HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

sedgwick®

Toll Free: 866-340-9284 Fax: 855-800-5116 Mail: PO Box 14648 Lexington, KY 40512

Date

Name
Address
City, State Zip

RE: Claim Number: ###############

Dear Name:

Sedgwick is the Third-Party Claims Administrator for the University of Michigan Long-Term Disability (LTD) Program. Please find the necessary forms enclosed that you will need to complete to apply for benefits under the LTD Plan. Please note, a *Faculty/Staff Member Signature* is required on all forms, and missing signatures may cause a delay in the process.

The LTD application forms should be returned to Sedgwick within **fifteen (15) calendar days** of the date of this letter. Failure to return the forms may cause your claim to be denied.

Please return your forms in one of the following ways:
Mail: PO Box 14648 Lexington, KY 40512 Fax: 855-800-5116 Email: claimdocuments@sedgwick.com

We will advise you if any additional information is needed. Upon receipt of your full medical file and LTD application forms, Sedgwick will review your claim for approval or denial of LTD benefits. You will be notified in writing once a claim determination has been made.

In accordance with LTD plan provisions, if your LTD claim is approved, you are required to apply for Social Security Disability Insurance (SSDI). You may be contacted by representatives from Integrated Benefits, Inc. (IBI) regarding our Social Security Advocacy Attorney Referral Assistance Program. The program is voluntary and at no cost to you; however, failure to apply for SSDI benefits will affect your eligibility for receipt of LTD benefits.

Please contact Sedgwick Monday through Friday, 8:00 a.m. to 4:30 p.m., if you have any questions regarding this correspondence.

Sincerely,

Examiner
Sedgwick, University of Michigan LTD
Toll Free: 866-340-9284
Fax: 855-800-5116

University of Michigan
WorkConnections
Illness and Injury Assistance

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

LONG-TERM DISABILITY (LTD) APPLICATION PROCESS CHECKLIST

	WHAT TO DO	WHEN TO DO IT
☐	Contact Work Connections at 734-615-0643 or toll-free at 877-869-5266, or visit their website at: workconnections.umich.edu/.	As soon as possible after you can no longer work or when you expect to be absent from work for a period of ten (10) consecutive days or more.
☐	Fully cooperate with Work Connections and provide medical information and documentation. This may include, but is not limited to: A Health Care Provider Statement (HCPS), A Functional Abilities Form (FAF), Clinical Notes, Summaries, and Diagnostic Testing Results, A Functional Job Description, and/or Any other medical evidence, documentation, or forms. To determine the nature and extent of your disability or impairment, you may be required to undergo examinations by other physicians/psychologists/psychiatrists and/or be interviewed by nurse case managers and/or vocational rehabilitation specialists.	You will work with Work Connections to determine the appropriate time to apply for LTD benefits.
☐	Complete the LTD application forms **before** termination of coverage or employment, retirement, reduction in force (RIF) leave, educational leave, military leave, or Workers' Compensation Redemption/Settlement. The UM Benefits Office and its Third-Party Claims Administrator, Sedgwick, are the only offices authorized to distribute and process an application for LTD benefits. The LTD application packet includes: **Employee Request for Participation and Personal Profile** **Medical Release Authorization** **Other Disability Income and Reimbursement Agreement** **Social Security Administration Consent for Release of Information**	Within 15 days from the date of the cover letter included with the forms mailed to you.
☐	Undergo examinations by other physicians/psychologists/psychiatrists and/or meet with nurse case managers and/or vocational rehabilitation specialists.	As requested by Sedgwick
☐	Contact the Social Security Administration (SSA) to apply for Social Security Disability Income (SSDI) benefits. You can contact SSA by phone at 1-800-772-1213 or visit their website at: ssa.gov	Immediately upon approval of LTD benefits, if not already done.

For further information about the university's LTD Program, please visit the Benefits Office website at: http://benefits.umich.edu/plans/ltd. You may also contact a benefits representative at 734-615-2000 during normal business hours.

