FAMILY MEDICAL LEAVE CHECKLIST for EMPLOYEES of INDIANA STATE GOVERNMENT

Did you…

- ☐ Notify your supervisor about anticipated absences?
- ☐ Review the website for FML for Employees of Indiana State Government at http://www.in.gov/spd/2397.htm including
  1. Information on eligibility and reasons for FML, and
  2. Instructions on the electronic request process, and
  3. Application forms for the State's Short/Long Term Disability Plan?
- ☐ Log-in to PeopleSoft® Self Service, choose Leave of Absence and then FMLA Leave Request?
- ☐ Review the pre-filled identifying information and make any corrections?
- ☐ Include at least one e-mail address?
- ☐ Complete all fields, save, and submit your FML Request?
- ☐ Receive an e-mail response that:
  1. you do not meet eligibility requirements so your request is denied, or
  2. your request and documentation were received and routed for processing, or
  3. you have a 15-day deadline to submit supporting documentation?

  If not, call the FML Line at 317.234.7955 or toll-free at 1.855.SPD.INHR to request assistance.
- ☐ Download and print the appropriate Certification Form at: http://www.in.gov/spd/2397.htm?
- ☐ Complete the identifying information sections on that certification and visit the health care provider who must complete the medical sections?
- ☐ Attach the completed certification within the specified time limit to that request in your PeopleSoft® Self Service account?
- ☐ Frequently check your e-mail account for notices related to your request?
- ☐ Comply with any request for clarification within the 7-day deadline?
- ☐ Receive notice of the approval or denial of your request?
- ☐ Use FML only for appropriate absences and in accordance with the approval notice?
- ☐ Comply with your agency's call-in procedures for absences, if applicable?
- ☐ Code your attendance/timesheets correctly for each use of FML as well as concurrent use of other leaves, as appropriate?
- ☐ Have questions? Call the FML Line at 317.234.7955 or toll-free at 1.855.SPD.INHR (1.855.773.4647).

INSTRUCTIONS FOR
SUBMISSION OF A
DISABILITY CLAIM
State Form 50106 (R/12-03)

STATE OF INDIANA
State Personnel Department, Benefits Division
Disability Program

Your Responsibility
THE APPLICATION

1 **Employee's Claim Statement:** Answer each question completely, **sign and date.** IF ALL QUESTIONS ARE NOT ANSWERED, IT IS NOT COMPLETE AND CANNOT BE PROCESSED.

2 **Employee's Authorization For Release of Information:** This **MUST** be signed and dated. Without a signature, your authorization is incomplete and will not be honored by your physician or hospital.

3 **Options Statement:** Please **complete, sign and date** this form.

4 Return the **Application** *(the three forms above)* to your Agency.

The Elimination Period for disability benefits is 30 consecutive calendar days. The elimination period for disability benefits from on-the-job injuries resulting from the tortious act of another person is 7 calendar days. The effective date for disability benefits cannot precede the date your application (the 3 *forms* listed *above) is* made. Late application **WILL** result in a loss of benefits.

1 **Attending Physician's Statement:** Complete the top portion and deliver to your physician.

DO NOT TAKE the Employee's Claim Statement, Employee's Authorization for Release of Information, or Option's Statement *(your application for benefits)* ***to*** **your physician.** This may result in a delay or loss of your benefits.

Physician's Responsibility

1 **Attending Physician's Statement:** After you have completed the top portion, your treating physician completes the remainder. Have your physician return the completed form to you or mail it to JWF Specialty. The Impairment Rating and the Disability Date must be on Attending Physician's Statement.

You are not eligible to receive benefits until the Attending Physician's Statement has been received by JWF Specialty to enable the determination of disability.

Agency's Responsibility

1 Complete the **Employer's Report of Claim.**

2 Confirm current salary, leave balance and last day worked.

3 Document the date the application is received.

4 Agency should send the **Employer's Report of Claim** and the employee's **Application** to JWF Specialty immediately. Caution: Do not wait for the Physician's Statement. This may cause a delay in the employee's benefits. You should also file a Report of Injury Claim if this is an on-the-job injury.

5 Forward Attending Physician's Statement to JWF Specialty upon receipt.

EMPLOYEE'S CLAIM STATEMENT

State Form 45544 (R6 / 7-17)

STATE OF INDIANA
State Personnel Department Benefits Division
Disability Program

This form is confidential per IC 4-1-8 and 31 IAC 3-1 4S.

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (888) 818-7795
Fax: (866) 893-4674

* The request for your Social Security number is MANDATORY according to IC 4-1-8 and this record cannot be processed without it.

