosure of information concerning the period of sickness or injury on which my claim is based. I certify that I understand and agree to the requirements in Booklet UB-11. I know that disqualification and civil and criminal penalties may be imposed on me for false or fraudulent statements or claims or for withholding information to get benefits from the RRB. I affirm that the information given on this form is true, correct and complete. **NOTE:** If the sick or injured employee is unable to sign this form, sign your name and complete Section 1 of the attached Form SI-10, Statement of Authority to Act for Employee.

SIGNATURE _____ **DATE** _____

Form Approved
OMB No. 3220-0039

Statement of Sickness

Instructions: ***This form is to be executed by (1) a doctor trained in medical, surgical, dental or psychological diagnosis of the infirmity described, (2) a certified nurse/midwife in cases of pregnancy or childbirth, (3) a supervisory official of a hospital or similar institution, (4) a chiropractor, (5) a Physician Assistant - Certified, or (6) a nurse practitioner. This form should be completed and returned to the patient immediately for prompt mailing; otherwise he/she may lose benefits. Supplementary medical information may be attached or furnished directly to the Railroad Retirement Board (RRB) at the address shown below. If such information is furnished, please include the patient's social security number and name on the report. Please complete section 2 on the reverse side if patient is incapable of signing forms.***

The RRB is not liable for any charge in connection with completing this form.

1. Patient's Name (First, Middle, and Last)	**2.** Patient's Social Security Number

3. Have you examined or treated the patient for his or her injury or illness? ☐ Yes ☐ No – **Go to Item 9**

a. Date patient became sick or injured	**b.** List all dates of examination and treatment for this infirmity
c. Probable date of next examination	

4. Diagnosis and concurrent conditions

5. Does the patient's condition require surgery? ☐ Yes ☐ No – **Go to Item 6**

a. Date on which surgery was or will be performed	**b.** Surgical procedure that was or will be performed

6. Does the patient's condition require hospitalization?

☐ Yes – Enter the period of hospital confinement: From _____ To _____

☐ No

7. If patient is not working because of maternity or childbirth, complete 7a and 7b.

a. Date patient became unable to work ▶ b. Estimated or actual date of delivery ▶

8. Give the date you believe the patient became or will become able to resume work in his or her occupation. (If indefinite or unknown, please give an estimated date.) ▶

9. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.

Please print or type:

Name of Doctor	Signature of Doctor	Degree/Title
Address	Office Telephone Number (Include Area Code) ( )	Date
	National Provider Identifier	

PAPERWORK REDUCTION ACT NOTICE TO DOCTOR

Medical evidence is needed to support the payment of claims for sickness benefits under the Railroad Unemployment Insurance Act (RUIA). The RRB is authorized to collect this information under section 12(i) of the RUIA. You are not required to furnish this information. If you do not, however, no benefits can be paid to your patient. We estimate this form and the form on the back of this page take an average of 8 and 6 minutes to complete, respectively. The estimates include the time for reviewing the instructions, getting the needed data, and reviewing the completed forms. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Chief of Information Resources Management, Railroad Retirement Board, 844 N Rush Street, Chicago, Illinois, 60611-2092. Send completed forms to:

U.S. RAILROAD RETIREMENT BOARD
OFFICE OF PROGRAMS—OPERATIONS
POST OFFICE BOX 10695
CHICAGO, ILLINOIS 60610-0695

Doctor: See Next Page

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0034

Statement of Authority to Act for Employee

Employee _____

Social Security Number _____

This statement is to be completed when applying for sickness benefits under the Railroad Unemployment Insurance Act (RUIA) on behalf of an employee who is incapable of signing documents and transacting business in connection with his or her benefit payments. The Railroad Retirement Board's (RRB) authority for obtaining this information is section 5(b) of the RUIA. **It is not necessary to file this statement for an employee who can sign papers by mark and understand the transactions.** In such a case, the application should be filled out for the employee, signed by the employee by mark, and the mark witnessed by two persons who should give their full addresses.