Employee Request for Participation and Personal Profile

The University of Michigan Long-Term Disability Plan

Name:
Claim Number:

Please complete all pages of this application to submit your claim for Long-Term Disability (LTD) benefits and return within 15 calendar days from the date the forms were mailed to you. Omitted information will cause delays, and in no case will your application be accepted after your employment with the university has terminated or LTD coverage is no longer in force.

Please return your forms in one of the following ways:
Mail: PO Box 14648 Lexington, KY 40512 Fax: 855-800-5116 Email: claimdocuments@sedgwick.com

SECTION I

CONTACT INFORMATION

1. Faculty or Staff Member Information.

Name (Last, First, Middle Initial)		UMID	☐ Single
Street Address	City, State, Zip	Daytime Phone Number	☐ Married ☐ Divorced
Title	Date of Hire	Email Address	☐ Widowed

2. Authorized Alternate Contact Information.

If you have a family member, friend, or other support person you would like to list as an authorized alternate contact for the University of Michigan and its Third-Party Claims Administrator, York Risk Services Group, Inc., please provide his or her information below.

Name (Last, First, Middle Initial)		Email Address
Street Address	City, State, Zip	Daytime Phone Number
Relationship to You (i.e., spouse, partner, son, daughter, friend)		

3. Spouse, Partner, and/or Dependent Information.

Please provide the following information for your spouse, partner, dependent children under age 19, and/or disabled dependent children who are any age.

Last Name	First Name	UMID (if applicable)	Relationship	Date of Birth MM/DD/YY	Gender M/F	Disabled?
						Yes No
						Yes No
						Yes No
						Yes No

Name:
Claim Number:

SECTION II
EDUCATION, TRAINING, AND EXPERIENCE

1. Please indicate your current and previous occupations. _____

2. Are you involved in any kind of business for wage or profit (as sole owner, co-owner, consultant, manager, investor, etc.)? Yes ☐ No ☐
If Yes, please provide further details as to the extent of your involvement/participation in the business.

3. Please indicate: Your highest level of education: _____
Specific degree(s) and/ or certifications held: _____
Any trade, vocational program, or other special training you have completed or expect to complete:

4. Have you served in the military? Yes ☐ No ☐
If Yes, please indicate the dates you served: _____
Your branch and rank: _____
The job/roles you held while serving: _____

5. Do you participate in any social or community activities? Yes ☐ No ☐

Do you hold offices in any group(s)? Yes ☐ No ☐
If Yes, please list and describe each activity and/or office. _____

6. What kind of hobbies, interests, or other activities do you have (fishing, bowling, sewing, swimming, traveling, sports, movies, etc.)?
Please list all hobbies or activities and indicate how often you participate in each. _____

7. Please indicate any other skills you have acquired as a result of your education, training, or work experience.

8. Do you possess a valid driver's license? Yes ☐ No ☐
Do you drive a motor vehicle? Yes ☐ No ☐
If Yes, how often do you drive and what is the typical distance you travel?

Name:
Claim Number:

SECTION III
MEDICAL INFORMATION

1. Please describe the nature of your illness or injury: _____
   What date did you first treat for this illness or injury? _____
If due to injury, what was the date of the accident? _____
   Where and how did the accident occur? _____
Please list all physical and/or psychiatric/psychological symptoms, complaints, and limitations: _____

2. What was your most recent last day of work prior to your current illness or injury? _____

3. Please list all physicians you have consulted because of your current illness or injury.

Physician Name/Specialty	Telephone	Hospital Affiliation	Treatment Dates / Date Range

4. Please list all inpatient hospital stays related to your current illness or injury.

Name of Hospital	Admission Date	Discharge Date

5. Do you need any special help to take care of your personal needs and grooming? Yes ☐ No ☐
   If Yes, please indicate what kind of help you require (washing, bathing, dressing, and so on), why, and how often.

6. Please provide a detailed description of your daily activities, including household chores such as laundry, vacuuming, dusting, mopping, washing dishes, household repairs, lawn care, shoveling snow, shopping, etc.

