

# STD PROCEDURES

*for eligible bi-weekly 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 one normal work week schedule. STD begins replacement of pay on the first work day of the second work week.

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 to forward the needed information 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 form.

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.

## STD DEADLINE

The complete application form, as well as medical certification, **must** arrive in the Benefits Office by noon, 10 days prior to the pay date.

## 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
- Time sheet indicating the first work week out on disability

## TIME SHEETS

The supervisor should submit time sheets showing the first week of absence due to disability to the Benefits Office when submitting the application form. The Benefits Office will complete time sheets for STD payments beginning on the first work day of the second week out on disability.

Often, when STD payments change from 100% of pay to 60% of pay, employees like to use personal or vacation time to make up the difference. When this is desired, the department will have to complete a time sheet for the personal or vacation hours claimed and forward the original form with the supervisor's signature to the Benefits Office prior to the payroll deadline so that STD hours can be added to the time sheet. (Only one time sheet per pay cycle can be submitted to Payroll for the individual.) The Benefits Office cannot authorize personal and vacation hours paid from a department's budget.

## 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.

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

Medical certifications 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.

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.

## 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 week of the disability absence where the employee must take personal, vacation, or unpaid time, all 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 an 8-hour workday, but the treating Health Care Provider recommends no more than 4 hours of work per day. The 4 hours worked are paid by the department at the regular wage; STD replaces 60% of the remaining 4 hours not worked (2.4 hours).

When the employee returns to work part-time, the department must complete a time sheet for hours worked and forward this to the Benefits Office before the payroll deadline. The Benefits Office will add STD hours to the time sheet and forward it to the Payroll Office.

## **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 <sup>2/02</sup>

FOR FAMILY MEDICAL LEAVE AND SHORT TERM DISABILITY PLAN

Return form to: Dartmouth Benefits Office 7 Lebanon Street, Suite 203, Hanover, NH 03755

Fax: 603-646-1108

## TO BE COMPLETED BY EMPLOYEE

Employee's Name	Social Security Number
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Patient's Name (if different from employee)

**Complete this section if the Family Medical Leave is to care for a family member:**  
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee's Signature	Date:
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## MUST BE COMPLETED BY HEALTH CARE PROVIDER

Date of examination	Date of onset of illness/injury
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First Date of Disability - (out of work)

Expected duration of incapacity	Expected date of return to work
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**Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories below:**

Does the patient's condition qualify as a "serious health condition" under any of the categories described? If so, please check the applicable category.

- (1)  (2)  (3)  (4)  (5)  (6)

- Hospital Care** - Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with such inpatient care.
- Absence Plus Treatment** - A period of incapacity of more than three consecutive days, including any subsequent treatment or period of incapacity relating to the same condition that also involves:
  - Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider; or
  - Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.
- Pregnancy** - Any period of incapacity due to a pregnancy, or for prenatal care.
- Chronic Conditions Requiring Treatments** - A chronic condition which:
  - Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of the health care provider.
  - Continues over an extended period of time (including recurring episodes of a single underlying condition); and
  - May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes).
- Permanent/Long Term Conditions Requiring Supervision** - A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under continuing supervision of, but not by receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
- Multiple Treatments (non-Chronic Conditions)** - Any period of absence to receive multiple treatments by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment.

Please complete next page ►►

**Section I**

State the approximate **date** the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present **incapacity** if different):

Will it be necessary for the employee to take work only **intermittently or on a reduced schedule** as a result of the condition? If yes, give possible duration.

If the condition is a **chronic condition** or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**.

**Section II**

If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment on an intermittent or part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

If any of these treatments will be provided by **another provider of health services** (e.g. physical therapist), please state the nature of the treatments:

**If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

**Section III**

(a) If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work of any kind**?

(b) If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or Dartmouth can supply you with information about the essential job functions)?

(c) If yes, please note the essential functions the employee is unable to perform.

If neither (a) nor (b) applies, is it necessary for the employee to be **absent from work for treatment**?

**Section IV**

If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

(a) If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

(b) If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

**Section V**

**I certify that I have completed the Health Care Provider Section of this form. Telephone number:**

Print name of Health Care Provider

**Signature of Health Care Provider**

**Date:**

**Dartmouth College**  
**Short Term Disability/Family Medical Leave**  
**AUTHORIZATION FOR RELEASE OF INFORMATION**

**PERSONAL INFORMATION**

Employee's Name: \_\_\_\_\_  
(please print)

Patient's Name (if different): \_\_\_\_\_

Employee's Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient's Social Security Number (if different): \_\_\_\_\_

**TO BE COMPLETED BY PATIENT OR PARENT OF MINOR CHILD:**

**Medical Release Form**

I hereby voluntarily authorize any doctor, hospital, clinic or other medical institution to disclose and furnish copies of any and all medical information concerning the disability described below to the Coordinator of Short Term Disability or an authorized Dartmouth College representative. A photocopy of this authorization shall have the same effect as the original.

Nature of Disability: \_\_\_\_\_

Date of Onset of Disability: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature (if different): \_\_\_\_\_ Date: \_\_\_\_\_

**Return to:**

Dartmouth College  
Benefits Office, Hinman Box 6042  
7 Lebanon Street, Suite 203  
Hanover, NH 03755

*If you have questions about this form, please call (603) 646-1296 or fax (603) 646-1108*