CHECKLIST FOR:
SHORT TERM DISABILITY WRAP FOR FULLY-INSURED PLANS

General Information

Employer's Full Name: _____

Address: _____

_____

Telephone: _____

Employer Identification Number: _____

Plan Sponsor *(if different from Employer)*: _____

Plan Administrator *(if different from Employer)*: _____

Plan Year: _____ through _____

ERISA Plan Number: _____

Agent for Service of Process: _____

Address: _____

_____

Telephone: _____

Trustees *(if any)*: _____

Address: _____

_____

Telephone: _____

Name of Carrier: _____

Address: _____

_____

Telephone: _____

Title or Name of Contact Person for Questions: _____

Telephone: _____
Fax: _____
Email: _____

Original Effective Date: _____

Restated Date: _____
(Date when you plan to distribute this document – must be at least 20 days following submission)

Participating Employer(s): _____
_____

(Employers whose employees are eligible to participate in this plan – must be affiliated companies – if you are unsure whether the entities meet ERISA's requirements for affiliation, please describe the relationship.)

Does HIPAA apply to the Employer(s)? Yes _____ No _____
(HIPAA applies to group health plans and group health insurance coverage for any plan year if, on the first day of the plan year, the plan has 2 or more participants who are current employees. It does not apply to any plan or coverage providing "excepted benefits," which include limited scope dental or vision benefits if offered separately from any other benefits.)

Does COBRA apply to the Employer(s)? Yes _____ No _____
(COBRA applies to all group health plans maintained by all public and private employers, other than churches; governmental entities of the U.S., the District of Columbia and U.S. territories and possessions; state and local government agencies that are not recipients of PHSA fund; and employers, including related employers, whose total number of employees (full-time and part-time), including leased employees, was less than 20 on at least 50% of the typical business days in the prior calendar year.)

Does FMLA apply to the Employer(s)? Yes _____ No _____
(FMLA applies to private sector employers of 50 or more employees and public agencies.)

Is this a Union Plan (maintained pursuant to a collective bargaining agreement): _____
If so, what is the Name of the Union: _____
If so, what is the Local Number: _____
If so, what is the Local Location: _____

Is this a Government Plan: _____
If so, is HIPAA applicable: _____
(A "Government Plan" is any plan established or maintained for its employees by the U.S. Government, the government of any state or political subdivision thereof, or by any agency or instrumentality of the foregoing. It also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act, and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act.)

Is this a Church Plan: _____

If so, is HIPAA applicable: _____

(A "Church Plan" is a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches which is exempt from tax under §501 of the Internal Revenue Code of 1954 ("IRC"). It does not include a plan where the employees or their beneficiaries are employed in connection with one or more unrelated trades or businesses (as described in IRC §513) or if less than substantially all of the individuals included in the plan are employees or beneficiaries. "Employee" means a duly ordained, commissioned or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation, or an employee of an organization which is exempt from tax under IRC §501 and which is controlled by or associated with a church or a convention or association of churches.)

Type of Benefit Plan: ***(Please list FULL name of plan (i.e., PPOBlue High Option II, Keystone HMO, etc.):***

_____

Address: _____

_____

Telephone: _____

Please enclose a copy of your most recent benefit materials received from Highmark, Concordia, Fashion Advantage, VBA, etc.

Are employees required to contribute for their coverage? Yes ____ No ____

Are employees required to contribute for dependent coverage? Yes ____ No ____

DEFINITIONS

"Employee"

Such person must be scheduled to work at least [_____] hours per week and at least [_____] months per year in order to be considered "full-time."

This excludes…

	…temporary employees…
	…seasonal employees…
	…casual employees…
	…leased employees…
	…inactive employees (for non-health related reasons)…
	…individual contractors.

ELIGIBILITY FOR COVERAGE

When am I eligible for coverage?

Each *employee* will become eligible for coverage under this *Plan* with respect to himself or herself on the [_____] day…

	…of the month following completion…

	…of completion…

…of a Service Waiting Period of [_____] days, provided the Employee has begun work for his or her Participating Employer.

If employment is terminated and the *employee* returns to *active employment* within [_____] from the date of termination, the *service waiting period* will be waived and coverage will take effect on the first day the *employee* returns to *active employment*.
VARIABLE – KEEP or REMOVE

When does coverage begin?
Newly hired *employees* who enroll in the *Plan* immediately upon hire will become eligible for coverage on the…

	…first day of the first pay period after the *employee* completed one full pay period of employment…
	…date the *employee* applies for insurance…
	…date the *insurance company* approves the *employee's* application.

