City of San Diego
Long-Term Disability Income Plan
Application

Instructions: This application consists of four forms. Please fill out the claims forms as completely and accurately as you can. If you need assistance, please contact the Long-Term Disability (LTD) Office at (619)236-6100. Our fax number is (619)533-3203 and our Email Address is LTD@sandiego.gov. The four forms are:

1. Authorization to Obtain and Release Other Income/Benefits Information (D-1) 2 pages

2. Employee Statement (D-2) 3 pages

3. Other Income Benefit Questionnaire (D-3) 2 pages

4. Attending Physician Statement (P-1) 2 pages
   Part A should be signed and dated by you. Please forward the Attending Physician's Statement to your physician for completion.

   If your health plan carrier is Kaiser: Please contact the Kaiser Disability Office to request an Attending Physician Statement.

   Your application (D-1, D-2 & D-3) must be submitted within sixty (60) days of your disability to:

Risk Management – M.S. 51B
Long-Term Disability Program
1200 Third Avenue, suite 1000
San Diego, CA 92101

PLEASE NOTE: FALSIFICATION OF THIS CLAIM MAY BE SUBJECT TO DISCIPLINARY ACTION AND/OR PROSECUTION

This information is available in alternative formats upon request

CITY OF SAN DIEGO
LONG-TERM DISABILITY INCOME PLAN
AUTHORIZATION TO OBTAIN AND RELEASE OTHER INCOME/BENEFITS INFORMATION

This form must be signed by you and returned to the City's Risk Management Department's Long-Term Disability Program

EXPLANATION: By signing this form, you authorize the City of San Diego's Risk Management Department to obtain information concerning benefits you are receiving or may be entitled to receive from the Social Security Administration, Veterans Administration, Workers' Compensation Appeals Board, San Diego City Employees' Retirement System, or other governmental agencies. You have the right to request and receive a copy of this Authorization once completed and signed.

TERM: This Authorization will remain in effect for 12 months from the date you sign this form or for the duration of your claim, whichever occurs first.

RE-DISCLOSURE: The information obtained by use of this form will be used exclusively for processing your claim for disability benefits and this information will not be released by the City of San Diego to any City employee or department or to any other person or organization except those who are performing business or legal services for the City of San Diego relating to the processing of your claim for disability benefits.

RIGHT TO REVOKE: If you change your mind, you have a right to revoke this authorization at any time by providing a written notice of revocation to the City of San Diego's Risk Management Department at the address listed on this form. The revocation will be effective immediately, except that the revocation will not have any effect on any action already taken by a third party to comply, or by the City of San Diego, or other party in reliance on this Authorization before it received my written notice of revocation. However, if you revoke this authorization, the City of San Diego may not be able to process your claim, which may lead to your claim being denied.

COPY OF INFORMATION RECEIVED PURSUANT TO THIS AUTHORIZATION: By checking the box below, I request that the City of San Diego provide me with a copy of all information or records it receives pursuant to this Authorization.

- ☐ Please provide me with a copy of all information received by the City of San Diego at the following address:

_____
_____
_____

Questions: You may contact the City of San Diego's Risk Management Department for answers to any questions you may have about the privacy of your health and benefits information at M.S. 51 B, Long-Term Disability Program, 1200 Third Avenue, Suite 1000, San Diego, CA 92101, by telephone at 619-236-6100, or by email at LTD@sandiego.gov.

I hereby authorize you to release to the City of San Diego's Risk Management Department copies of the records you have related to me on the following subject matter:

_____.

_____ _____
Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____
Name of Guardian/ Representative | Legal Relationship | Date

City of San Diego
Long-Term Disability Income Plan
EMPLOYEE STATEMENT

1. Personal Information

Social Security No. _____ Date of Birth_____

Name _____

(Last) (First) (Middle)

Address _____

City _____ State _____ Zip Code _____

Mailing Address if other than street address: _____

_____

Home Telephone No. _____ Work Telephone No. _____

Personal Email address that can be used to send LTD communications _____

Marital Status: Single _____ Married _____

If married, Spouse's Name _____

(Last) (First) (Middle)