EMPLOYEE'S CLAIM STATEMENT		
EMPOYEE NOTE: To avoid delay in processing, be sure all answers are complete. Use separate sheet if additional space is needed. Please print.		
Name of employee	PeopleSoft Identification	Social Security number *
Date of birth *(month, day, year)*	Sex ☐ Male ☐ Female	Home telephone number ( )
Address *(number and street, city, state, and ZIP code)*		
Job title	Name of agency	
IF THE DISABILITY IS DUE TO AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING SECTION:		
Date and time the accident happened ☐ A.M. ☐ P.M.	Is it work related? *(If "Yes", enclose Report of Injury)* ☐ Yes ☐ No	
Where did it happen? Give place / address. If at home, indicate.		
Describe injury and how it happened.		
If a vehicular accident, a police report must also be included.		
IF THE DISABILITY IS DUE TO AN ILLNESS, PLEASE COMPLETE THE FOLLOWING SECTION:		
Name of illness		
Date it began *(month, day, year)*	Date last worked due to accident / illness *(month, day, year)*	Date first treated by a physician for this accident or illness *(month, day, year)*
Name and address of physician:		
Name(s) / address(es) of all other physicians treating this injury / illness:		
IF HOSPITALIZED DUE TO THIS ACCIDENT OR ILLNESS, ANSWER THE FOLLOWING:		
Name of hospital		Date admitted *(month, day, year)*
Address *(number and street, city, state, and ZIP code)*		
I hereby certify that this is a true and complete statement to the best of my knowledge and belief. I understand that a fraudulent misstatement in completing this form will result in disqualification of eligibility for benefits.		
Signature of claimant **		Date signed *(month, day, year)*

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

State Form 50107 (R3 / 7-17)

STATE OF INDIANA
State Personnel Department,
Benefits Division
Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (888) 818-7795
Fax: (866) 893-4674

To Whom It May Concern:

I, _____ *(employee's name),* hereby authorize any hospital, physician, medical practitioner, clinic, other medically related facility, pharmacy, or Government agency, to disclose or furnish to the State of Indiana, JWF Specialty Co.*, or its representatives, any and all information with respect to the illness *(including mental illness, drug / alcohol abuse)* or injury causing the disability, including consultations, prescriptions, treatments and copies of all applicable records that may be requested.

This information provided to the State of Indiana or its representatives is to be used solely for the administration of disability claim(s) as captioned above. A photostatic copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

_____
Patient's or Authorized Person's Signature

_____
Authorized Person's Relationship

_____
Date *(month, day, year)*

* This authorization to release medical information to JWF Specialty Co. is only valid during the term of its contract with the State of Indiana.

Note: **A true copy of this authorization is available to the patient or the authorized representative at any time, upon request.**

OPTIONS STATEMENT

State Form 50108 (R2 / 7-17)

STATE OF INDIANA
State Personnel Department, Benefits Division
Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240
Telephone: (888) 818-7795
Fax: (866) 893-4674

Carefully read the following options. Please check the option that you wish to use. You may change your option at any time during the disability. The options can only be changed with the completion of a new Options Statement. The effective date for the change in options will be the date the new Options Statement is received by JWF Specialty Co., Inc. The change in options will only apply to future benefits.

After the thirty (30) day Elimination Period I elect:

☐ OPTION 1: BASIC DISABILITY BENEFITS 60% of regular biweekly salary while on Short Term Disability or see below *

☐ OPTION 2: INCREASED DISABILITY BENEFITS

May choose to receive 20% more than the basic benefit by using a prorated charge against accrued leave balance. *

Please indicate the order in which these days are to be used:

_____ SICK _____ PERSONAL

_____ VACATION _____ COMPENSATORY

Special Sick Leave may be used **once all other leave balances have been exhausted.**

Do you wish to use Special Sick Leave? ☐ Yes ☐ No

☐ OPTION 3: USE OF ACCRUED LEAVE

100% of regular biweekly salary by choosing to use your vacation, sick, personal, compensatory, or special sick leave at the rate of five (5) days per week in lieu of disability benefits. This option pays **NO** disability benefits. You will be paid by your agency.**

Please indicate the order in which these days are to be used:

_____ SICK _____ PERSONAL

_____ VACATION _____ COMPENSATORY

Special Sick Leave may be used **once all other leave balances have been exhausted.**

Do you wish to use Special Sick Leave? ☐ Yes ☐ No

*** Short Term Disability benefits may not exceed five (5) months. Long Term Disability benefits are 50% for the first two (2) years, 40% for third and fourth years.**

**** Once all leave is exhausted, you are automatically eligible for OPTION 1, provided all other requirements are met.**

If you were injured on the job and wish to increase your Workers' Compensation benefits by using your accrued leave, **CONTACT YOUR AGENCY**.