Newly hired *employees* who enroll in the *Plan* after the first pay period, but within 31 days after the date of hire, will become eligible for coverage on the…

	…first day of the first pay period after the *employee* completed one full pay period of employment…
	…date the *employee* applies for insurance…
	…date the *insurance company* approves the *employee's* application.

What if I am temporarily not working?
If the *employee* is on a temporary lay-off, and the premium is paid, the *employee* will be covered through the end of the month that immediately follows the month in which the layoff begins.
VARIABLE – KEEP or REMOVE

TERMINATION OF COVERAGE

Does coverage terminate when the *participant* enters the *uniformed services*? _____

OPTION I (date/day of the event)
The coverage of any *employee* for himself under this Plan will terminate on the earliest to occur of the following dates:

- The date of termination of the *Plan*;
- The day of the month in, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;
- The date of the expiration of the last period for which the *employee* has made a contribution, in the event of his failure to make, when due, any contribution for coverage for himself to which he has agreed in writing;
- The date of the month in which he ceases to be eligible for such coverage under the *Plan*;
- [The date of the month in which a *participant* becomes a member of the *uniformed services*;]
  OPTIONAL – KEEP or REMOVE
- The date and time of the month in which the termination of employment occurs;
- Immediately after an *employee* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information; or
- The last day of the month for which the *participating employer* has made the required contribution.]

OPTION II – (last day of the month in which the event occurs)
The coverage of any *employee* for himself under this *Plan* will terminate on the earliest to occur of the following dates:

- The last day of the month following termination of the *Plan*;
- The last day of the month in, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;

- The last day of the month for which the *employee* has made a contribution, in the event of his failure to make, when due, any contribution for coverage for himself to which he has agreed in writing;
- The last day of the month in which he ceases to be eligible for such coverage under the *Plan*;
- [The last day of the month in which a *participant* becomes a member of the *uniformed services*;]
  OPTIONAL – KEEP or REMOVE
- The last day of the month in which the termination of employment occurs;
- The last day of the month in which an *employee* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information; or
- The last day of the month for which the *participating employer* has made the required contribution.]

PLEASE CHOOSE – OPTION I or OPTION II

CLAIM PROCEDURES

When must disability claims be filed?
Disability claims must be filed with the *insurance company* within [_____] **(days OR months)** of the date of the onset of the disability.

YOUR SHORT-TERM DISABILITY BENEFITS

Your Short-Term Disability Benefits

Benefit limits:	
Weekly Benefit	[_____]% of *weekly earnings* (not including overtime, bonuses or commissions) to a maximum of $[_____] per week
Minimum Benefit	$[_____]
Maximum Period of Payment	[_____] weeks per period of total disability
Benefits are payable:	
For *Illness*	Beginning on the [_____] day [, retroactive to the [_____] day if hospital confined/
For *Injury*	Beginning on the [_____] day [, retroactive to the [_____] day if hospital confined/

Am I entitled to short term disability benefits?
This benefit applies when you have a *total disability* that meets all of these tests:

	For purposes of this benefit, "*total disability*" and "*totally disabled*" means the complete inability to perform substantially all of the duties of your occupation as a result of *illness* or *injury*
	For purposes of this benefit, "*total disability*" and "*totally disabled*" means the complete inability to perform substantially all of the duties of your occupation [or of a similar occupation for which you are reasonably capable due to education and training,] as a result of *illness* or *injury*

	Your *total disability* is due to an *illness* or *injury* that, in either case, is non-occupational – that is, not arising from work for wage or profit;
	Your *total disability* is due to an *illness* or *injury* that, in either case, is non-occupational – that is, not arising from work for wage or profit [except as provided under the section, "Coordination with Worker's Compensation Benefits"];

The benefits of this *Plan* also apply when you have a *partial disability* that meets all of these tests:

	For purposes of this benefit, "partial disability" and "partially disabled" means an inability to perform substantially all of the duties of your occupation as a result of *illness* or *injury*, but, at the same time, the ability to work for the *participating employer* on a part-time or light-duty basis;
	For purposes of this benefit, "partial disability" and "partially disabled" means an inability to perform substantially all of the duties of your occupation [or of a similar occupation for which you are reasonably capable due to education and training,] as a result of *illness* or *injury*, but, at the same time, the ability to work for the *participating employer* on a part-time or light-duty basis;

- Such part-time or light-duty work is available for you with your *participating employer*;
- Your *partial disability* begins while you are covered for this benefit;
- Your *partial disability* is due to an *illness* or *injury* that, in either case, is non-occupational – that is, not arising from work for wage or profit except as provided under the section, "Coordination with Worker's Compensation Benefits"; and
- You are under the continuous care of a *physician* who is certifying the partial disability throughout the entire period of *partial disability*.