Although you are not required to provide information requested on this form, if you fail to do so, the RRB cannot grant authorization to you to act on behalf of the employee.

We estimate this form takes an average of 6 minutes to complete (4 minutes for the applicant and 2 minutes for the doctor), including the time for reviewing the instructions, obtaining the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to: Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-1275.

Please read the instructions on the *next page* concerning the completion and return of this form to the Railroad Retirement Board.

Form Approved
OMB No. 3220-0034

Statement Of Authority To Act For Employee

It is not necessary to complete this form for an employee who can sign papers or can sign by mark and understands transactions relating to his or her sickness benefits.

Instructions

1. Complete Section 1 and have the employee's medical doctor complete Section 2. If you are not related to the employee by blood or marriage, state your relationship and explain why no relative is acting for the employee. For example, an employee's union representative might explain: "I am his union chairman. He has no immediate family."

2. Complete this statement by following the instructions in the UB-11 booklet under "Instructions for Completing Forms, Statement of Authority to Act for Employee (SI-10)." Signing this statement gives you the authority to sign any claim forms on behalf of the employee. When signing claim forms use your full name, and beneath your signature, write "On behalf of" and the employee's full name.

3. Return this form with the next application or claim form you file with the RRB.

Section 1 Statement of Individual Acting for Employee

It is my belief that _____ _____
(Employee's Name) (Social Security Number)

whose address is _____
(Employee's Address)

is at this time incapable of signing forms in connection with obtaining sickness benefits under the Railroad Unemployment Insurance Act; of transacting the necessary business relative to his or her application and claims for such benefits; and of applying the proceeds of any sickness benefit payments.

I believe the employee to be incapable because _____

_____
(Briefly describe employee's condition)

My relationship to the employee is _____

I affirm that, in the transaction of business relating to the application and claims of this employee, including the use of any benefit payments, I will act on behalf of and in the best interest of the employee. I will promptly notify the RRB at such time as this employee's condition changes so that I need no longer act for him or her. I understand that criminal and civil penalties may be imposed on me for providing false, incomplete, or fraudulent statements; using the benefits received on something other than the claimant; or for withholding information to cause the payment of benefits. I certify that, to the best of my knowledge, the information I have provided is true, complete, and correct.

Name (please print)	Signature			Phone Number ( )
Street Address (please print)	City	State	ZIP Code	Date

Section 2 Statement of Employee's Doctor

I have examined the employee named above and find that he/she is incapable of signing forms and transacting business relative to his/her claims for sickness benefits under the Railroad Unemployment Insurance Act.

Name of Doctor (please print)		Signature of Doctor		
Office Street Address (please print)	City	State	ZIP Code	Date
National Provider Identifier				

RETURN TO WORK NURSES

KAYLA 402-544-6558

CHRISTIN 402-544-6552

DR. GILLIS 402-544-4679

Electronic Funds Transfer (EFT) Request Form

Instructions

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to The Hartford Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: ( ) - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: ( ) - _____

Type of Account (select one):

Checking: **Saving:**

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize (_____)
and affiliated companies (herein after called The Hartford), to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of A C H transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Hartford has received written notice from me (us) of its termination in such time and in such manner as to afford The Hartford and Depository a reasonable opportunity to act on it.

_____ _____

Signature(s): **Date:**

_____ _____

TERMS AND CONDITIONS

The Hartford will not be responsible for any banking fees charged for direct deposit or electronic funds transfer.

I understand that this agreement may be terminated by me upon written notice to The Hartford.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Hartford of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Hartford. I agree that the financial institution shall have the right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Hartford with my home address and the names of any joint account holders for the account specified herein.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Hartford of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Hartford. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Hartford with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Hartford or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Hartford if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Hartford.