7. Have there been any changes in your ability to do these activities since your condition began? Yes ☐ No ☐

   Do you need assistance with completing any of the above activities? Yes ☐ No ☐

   If Yes, please indicate what kind of help you need. _____

Name:
Claim Number:

8. In your opinion, how do your symptoms, complaints, and limitations prevent you from performing your usual job duties?

_____
_____
_____
_____

9. Have you discussed returning to work with your physician(s), your department or human resources, or other rehabilitation specialist(s)?
Yes ☐ No ☐ If Yes, please provide further details including the opinions of those with whom you have discussed returning to work

_____
_____
_____
_____

10. On what date were you able to return to work, or on what date do you expect to return to your current occupation?

_____

11. Do you expect to return to work in another occupation on a full-time or part-time basis? Yes ☐ No ☐ If Yes, please provide further details.

_____
_____
_____

SECTION IV
Other Disability Income

1. Have you applied for, or are you entitled to, benefits from the following sources because of your current illness or injury?

Social Security Disability Income (SSDI) Benefits	Yes	☐	No	☐	Date applied: _____	Date awarded: _____
Workers' Compensation	Yes	☐	No	☐	Date applied: _____	Date awarded: _____
Veterans Affairs Disability Compensation	Yes	☐	No	☐	Date applied: _____	Date awarded: _____
Travel Accident Benefits	Yes	☐	No	☐	Date applied: _____	Date awarded: _____
Canada/Quebec Pension Plan Benefits	Yes	☐	No	☐	Date applied: _____	Date awarded: _____
Any Other Federal, State, Provincial, or Public Program	Yes	☐	No	☐	Date applied: _____	Date awarded: _____

NOTE: If LTD is approved, applying for SSDI is a requirement under the University of Michigan LTD Plan. You may be contacted by representatives from Integrated Benefits, Inc (IBI) regarding our Social Security Advocacy Attorney Referral Assistance Program. This program is voluntary and at no cost to you; however, failure to apply for SSDI benefits will affect your eligibility for receipt of LTD benefits.

2. If you answered Yes to any above, please return a copy of your application confirmation, award notice, or denial notice from each agency.

SECTION V
Statement of Disability Certification and Signatures

I believe that I am now totally disabled and unable to work. I believe that my disability has lasted, or is expected to last, for a continuous period of not less than twelve (12) months from my last day of work. I request that I be placed on the Long-Term Disability (LTD) Plan until recovery, retirement, in the event of death, or as otherwise defined under the provisions of the LTD Plan.

I have reviewed the LTD Plan booklet available online at https://hr.umich.edu/benefits-wellness/financial/long-term-disability-plan/long-term-disability-forms-documents and agree to abide by the terms of the LTD plan.

I hereby certify that all information I have given in this application is true and I understand that any willful falsification of facts presented may result in my claim being denied and/or the pursuit of legal action by the University of Michigan.

_____ _____
Faculty/Staff Member Signature Date

Medical Release –
Claimant Information Release Authorization
The University of Michigan Long-Term Disability Plan

Name:
Claim Number:
DOB:

I, _____, hereby authorize and direct any and all medical providers and facilities to release
(Print Name)
information contained in my patient records and to disclose any such information to authorized representatives of the University of Michigan (U-M), Sedgwick, approved managed care services and social security vendors, vocational rehabilitation vendors, and medical management vendors.

This specifically includes, but is not limited to, all medical, psychiatric, dental, hospital, clinical, employment, insurance claims, vocational records, and other such information. This authorization allows the University of Michigan, Sedgwick, and approved managed care services and approved social security vendors, approved vocational rehabilitation vendors, and approved medical management vendors to release and share the above-mentioned information and records with each other.

This release is valid during the pendency of my LTD claim and shall expire when my claim concludes. The purpose of this disclosure is to provide medical and related documentation in order for my claim(s) for LTD benefits to be adequately evaluated. This release may be revoked at any time. However, any information already obtained as a result of this release may be used for the purpose of evaluating my LTD benefit claim(s). I understand once the information has been disclosed, Michigan Medicine and/or my provider can no longer protect it from further disclosure. I understand that the records released for the above purpose will be handled in a confidential manner, and utilized only for the purpose of determining my U-M employment and LTD benefits.