ENTIRE SECTION ABOVE IS OPTIONAL – KEEP or REMOVE

When will I receive payments?
You will begin to receive payments when the *insurance company* approves your claim…

	…and any applicable elimination period has expired.
	…and you have exhausted your sick leave.
	…and any applicable elimination period has expired and you have exhausted your sick leave.

Payments will be made…

	…weekly.
	…monthly.
	Other:

Payment Amount
When an *Employee* is disabled and eligible for payments under the *Plan*, the gross weekly payment is [_____]% of the *Employee*'s *weekly earnings,* subject to a specified weekly maximum.

The amount is reduced by any *other income* payable for the same month (see "*Other Income*" below).
OPTIONAL – KEEP or REMOVE

Partial Payments for Return to Work
Partial payments are calculated by subtracting 80% of the gross pay for the basic hours worked from the gross payment. The calculation is made on a or twice monthly basis, as appropriate. *Employees* working reduced hours must provide proof of earnings.
OPTIONAL – KEEP or REMOVE

Maximum Weekly Payment
The maximum weekly short-term disability payment for all employees is $[_____].

How long will I receive short term disability benefits?
Benefits under this *Plan* will terminate on the earliest of the following:

	Acceptance of employment with any employer;
	Acceptance of employment with any employer[, other than part-time or light-duty work with the *participating employer*];

	Performance of work for compensation or profit;

	Performance of work for compensation or profit [other than part time or light duty work for the *participating employer*];

	Cessation of a *physician's* certification of *total disability*;
	Cessation of a *physician's* certification of *total disability* [or *partial disability*];

	Return to work; or
	Return to work [on a full-time basis]; or

How will my benefits be coordinated with *other income* sources?
In addition, if you are *partially disabled* and are performing part-time or light duty work for your *participating employer*, wages received for this work will be integrated along with any other income or disability benefits, so that the total amount from all sources does not exceed the maximum weekly benefit amount stated above.
OPTIONAL – KEEP or REMOVE

If you wish to have other deductions made from your Short Term Disability Benefits, please contact the *Plan Administrator*.
OPTIONAL – KEEP or REMOVE

Coordination with worker's compensation benefits
If your *injury* or *illness* is work-related, and you are being covered for worker's compensation disability income benefits, you will be eligible to receive benefits for short term disability:

- For a time period required to satisfy any waiting period for benefits from worker's compensation, and
- For the amount of this *Plan's* maximum weekly benefit that is in excess of the weekly benefit amount from worker's compensation,

provided, however, that income or disability benefits available from all sources will not exceed the maximum weekly benefit stated above. For purposes of coordination of disability benefits with worker's compensation, the *Plan's* exclusion of coverage for work-related *illness* or *injury* will not apply.
OPTIONAL – KEEP or REMOVE

What is not covered?
No benefits will be paid for the following:

- Any days for which you receive wage allowances (according to the terms of a bargaining agreement, if any); however, these days will extend the maximum benefit period;
  OPTIONAL – KEEP or REMOVE

	Any days on which you work full-time, part-time or light-duty, for any employer;
	Any days on which you work full-time, part-time or light-duty, for any employer, [other than part-time or light-duty work with the *participating employer*];

	Any period of disability resulting from a work-related *injury* or *illness,* including that of previous employers or while self-employed;
	Any period of disability resulting from a work-related *injury* or *illness,* including that of previous employers or while self-employed, [except as provided through "Coordination with Workers Compensation"];

	Disability related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony

	Disability related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony. [This exclusion will apply only if the participant is convicted of the illegal act;]
	Disability related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony [or misdemeanor, or any illegal act or illegal occupation].
	Disability related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony [or misdemeanor, or any illegal act or illegal occupation]. [This exclusion will apply only if the participant is convicted of the illegal act;]

What happens if you return to work and your disability occurs again?

Related Disability
If your current disability is related to or due to the same cause(s) as your prior disability for which *Insurance Company* made payment your current disability will be treated as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for [_____] consecutive days or less.

HIPAA PRIVACY

Please list the TITLES ONLY of those persons who will have access to PHI:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____