



**To:** Bargaining Employee

**From:** Employee Transitions Team (ETT)

**Subject:** STD/FMLA Packet Information for bargaining unit employees

**Comments:**



**Attn: Employee Transitions Team**  
5454 W. 110th St.  
KSOPKR0101  
Overland Park, KS 66211  
Phone:888-722-4372 Fax:913-397-3744

**Subject:** Short Term Disability (STD) for absences not relating to worker's compensation

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The Short Term Disability ("STD") Plan (the "Plan") generally provides benefits when you cannot work at the Embarq Corporation because of injuries and illnesses you incur off-the-job. This letter provides you with helpful information regarding STD claims under the Plan.

### **STD Claim Procedure**

- **To receive STD benefits, you must submit the enclosed STD forms within the specified requirements established for your bargaining unit.**
- STD leave runs concurrently with leave required under the Family and Medical Leave and similar state and local laws. You will be entitled to FMLA leave if you (1) have been employed by Embarq and its subsidiaries for one year, **and** (2) have worked for Embarq and its subsidiaries at least 1,250 hours during the 12-month period preceding the date your leave began.
- A Health-Care Provider Extension Form must be received by the Employee Transitions Team (ETT) **on or before the original date of return**, if your absence is extended by your health-care provider beyond the original estimated return-to-work date. Your STD benefits may be suspended or denied if a completed Health-Care Provider Extension Form is not received by the ETT before your original return-to-work date.
- Your absence may be considered unexcused if your STD or FMLA request is denied.

### **Independent Medical Examination (IME)**

- The ETT may require you to be examined by an ETT-designated, health-care provider to determine if you qualify for STD benefits. If an IME is required, you will be contacted about your scheduled appointment. STD benefits may be suspended while an IME is pending. The ETT may deny STD benefits if you do not cooperate with the IME process (e.g., attend the exam).
- The IME is final, meaning you will not receive STD benefits unless the IME dictates you are unable to work. The IME determination generally has no effect on your FMLA request.
- The ETT, or the ETT's designated IME health-care provider, may share information learned during the IME with those having a "need to know."
- The IME has final say regarding STD benefits except where superceded by a labor agreement.

### **STD Benefit Payments**

- Refer to your labor agreements to determine what benefits are available based on your service date.

### **New York-New Jersey Employees Only**

- You must complete the The Hartford forms and return them along with the respective STD forms to the ETT. There are two options to obtain the state forms. These options are to either 1) contact the Employee Resource Center at 888-722-4372; 2) contact The Hartford at 800-741-4306
- Refer to the Summary Plan Description for information regarding this benefit.
- While you are being paid NY/NJ state disability benefits, your Flexcare benefits remain active, however any missed payroll deductions will suspend and then be deducted from any future Embarq payroll check(s).

## ***EMPLOYEE CHECKLIST FOR SHORT TERM DISABILITY***

***ALL FORMS ARE DUE WITHIN 15-CALENDAR DAYS OF THE FIRST DATE OF ABSENCE OR BY THE 22<sup>ND</sup> CALENDAR DAY OF YOUR ABSENCE DEPENDING ON THE REQUIREMENTS ESTABLISHED FOR YOUR BARGAINING UNIT***

\_\_\_\_\_ Employee completes the Short Term Disability (STD) Application.

\_\_\_\_\_ Health-Care Provider completes the following forms:

- Health-Care Provider Form;
- Health-Care Provider Extension Form (*if your absence is extended*); and
- Medical Release Form (*to be completed and returned at the end of STD absence*)

\_\_\_\_\_ Mail or fax all completed forms to the Employee Transitions Team within 15-calendar days from the first date of absence or by the 22<sup>nd</sup> calendar day of your absence depending on the requirements established for your bargaining unit. Appropriate fax numbers are located on each form.

### **RETURN FROM STD ABSENCE:**

\_\_\_\_\_ Employee provides a completed Medical Release Form to his or her supervisor upon receiving a return-to-work date. Fax or mail the completed Medical Release Form to the Employee Transitions Team ***This form is required before employees will be allowed to return-to-work.***

Timely submission of the Medical Release Form to the Employee Transitions Team is necessary to update your status from leave to active status. **Late submission of the Medical Release Form may cause you to incorrectly remain in leave status, which may impact your pay.**



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## SHORT- TERM DISABILITY (STD) APPLICATION

For absences not relating to worker's compensation

**To be completed by employee:**

*Note: It is the employee's responsibility to ensure that this STD application and corresponding Certification form are returned and received by the ETT within the required timeframe. Failure to submit the forms timely may result in a suspension or denial of the STD benefit. If you have questions regarding the timeframes or questions about the STD benefit, please see the STD Summary Plan Description or contact the ERC at 888-722-4372.*

Employee's Name	Employee's Social Security Number	Today's Date
Home Address		Home E-mail Address, if applicable
Home Phone Number, or number where you can generally be reached		Last Day Worked (m/d/y)
Supervisor's Name & Work Number	If other than M – F work schedule, indicate your work schedule below: M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S <input type="checkbox"/> H _ H _ H _ H _ H _ H _ H _	

**Please answer the following questions:**

1. Is this a work related illness or injury?  IF YES, DO NOT COMPLETE THIS FORM AND IMMEDIATELY CALL  Workman's Compensation Claims Management at 1-800-733-1250		NO
2. Will you be working for another employer, or be self-employed during this absence?	YES	NO
3. Is your health-care provider licensed by the state where you are receiving treatment?	YES	NO
4. Is your absence due to cosmetic surgery? If yes, please answer question #5.	YES	NO
5. Is the cosmetic surgery the result of:		
An Illness	YES	NO
A Traumatic injury	YES	NO
To correct a medical condition?	YES	NO
6. Is your illness or injury:		
Caused by armed conflict?	YES	NO
A result of committing a felony or engaging in an illegal activity?	YES	NO
Intentionally self-inflicted?	YES	NO