Signature: _____ Date: _____

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

Signature(s) of Other Persons on Account: _____ Date _____

_____ Date: _____

NOTICE OF DISABILITY FORM – *Supplemental Sickness Benefit Plan*

The Hartford
P.O. BOX 14869
LEXINGTON, KY 40512
PHONE: (800) 205-7651
FAX: (833) 357-5153

THE HARTFORD is the claim administrator for your Railroad Supplemental Sickness Benefit Plan
Within 60 days of your first day absent from work call 1800-205-7651 or complete & mail or fax this form.

SECTION I THIS SECTION MUST BE COMPLETED BY OR ON BEHALF OF THE EMPLOYEE FOR ALL CLAIMS

Name of Employee (Please Print)	Date of Birth	Social Security Number	Employee Number

Employee's Address (Street) (City) (State) (Zip)	Telephone ( )	Hire Date

Name of Employer	Indicate which Organization represents you: ___ARASA
Department Last Worked / Location Last Worked	0 Maintenance of Way 0 Electrical Workers 0 Boilermakers, etc. 0 Other
Date You Last Worked / Next Scheduled Work Day	0 Signalmen 0 Railway Carmen 0 Firemen & Oilers
Rate of Pay (per hr./ per month) $	Occupation
Date You Became Disabled	Supervisor's Name / Telephone No. ( )
Name of All Treating Physicians / Telephone No. 1. ( )	Indicate Cause of Disability 0 Accident (Complete Part II) 0 Sickness
2. ( )	Have you returned to work? 0 Yes 0 No
3. ( )	• If Yes, provide your return to work date: _____ • If No, when do you expect to return to work? _____
4. ( )	Have you received vacation pay since your last day worked? 0 Yes 0 No provide date(s)
Date of First Treatment	Do you hold any of the following certifications? 0 Yes 0 No 0 DOT 0 CRANE 0 CDL 0 Other • If Yes, Have you been medically certified to return to work 0 Yes 0 No
Have you completed a total of at least 12 calendar months of employment with one or more participating railroads? 0 Yes 0 No	Did you work for the Employer named above (or take vacation with pay) in the month before you became disabled? 0 Yes 0 No

SECTION II TO BE COMPLETED ONLY IF ACCIDENT INVOLVED

Date of accident — Were you at work when the accident happened? 0 Yes 0 No — If yes, for whom?

Explain how accident happened

Was a railroad off-track vehicle involved? 0 Yes 0 No

Did injury result from a traffic accident 0 Yes 0 No

Will a liability claim be made? 0 Yes 0 No

SECTION III THIS SECTION MUST BE COMPLETED BY OR ON BEHALF OF THE EMPLOYEE FOR ALL CLAIMS

Benefits under the Railroad Unemployment Insurance Act:

1. Have you applied for sickness benefits under the Railroad Unemployment Insurance Act? 0 Yes 0 No

If not, why not? 0 I am not qualified under the Act 0 My benefits have exhausted for this benefit year 0 Other

Other Income Benefits:

1. Are any of the "Other Income Benefits" listed below available to you while disabled? (If yes, check each of the following that apply, and show the monthly amounts payable) 0 Yes 0 No

0	Railroad Retirement Act – Disability Annuity	$
0	Social Security Act 0 Because of Age 0 Because of Disability	$
0	Military Pension 0 Because of Years of Service 0 Because of Disability	$
0	Wage Continuation	$
0	Off-Track Vehicle Agreement	$
0	Protective Agreement	$
0	Advancement from possible settlement with Railroad	$
0	Any other plan toward the cost of which any employer has contributed. (Specify)	

FRAUD STATEMENT

If your application for benefits includes information that you know is false or misleading, you may be subject to criminal and civil penalties for fraud. Penalties may include imprisonment, fines, and denial of benefits. You may also be required to pay damages and could be subject to discipline by your employing railroad.

EMPLOYEE SIGNATURE: DATE:

You may file your claim over the telephone by calling: 1-800-205-7651, by mail, fax, or via the World Wide Web by logging onto: https://abilityadvantage.thehartford.com

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local , and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print)	Date of Birth	Employer/Policyholder's Name:

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as "My Information."

