

STD PROCEDURES

for eligible monthly paid employees

Dartmouth College • Benefits Office • 7 Lebanon Street • Suite 203 • Hanover, NH 03755-2112
603-646-1296

PREREQUISITE

To apply for Short Term Disability (STD), the employee must be absent from work due to disability for more than 2 consecutive weeks.

It's very important that the employee keep the supervisor informed when absent from work. For this reason, requests from the Benefits Office for additional information about an STD claim or any supporting documentation will be made through the supervisor. It is the responsibility of the supervisor to contact the employee for the needed information and forward it to the Benefits Office.

APPLICATION

An STD application form should be completed by the employee and submitted to the Benefits Office through his/her supervisor. These forms are available in the Benefits Office and on the website. When it is not possible for the employee to complete this form (because of hospitalization, for example), the supervisor should complete it. Also, the supervisor must complete their section on the application.

It is recommended that the supervisor keep a copy of the application form for reference.

Retroactive applications for STD (submitted after the employee has returned to work) will be denied.

APPLICATION CHECKLIST

The following forms must be completed and sent to the Benefits Office:

- STD application form
- Medical certification form
- Authorization for release of information

MEDICAL CERTIFICATION

The application form must be accompanied by a Dartmouth College Medical Certification Form from the treating Health Care Provider. These forms are available in the Benefits Office and on the website.

Medical notes which indicate disability of a longer duration will need to be renewed at least every 6 weeks. Employees will be notified at least 1 week in advance when a renewal is required.

The medical certification must include the following information to be acceptable for consideration:

1. employee's name
2. initial date of disability
3. expected duration of incapacity
4. diagnosis
5. treatment plan
6. expected date of return to work (if unknown, date of next office visit)
7. signature of the treating Health Care Provider

It is important to bring any new medical certification to the Benefits Office as close or prior to the expiration of the earlier medical certification as possible so that the employee does not experience a break in STD payments. When necessary, medical certifications can be faxed to the Benefits Office at 603-646-1108.

Retroactive medical certifications are not acceptable.

PAYMENTS

The department pays the salary for the first 2 weeks of absence due to disability (this should not be counted as employee vacation time but does count as STD), and the Benefits Office begins payment on the third week of absence due to disability. Disability payments for the first 8 weeks are at 100% of pay; STD payments beginning on week 9 of disability are at 60% of pay. The maximum length of STD is 26 weeks.

PAYROLL AUTHORIZATION

The Benefits Office will generate a payroll authorization to begin payment of wages on the third consecutive week of absence from work due to disability.

Often, when STD payments change from 100% of pay to 60% of pay, employees like to use vacation time to make up the difference. When this is desired, the department will have to contact the Benefits Office with the appropriate account number for the vacation time charges, prior to the payroll deadline. The Benefits Office cannot solely authorize vacation time paid from the department's budget.

If the employee has not returned to work when STD payments end, it is important that the department realize the payroll system automatically begins paying salary again for the employee, once the Benefits Office submits a payroll authorization to terminate STD payments. To change this, the department must generate a payroll authorization.

STD AND FAMILY AND MEDICAL LEAVE

Under the provisions of the Family and Medical Leave Act (FML), employees can receive up to 12 weeks of paid and unpaid leave for specific reasons outlined in the employee handbook. To be eligible for FML you must have at least (12) months of continuous service and have worked at least 1,250 hours in the preceding (12) months prior to applying for FML.

Time on STD, as well as the first 2 weeks of disability absence, count as part of the annual allotment of the 12 weeks of FML.

The employee should contact the Benefits Office in cases where the STD benefits end and the employee plans to continue on FML.

RETURN TO WORK PART-TIME

When an employee returns to work part-time, wages for hours worked are paid by the department and STD replaces the regular hours not worked at the pay replacement level then available under STD (either 100% or 60%).

For example, an employee at the 60% pay level under STD returns to work on a part-time basis. The normal schedule is full-time, but the treating Health Care Provider recommends no more than half-time. The department pays half the regular salary; STD replaces 60% of the remaining half salary.

When the employee returns to work part-time, the department must notify the Benefits Office to coordinate the employee's pay.