**I acknowledge and agree:**

- I have reviewed, understand and will comply with the terms and conditions outlined in the attached letter.
- STD leave runs concurrently with leave required under the Family and Medical Leave and similar state and local laws.
- The health-care provider designated on the "Health-Care Provider Form" is authorized to release medical information to my employer or my employer's designated Independent Medical Examination health-care provider.
- The ETT may recover any applicable overpayments and subrogation of claims against third parties from future payments of benefits, wages or other compensation to the extent permitted by applicable law.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



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**HEALTH-CARE PROVIDER FORM for STD  
 TO BE COMPLETED BY YOUR HEALTH-CARE PROVIDER**

<u>Employee's Name:</u>	<u>Employee's Social Security Number:</u>
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1. Date the employee was first unable to perform his/her job due to disability: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Date you anticipate releasing patient to regular work: \_\_\_\_/\_\_\_\_/\_\_\_\_ (unknown & indefinite are not acceptable answers)
3. Date of initial office visit : \_\_\_\_/\_\_\_\_/\_\_\_\_ 4. Date of follow up visit(s) : \_\_\_\_/\_\_\_\_/\_\_\_\_
5. ICD9 Primary disease code(s), (**required unless diagnosis not yet obtained**): \_\_\_\_\_ Secondary: \_\_\_\_\_
6. State diagnosis or if no diagnosis has been determined, enter objective findings or a detailed statement of symptoms.

7. Does employee's condition qualify as a serious health condition under the Family and Medical Leave Act

- Yes  No If yes, under which category?
- Hospital Care  Absence Plus Treatment  Pregnancy  Chronic Condition Requiring Treatment
- Permanent/Long Term Condition Requiring Treatment

8. Type of treatment / medication rendering to patient: \_\_\_\_\_

9. At any time during your treatment for this medical problem has the patient been incapable of performing his/her regular or customary work  YES  NO If yes, check one  Daily  Weekly  Monthly  As Needed

10. If surgery: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type: \_\_\_\_\_ ICD9: \_\_\_\_\_

11. If patient was hospitalized, provide date of entry and discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

12. Is the condition (or are the conditions) due to injury or sickness arising out of employment? Yes  No

13. Health Care Provider's name as it appears on License ( Please Print) \_\_\_\_\_

Health Care Provider's State License number \_\_\_\_\_

Health Care Provider's Telephone Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Health Care Provider's fax number \_\_\_\_-\_\_\_\_-\_\_\_\_

Health Care Provider's address \_\_\_\_\_

14. Health Care Provider's Certification and signature (required): Having considered the patient's regular and customary work, I certify under penalty of perjury that based on my examination, the Health Care Provider's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.

I further certify that I am a \_\_\_\_\_ Licensed to practice in the state of \_\_\_\_\_  
 (Type of Doctor) (Specialty, if any)

**Original signature of attending doctor rubber stamp is not acceptable**

Date signed \_\_\_\_\_



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**EXTENSION FORM for STD**

**TO BE COMPLETED BY YOUR HEALTH-CARE PROVIDER only if your absence is going to continue past your original return to work date.**

<u>Employee's Name:</u>	<u>Employee's Social Security Number</u>
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1. State diagnosis or if no diagnosis has been determined, enter objective findings or a detailed statement of symptoms.

2. ICD9 Primary disease code(s), (**required unless diagnosis not yet obtained**): \_\_\_\_\_ Secondary: \_\_\_\_\_

3. Date the employee was first unable to perform his/her job due to disability: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. The extended date you anticipate releasing patient to regular work: \_\_\_\_/\_\_\_\_/\_\_\_\_ (**unknown & indefinite are not acceptable answers**)

5. Health Care Provider's name as it appears on License (Please Print) \_\_\_\_\_

Health Care Provider's State License number \_\_\_\_\_

Health Care Provider's Telephone Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Health Care Provider's fax number \_\_\_\_-\_\_\_\_-\_\_\_\_

Health Care Provider's address \_\_\_\_\_

6. Health Care Provider's Certification and signature (required): Having considered the patient's regular and customary work, I certify under penalty of perjury that based on my examination, this Health Care Provider's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.

I further certify that I am a \_\_\_\_\_ (Type of Doctor) \_\_\_\_\_ (Specialty, if any) Licensed to practice in the state of \_\_\_\_\_

\_\_\_\_\_  
 Original signature of attending doctor rubber stamp is not acceptable

\_\_\_\_\_  
 Date signed



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**MEDICAL RELEASE FORM**

***TO BE COMPLETED BY YOUR HEALTH-CARE PROVIDER ONCE A RETURN-TO-WORK DATE IS ESTABLISHED***

Employee's Name	Employee's Social Security Number
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**If released WITHOUT restrictions**

I certify that the above-named employee is able to resume performing the full functions of his/her position at Embarq on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date)

**If released on restricted schedule, please indicate:**

**Date released with restrictions:**    \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of hours per day:                    \_\_\_\_\_

Number of days per week:                    \_\_\_\_\_

Number of weeks:                                \_\_\_\_\_

Other restrictions:                                \_\_\_\_\_  
 \_\_\_\_\_

**Date released for full time:**                    \_\_\_\_\_

Health-Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Health-Care Provider Name: \_\_\_\_\_  
 (Printed)

Address: \_\_\_\_\_  
 \_\_\_\_\_

Phone Number:    (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax Number:        (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**THIS FORM SHOULD BE DELIVERED OR MAILED TO YOUR SUPERVISOR AND FAXED TO THE ETT NO LATER THAN YOUR RETURN-TO-WORK DATE**