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. Without limiting the foregoing, I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes ; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud (all entities and individuals listed in this paragraph including The Hartford defined as "Benefits Manager(s)"). *I understand that My Information disclosed to Benefits Managers and re disclosed could include HIV/AIDS, other communicable diseases and mental health records.*

I understand that My Information disclosed to Benefits Managers pertaining to certain alcohol or drug abuse treatment is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of certain types of alcohol or drug abuse treatment records.

(Continue to next page)

Therefore:

☐ **If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.**

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself.

If I change my mind about this Authorization before that time is up, I can tell my Records Holders and The Hartford in writing that I do not want them to share any more information with other parties. If I revoke my Authorization by telling them in writing to stop sharing information with other parties, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

_____ _____

Signature of Claimant or Legal Representative **Date**

_____

Name and Relationship to Claimant *(if signed by Legal Representative)*

Form must be signed and dated.

Contact Information

Supplemental Sickness Benefit Plan

Member Services: 1-800-205-7651

Hours of Operation: 8:00AM-8:00PM EDT

Claim Submission Options

Phone: 1-800-205-7651

Fax: 833-357-5153

Website: https://abilityadvantage.thehartford.com

Mail: The Hartford
P O Box 14869
Lexington, KY 40512

Submitting Medical Documents
Quick Reference Guide

BUILDING AMERICA℠

HR Health and Medical Services

There are two recommended methods to submit documents to Health & Medical Services:

- Bar coded fax coversheet
- Upload documents to your case

See Also:

- Obtaining Additional Coversheets
- Confirming receipt of Medical Documentation
- Tips for Requesting Documents from Medical Provider

Using a Bar Coded Coversheet

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Using a Bar Coded Coversheet helps ensure that your documents get to the right person as quickly as possible. (*Documents faxed without using the bar coded coversheet may take up to 24 hours to get to Health & Medical Services.)*

If Health & Medical Services has requested information from you, you should have been provided a Bar Coded Fax Coversheet.

Place the Bar Coded Fax Coversheet on **TOP** of your documents and fax them into the number provided on the coversheet.

NOTE: You can only use the Bar Coded Coversheet once see "Obtaining Another Bar Coded Coversheet" for directions on how to get additional Bar Coded Coversheets.

THIS PAGE ON TOP

4000715019

Barcode No.	4000715019
Employee ID	[redacted]
Employee Name	[redacted]
Case Number	000001359835
Service Number	1001396055
Document Type	BAR
Physical Type	BAR

Print the following document and fax or email this cover page and medical document (in that order) to the number or email address below:

Fax Number: 402-501-0067

Email: ehealthsafe@up.com

Note: Do not use or reuse same cover page for faxing multiple documents. A new cover page must be printed from eHealthsafe portal for each document that need to be faxed.

The only visible barcode in your transmission should be the one on this sheet.To avoid transmission errors conceal any other barcodes that may appear on the information being submitted.

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Obtaining Additional Bar Coded Coversheet Pages