STD AND WORKERS COMPENSATION

An employee receiving workers compensation payments can use STD in coordination for the number of weeks the employee is eligible for the 100% of pay level under STD only (no more than 8 weeks). In this situation, the employee will receive 60% of pay from workers compensation and 40% from STD. If the employee is still out of work when the number of weeks of STD at the 100% of pay level has expired, STD payments will end. Workers compensation payments are sent directly from the carrier, not Dartmouth College's Payroll Office.

REQUEST FOR AN INDEPENDENT MEDICAL EXAMINATION

The Benefits Office may request at any time that the employee using STD meet with a physician for an independent medical examination (IME). If this occurs, the full cost of the examination is paid by the Benefits Office. The Benefits Office will make this request through a letter sent directly to the employee.

To continue STD benefits, the appointment for the IME must be made within the time frame indicated in the letter and the employee must keep the appointment.

LONG TERM DISABILITY

When an employee is not expected to be able to return to work at the expiration of STD benefits, the employee may wish to apply for Long Term Disability benefits, if eligible. Generally, this begins after three months of absence due to disability. The employee should contact the Benefits Office directly. Prerequisites to receiving LTD benefits include: six months of absence due to disability within a 12 month period, application for a Social Security Award, and completion of LTD application forms.

QUESTIONS

This sheet cannot cover all the individual situations we've encountered when employees use STD and is not intended to be a Summary Plan Document. Please refer to the employee handbook for more information or call the Benefits Office at 603-646-1296 if you have questions.

SHORT TERM DISABILITY APPLICATION FORM

Rev(02/02)

Section 1 - Completed by the EMPLOYEE

Name: _____ Employee I.D. # _____

Home Address: _____ Social Security # _____

_____ Home Phone: _____

Description of Disability: _____

Doctor's Name and Address: _____

If confined to a hospital...

Name/location of hospital: _____

Date admitted: _____

If disability is due to an accident...

Date of accident: _____ Did it occur at work? _____

Time of accident: _____ Did you file for Workers' Compensation? _____

Signature of Employee: _____ Date: _____

NOTE: The employee must submit a medical certification signed by a Health Care Provider and an authorization for release of information.

Section 2 - Completed by the SUPERVISOR

Supervisor's Name: _____ Department: _____

Contact Person: _____

Phone Number: _____ Hinman Box: _____

Date Employee Last Worked: _____

Employee's Normal Work Schedule: _____ Shift (circle:) **1 2 3**

(Please show total work hours per day)

_____ S M T W T F S

Is the employee affected by any shutdowns? (circle:) Y / N / Not Applicable

If yes, list dates: _____

If the employee is paid by a grant, when does it expire? _____

Signature of Supervisor: _____ Date: _____

Section 3 - Completed by the BENEFITS OFFICE

Date of Employment: _____ Length of Service: _____

Maximum STD: _____ Maximum 100%: _____

Ben Cat: _____ Hours Per Year: _____

FTE: _____ D.O.B. _____

Age: _____ Hourly/Monthly Rate: _____

Job Code: _____ Location: _____

Job Title: _____

First Five days/First Two weeks: _____

Start Date: _____ End Date: _____

Total # of weeks/days out: _____ Total \$ Received: _____

DARTMOUTH COLLEGE MEDICAL CERTIFICATION FORM
Certification of Health Care Provider for
Employee's Serious Health Condition
Family and Medical Leave Act (WH-380-E)

Return form to: Dartmouth College Benefits Office, 7 Lebanon Street, Suite 203, Hanover, NH 03755 Fax: 603-646-1108

SECTION I: For Completion by the EMPLOYER

Employer name and contact: _____

Employee's job title: _____

Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE INSTRUCTIONS to the EMPLOYEE:

Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER INSTRUCTIONS to the HEALTH CARE PROVIDER:

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes If so, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition?

No Yes

Was medication, other than over-the-counter medication, prescribed?

No Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes If so, state the nature of such treatments and expected duration of treatment: _____

2. Is the medical condition pregnancy?

No Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition:

No Yes

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

No Yes

If so, estimate the beginning and ending dates for the period of incapacity: _____.

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?

No Yes

If so, are the treatments or the reduced number of hours of work medically necessary?

No Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

No Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?

No Yes If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