Signature of employee	Date signed (*month, day, year*)
Signature of witness	Date signed (*month, day, year*)

EMPLOYER'S REPORT OF CLAIM

State Form 45548 (R6 / 7-17)

STATE OF INDIANA
State Personnel Department
Benefits Division, Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (888) 818-7795
Fax: (866) 893-4674

* The request for your Social Security number is MANDATORY according to IC 4-1-8 and this record cannot be processed without it.

This information is to be completed by the agency.

Name of employee	PeopleSoft Identification	Social Security number *

Type of claim:
☐ Short Term Disability ☐ Tort ☐ Workers' Compensation Minimum Benefits

Salary (bi-weekly)	Payroll A or B	Latest hire date *(month, day, year)*

Date employee was last present at work *(month, day, year)*	Check one: ☐ Full Time ☐ Part Time

Leave balances as of 31st day off work:

_____ VACATION

_____ PERSONAL

_____ SICK

_____ COMPENSATORY

_____ SPECIAL SICK LEAVE *(if applicable)*

Date employee went or will go out of Pay Status *(month, day, year)*	Did claim result from job activity? ☐ Yes ☐ No	Has State Form 34401, Indiana Worker's Compensation First Report of Employee Injury, Illness, been filed? ☐ Yes ☐ No

If the employee chooses option #3, please notify the Disability Program before all leave has been exhausted.

Please add any additional comments:

Name of agency	Telephone number ( )

Address of agency *(number and street, city, state, and ZIP code)*

Name of person completing this form *(please print)*	Title

Signature of authorized representative	Date signed *(month, day, year)*

ATTENDING PHYSICIAN'S STATEMENT

State Form 45547 (R6 / 7-17)

STATE OF INDIANA
STATE PERSONNEL DEPARTMENT
Benefits Division, Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (888) 818-7795
Fax: (866) 893-4674

This form is confidential per IC 5-14-3-4(A) (9).

This form is to be completed without expense to the State of Indiana.

THIS SECTION IS TO BE COMPLETED BY EMPLOYEE / PATIENT *(Please print.)*

Name of patient	Date of birth *(month, day, year)*
Name of agency	
Job title	Gender ☐ Male ☐ Female

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

I. HISTORY

a.) When did symptoms first appear or accident happen?

b.) Has the patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown	If Yes, state when and describe.

c.) Name(s) and address(es) of other treating physician(s).

Is the condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No ☐ Unknown

II. DIAGNOSIS

a.) Diagnosis (including any complications)

b.) CPT code

c.) If pregnancy, estimated date of delivery *(month, day, year)*

d.) Subjective symptoms

e.) Objective findings *(including current x-rays, EKGs, laboratory data and clinical findings)*

III. TREATMENT

a.) Date of first visit *(month, day, year)*	b.) Date of last visit *(month, day, year)*

c.) Frequency of treatment:

Weekly _____; Monthly _____; Other *(specify)*: _____

d.) Nature of treatment *(including surgery and medications prescribed, if any)*

e.) Has the patient been hospital confined? ☐ Yes ☐ No	f.) If yes, dates confined from / through *(month, day, year)*

Name and address of hospital

IV. PHYSICAL IMPAIRMENT (* As defined in federal dictionary of occupational titles.)

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions * (0-10%)
- ☐ Class 2 - Medium manual activity * (15- 30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work * (35- 55%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical / administrative (sedentary) activity * 60- 70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity * (75- 100%)
- ☐ Other limitations: _____

V. MENTAL / NERVOUS IMPAIRMENT *(If applicable.)*

a.) Please define "stress" as it applies to this claimant

b.) What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no Limitations)
- ☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in limited interpersonal relations (moderate limitations)
- ☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- ☐ Other limitations: _____

_____

V. WORK STATUS

a.) Date patient became totally disabled from this condition *(month, day, year)*	b.) Anticipate return to work date?

VI. REMARKS

(Limitations, therapy, etc.)

I declare that I have examined this report and the statement contained herein is to the best of my knowledge and belief true, correct, and complete. I further understand that a fraudulent misstatement in completing this form would result in a loss of benefits for my patient.
Do not provide any genetic information when responding to this request.

Signature of attending physician	Date of last visit *(month, day, year)*

Printed name	Degree	Telephone number
		( )

Address *(number and street, city, state, and ZIP code)*