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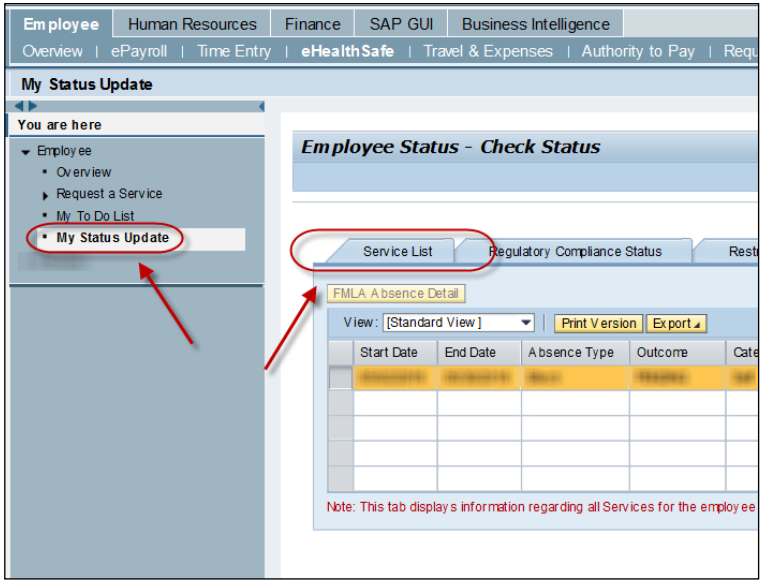
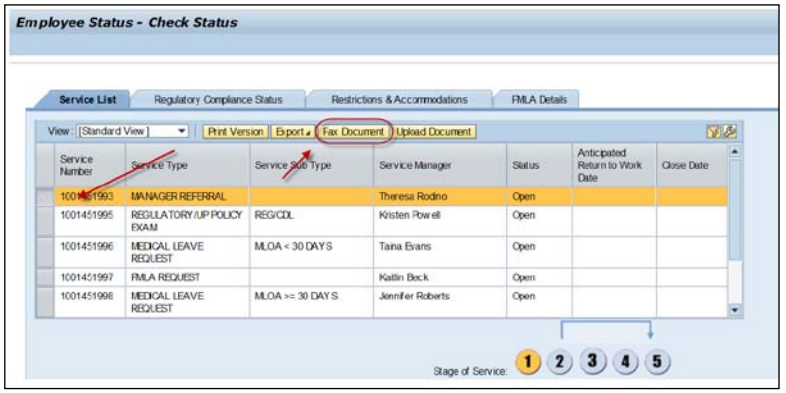
To print a fax coversheet page from the My Status Update Page:

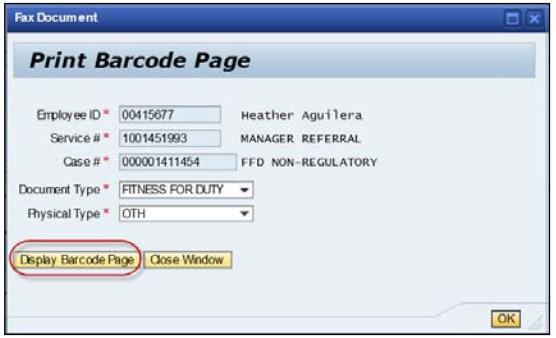
1. Go into eHealthSafe
2. Click My Status Update
3. Click on Service List



4. Highlight the Service you want to submit your document too
5. Click <**Fax Document**>



6. Click <**Display BarCode Page**>



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7. Print the Bar Coded Coversheet

8. Fax your medical documents with the Bar Coded Coversheet ON TOP of your documents.

   The Bar Coded Coversheet MUST be the first page you fax in or it will not assign to your service.

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Uploading Documents

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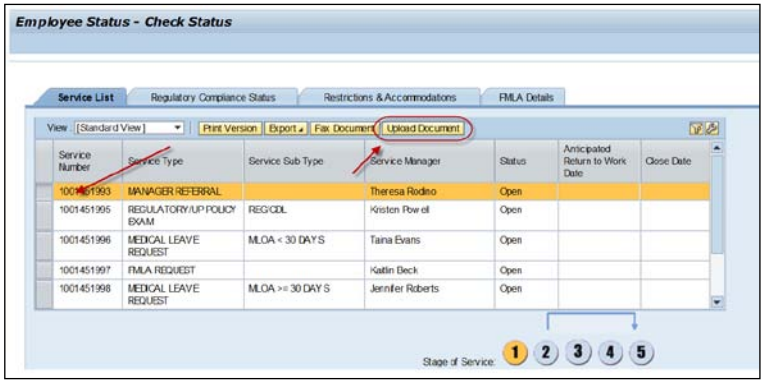
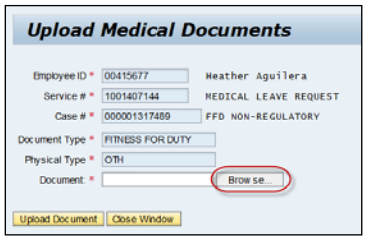
If you have electronic copies of your documents:

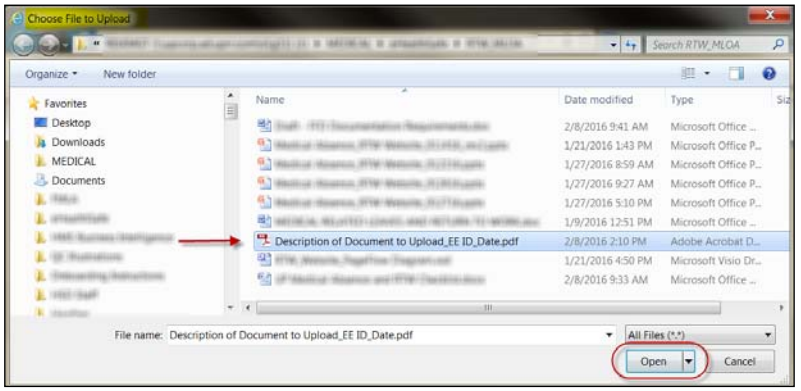
1. Save the document as a PDF(if possible)
2. Name the documents with the following Naming Convention:
   - Description of what the document is
   - Your Employee ID and
   - The Date of the Document
     i.e. ReleasetoWork_0015248_120315.pdf
3. Highlight the Service you want to submit your document too
4. Click <**Upload Document**>



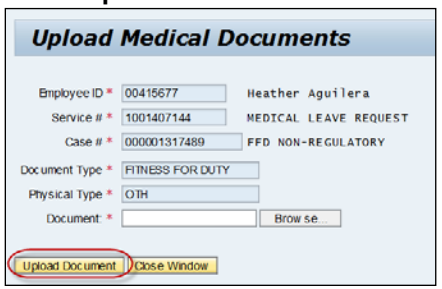
5. Click <**Browse**>



6. Select the File to Upload



7. Click <**Open**>
8. Click <**Upload Document**>



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Confirming Receipt of Medical Documents

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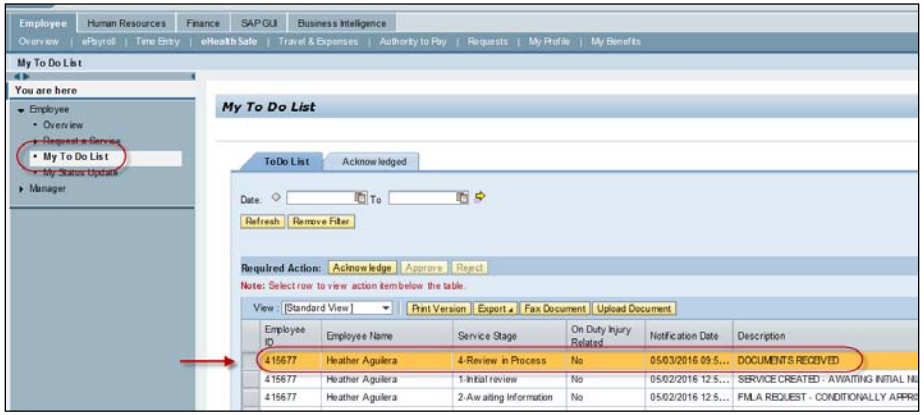
Employee may check eHealthSafe portal to confirm receipt of medical documentation.

When documents have been assigned to your Health & Medical Case a message is sent to your "My To Do List"



If medical has not been received within 72 hours of submission, contact FFD@up.com or the FFD Help Line at 1-402-544-7096.

Tips for Requesting Documents from Medical Provider

When requesting documentation from a medical provider, consider the following:

- Provide them the release of medical records included in mailing received from HMS.
- Provide them the bar code included in mailing received from HMS.
- Build understanding of their process for handling information requests, including when the documents will be sent.
- If requesting documents from a hospital, ask for the Medical Records department. Again, ask how long it will be before information is sent.

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