CITY OF LINCOLN EMPLOYER'S LONG TERM DISABILITY STATEMENT

To be completed by employer.

Employee's Name ________________________________ First _____________________________ Middle Initial _____

Date of Birth _________________________ S.S. # _________________________ Male _______ Female _______

Address ____

City ____ State ___________________ Zip ___________________

Phone Number *(Area Code First)* ____

Date of hire ____________________________________ Date last worked ____________________________________

Cause of disability ____

____

Did disability occur due to a work related injury? ____ Yes ____ No

Basic monthly earnings $ ___________________

Has employee been laid off or was the employment terminated? If so, when? ____________________________________

Date employee returned to work or date expected to return. ____

Signature ____ Title ____

Date _______________________

CITY OF LINCOLN
EMPLOYEE'S
LONG TERM DISABILITY STATEMENT

To be completed by employee.

Last Name ______________________________________ First _____________________________ Middle Initial _____

Date of Birth _________________________ S.S. # _________________________ Male _______ Female _______

Address ____

City ____ State ___________________ Zip ___________________

Phone Number *(Area Code First)* ____

Mailing Address, if different from address above ____

NATURE OF ILLNESS

When did symptoms first appear?

If due to injury, how and when did this accident occur?

Is injury due to employment?

When did you became unable to work because of this disability?

When did you begin your first medical treatment?

How does this illness/injury prevent you from returning to work?

Have you returned to work? ____ Yes *(what date __________)* ____ No Part time ______ Full time______

If you have not returned to work, on what date do you expect to return to work? __________________________

Have you engaged in any work, part time or otherwise, during your period of disability? ____ Yes ____ No

If yes, please explain. ____

____

____

List the primary physicians that you have consulted because of this disability.

Physician's Name	*Address*	*Phone*	*Dates Treated*

Please complete form on reverse side.

Have you applied for or are you receiving benefits from:	Applied		Receiving		Date Applied	Amount Received		Effective Date	Paid Thru Date
	Yes	No	Yes	No		Weekly	Monthly		
a. Social Security	☐	☐	☐	☐					
b. Worker's compensation	☐	☐	☐	☐					
c. Salaries, wages, commissions, etc.	☐	☐	☐	☐					
d. Retirement or pension	☐	☐	☐	☐					
e. Veterans disability benefits	☐	☐	☐	☐					
f. Other	☐	☐	☐	☐					

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals or other institutions rendering care to furnish the City of Lincoln with full information regarding treatment rendered (including copies of their records).

Signature ____ Date ________________________

CITY OF LINCOLN PHYSICIAN'S LONG TERM DISABILITY REPORT

Notice to Employee: This form must be completed by each physician you consulted for your disability. The completed form must be returned to the below address:

CITY OF LINCOLN
PERSONNEL DEPARTMENT, BENEFITS AREA
555 S. 1OTH ST, SUITE 302
LINCOLN, NE 68508

Patient's Name ____ Date of Birth _____________________

Patient's Address ____

City ____ State _________________ Zip _________________

Phone (Area Code First) ____

MEDICAL CONDITION

a. Primary, Secondary and Other Diagnosis: ICD Codes ___________________

b. Complications:

c. Prognosis for a return to present occupation:

d. Prognosis for a return to any employment:

e. Is this a nervous or mental health condition? Yes _____ No _____

HISTORY

a. When did symptoms first appear or accident happen? Month _______________ Day______ Year _______

b. Date of first visit: Month _______________ Day______ Year _______

c. Date of last visit: Month _______________ Day______ Year _______

d. Date you first advised patient to cease work Month _______________ Day______ Year _______

e. Is condition due to injury or sickness arising out of patient's employment? Yes _____ *(describe)* No _____

TREATMENT

a. What are the treatment plans?

b. Surgery?

c. Medications:

d. Is further treatment required?

e. Hospitalizations?

The Patient has been continuously disabled *(unable to work)* From ____________ through _______________.

If still disabled, When should patient be able to return to work? Date _____________________

Would job modification enable patient to work with impairment? Yes _____ *(describe)* No _____

Physician's Name ____

Physician's Address _____________________________ City ___________________ State _____ Zip __________

Signature ______________________________________ Date _____________________

CITY OF LINCOLN
LONG TERM DISABILITY AUTHORIZATION
FOR DISCLOSURE OF HEALTH INFORMATION

Name ____ Phone Number ___________________________

Address ____

City ____ State _______________ Zip __________________

I am either the patient named above or the patient's legally authorized representative.
By signing this form, I *authorize* the following medical provider(s):

____

____

____

____

To disclose my protected health information to the individuals or organizations listed below:

CITY OF LINCOLN

The specific type of information to be disclosed shall consist of true, correct, and complete copies of all medical records of any kind, including, but not limited to, medical reports, consultation reports, doctors' notes, nurses' notes, correspondence, and documentary material of any kind, including but not limited to drug or alcohol records and health information related to psychological or psychiatric conditions, including psychotherapy notes, relating in any way to treatment of the above described patient rendered by the above described provider.

The purpose and need of such disclosure is to receive long term disability (LTD) benefits.

Expiration: Without express revocation, this consent shall expire one year from the date of this authorization.
Revocation: I understand that I may revoke this consent by providing written notice to the above mentioned provider at any time except to the extent that the provider has taken action in reliance on this authorization.
I may revoke the consent by providing a written notice to the Provider listed above.

Prohibition of Conditioning of Treatment: I understand that the provider's treatment to me is not contingent upon my decision to provide or withhold consent or release information.
Further Uses and Disclosures: I understand that there is a potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal privacy laws.

I understand that a photocopy or a faxed copy of this authorization will be considered as valid as the original.

____ ____________________________
Printed Name (Employee/Patient) Date of Birth

____ ____________________________
Signature (Employee/Patient) Social Security Number

Date __________________________________