Spouse's Social Security No. _____ Date of Birth _____

Dependent Children? Yes_____ No_____ If yes, number of dependent children? _____

Youngest child's date of birth _____

2. Employment Information

Current Department and Division Name _____

Current Classification _____

Supervisor's Name _____Supervisor's Telephone No. _____

Last day you worked full duty_____

3. Nature of Disability (Complete appropriate section a, b, or c.)

a) Illness

Describe_____ Date first noticed _____

Have you ever had the same condition or related illness before? Yes_____ No _____

If yes, Date such condition occurred? _____

b) Injury

Describe _____

Cause _____

Location of Accident _____

Date _____ Time: _____ a.m._____ p.m._____

Was the accident caused by another person or party? Yes _____ No_____

Was a Police Report completed regarding the accident or incident? Yes _____ No _____

c) Pregnancy

Expected delivery date _____

Foreseeable complications? Yes_____ No_____

4. Attending Physician

Name_____

Address_____

City_____ State_____ Zip Code_____

Please list other physicians' names and addresses who are currently treating you (including psychiatrist/psychologist).

_____ _____

_____ _____

5. Hospital (Complete if you were or will be hospitalized for this disability.)

Hospital Name_____ Address _____

Reason for Confinement _____

Date admitted_____ Date discharged_____

6. <u>History</u>

Significant injuries or illness (including any mental illness) which required medical treatment over the past five years.

Disability	**Date**	**Physicians' Name and Address**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Acknowledgment: I certify the above answers are true and complete to the best of my knowledge.

_____

Print/Type Name

_____ _____

Signature **Date**

City of San Diego
Long-Term Disability Income Plan
Other Income Benefit Questionnaire

Income you receive or are entitled to receive should be reported to assure proper calculation of your bi-weekly Long-Term Disability benefits. Please attach copies of any payroll vouchers or paystubs from your social security, San Diego Employees' Retirement, Workers' Compensation or any other income you are receiving, or which are available to you. If you are unable to make copies of these documents, please forward the originals. They will be photocopied and returned to you promptly. Please check either yes or no to the following income sources.

1. Are you currently receiving income from any of the following sources?

Wages, salary, or other remuneration:	**YES**	**NO**
City of San Diego?	_____	_____
Any other employer?	_____	_____
Any self-employment?	_____	_____
Retirement or Pension Benefits:		
City of San Diego?	_____	_____
Any other past employer?	_____	_____
Insurance Disability Benefits:		
Group Life Insurance?	_____	_____
Group Disability Income Plan?	_____	_____
Retirement Plan?	_____	_____
Government Sources		
Social Security Benefits?	_____	_____
Industrial Leave?	_____	_____
Workers' Compensation Benefits?	_____	_____
Unemployment Compensation?	_____	_____
State Disability Insurance?	_____	_____
Welfare?	_____	_____

	YES	NO
2. Are you currently receiving income from sources other than those listed under question 1, on account of your disability?	_____	_____
3. Do you expect to receive income benefits from any sources listed under question 1, or any other source?	_____	_____

If you answered yes to any of the previous questions, please provide the following information:

Name of Source	Amount	Frequency (Week, Mo., etc.)	Date Benefits Start(ed) or Will Start
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that I may be requested to furnish the LTD Plan Administrator, upon request, satisfactory information and/or documentation as to the amount I am receiving or expect to receive from any of the above income benefit sources. Copies of the following could be requested: IRS Form 1040 (signed and dated), paystub, pay voucher. If necessary, this information will be verified by the Internal Revenue Service and/or other employers. Failure or refusal to provide requested information or documentation; or, if erroneous or misleading information is provided, the LTD Plan Administrator has the authority to withhold, correct or adjust benefit payments based upon the facts or data available.

I understand falsification of this claim may be subject to disciplinary action and/or prosecution.

Insurance Fraud is a felony punishable by five years in state prison and a $50,000 fine.

Acknowledgement: I certify the above answers are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

Family Medical Leave Act (FMLA)

If your absence meets the qualifying criteria under FMLA, it will count toward your 12-week FMLA allotment even if it does not qualify for Long-Term Disability (LTD).