This medical release can be faxed, or copied, and a fax or photocopy of this medical release is as valid and acceptable as the original medical release. I understand that failure to provide a signed copy of this medical release may prevent Sedgwick from processing my LTD claim and may result in the denial of my LTD claim.

_____ _____

Long-Term Disability Participant Signature **Date**

We value your privacy. For more on what personal information we may collect, how we may use this information and other important areas relating to your privacy and data protection, please read our privacy notice www.sedgwick.com.

Other Disability Income and Reimbursement Agreement
The University of Michigan Long-Term Disability Plan

Name:
Claim Number:

I, _____, hereby acknowledge that I have received a copy of the University
(Print Name)
of Michigan (U-M) Long-Term Disability Plan booklet and understand that I must pursue, to the fullest extent possible, Other Disability Income (ODI) for my dependents and me. ODI includes, but is not limited to, Social Security Disability and/or Early Retirement Insurance Benefits, other Retirement Benefits, Workers' Compensation, Veterans Affairs (VA) Disability Compensation, Travel-Accident Benefits, and/or any other source of income from a public program. If approved, I understand that ODI will be subtracted from my maximum LTD income replacement benefit for coordination. As such, I agree to:

1. Apply immediately for ODI benefits in which me or my dependents may be eligible as stipulated under the terms of the U-M LTD Plan, and
2. Inform and provide the U-M Benefits Office with a copy of **all pages** of any written correspondence, including award and denial letters for me and my dependents, for ODI benefits within seven (7) days.

If I do not apply for ODI, do not provide information upon request, or fail to provide the U-M Benefits Office with ODI award and/or denial letters, the U-M Benefits Office has the right to:

- Reduce the LTD benefits by the amount of ODI my dependents and I are eligible to receive, as determined by the U-M based on its reasonable estimation,
- Withhold or discontinue all LTD benefits, and/or
- Seek termination of my employment status.

When an LTD overpayment occurs, it is my responsibility to notify and repay the U-M in full within fifteen (15) days of such overpayment. If I fail to do so, I will promptly repay the U-M within fifteen (15) days of written notice from the U-M Benefits Office. To repay U-M in full, I promise to reserve any lump sum payment(s) from the Social Security Administration or any other office for my dependents and me. If full repayment is not received within fifteen (15) days from the date of notice from the U-M Benefits Office, the U-M Benefits Office has the right to:

- Reduce my LTD benefits by the full amount of the overpayment (without receiving credit for or being entitled to offset any attorney fees or other costs incurred by me related to the overpayment),
- Withhold or discontinue all LTD benefits,
- Seek termination of my employment status, and/or
- Pursue collection efforts and any other available legal rights in order to recover my LTD overpayment.

Other Disability Income and Reimbursement Agreement
The University of Michigan Long-Term Disability Plan

Name:
Claim Number:

In addition to the foregoing, I promise to pay all attorney fees, any and all percentage-based collection fees incurred, up to 40 percent of the total overpayment, and charges necessary for the collection of any amount not paid when due. My obligations under this agreement will survive the termination of my employment. This agreement can be faxed or copied, and a photocopy of this agreement is as valid and acceptable as the original. I understand that my failure to sign this agreement or abide by the terms of the U-M LTD Plan gives the U-M Benefits Office the right to discontinue all LTD benefits and the right to seek termination of my employment status.

_____ _____

Faculty/Staff Member Signature **Date**

Social Security Administration
Consent for Release of Information

Form Approved OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration:

*Name	*Date of Birth	*Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
University of Michigan	3003 S. State Street, Suite G405 Ann Arbor, MI 48109-1278

*I want this information released because:
There may be a charge for releasing information. Under the University of Michigan's Long-Term Disability Plan, I am required to provide documentation regarding the status of my OASDI claim.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☒ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☒ My benefit/payment amounts from _____ to Present
- ☒ My Medicare entitlement from _____ to Present
- ☐ Medical records from my claims folder(s) from _____ to _____

If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.

- ☐ Complete medical records from my claims folder(s)
- ☒ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) Notice of Award or Disapproved Claim for me, and/or my dependents, or any other SSA Favorable or Unfavorable Decision letters.

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____