Macomb Intermediate School District
44001 Garfield Road • Clinton Township, MI • 48038-1100 • 586/228-3300

MEMORANDUM
Human Resources

TO: MISD Employee

FROM: Rosetta Mullen
Assistant Superintendent
Human Resources/Legal Affairs

RE: FMLA (Family and Medical Leave Act)

Due to your current request to apply for disability benefits, you may be eligible to take leave under the Family and Medical Leave Act (FMLA). Please review the notice printed on the back of this memo from the U.S. Department of Labor regarding the *Employee Rights and Responsibilities under the Family and Medical Leave Act.*

If you have any further questions or concerns regarding FMLA eligibility, please contact the Human Resources Department @ 228-3311.

/pw

(over)

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

EMPLOYEE'S

FORMS

TO

FILL OUT

Madison National Life
a Horace Mann company

P.O. BOX 305 ADDISON, TX 75001-0305
Telephone: 800-356-9601 Fax: 608-830-2701

EMPLOYEE'S STATEMENT OF CLAIM FOR BENEFITS

As your disability insurer we are committed to assisting you in a return to health and to productive employment. Please complete the following form as thoroughly as possible. By accepting forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights and / or defenses. Any incomplete claim form will not be accepted. We highly recommend that you also provide medical records from each of your treating physicians to help expedite the review of your claim. Lack of medical records may result in a delay in the review of your claim. We highly encourage the filing of claims as soon as possible following the onset of a disability, or in advance in cases of planned disability events. Please submit completed forms to GCA@madisonlife.com, via fax or regular mail. This form can also be completed online at www.madisonlife.com using our "File a Claim" option.

BACKGROUND INFORMATION

Type of benefit this claim is being filed for? (Please check all applicable claims):

☐ **Short Term Disability benefits** ☐ **Long Term Disability benefits** ☐ **Life Insurance Waiver of Premium benefits**

Name (print): _____ Social Security number: _____

Address: _____ Telephone number: _____

City: _____ State: _____ Zip: _____ Email address: _____

Date of Birth: _____ ☐ Male ☐ Female Height: _____ Weight: _____ ☐ Single ☐ Married

Name and birth date of spouse and all dependent children (Dependent children are all unmarried children (1) under age 18, (2) under age 19 (if in elementary or secondary school or (3) disabled children regardless of age if their disability began before age 22):

_____

_____

Your employer's name: _____ Occupation/Job title: _____

Date of hire: _____ Annual salary: _____

Please indicate the extent of your formal education (*circle one*).

Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School

If your education exceeds 12th grade, please indicate your major: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*):

Job title, Employer, City and State	Duties:	Dates worked:
(a)		
(b)		
(c)		

CLAIM INFORMATION

Specific dates for which you are claiming disability: From _____ up to _____ or unknown (circle if applicable)

Is your claim related to an accident or injury? ☐ No ☐ Yes If yes, date and time of accident or injury: _____

Describe how and where the accident or injury occurred: _____

_____

Is your claim related to your occupation? ☐ No ☐ Yes If yes, have you filed a Worker's Compensation claim? ☐ No ☐ Yes

If you have filed a Workers' Compensation Claim, please indicate the status of your claim as well as your weekly benefit amount if your claim has been approved: _____

If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation Services? ☐ No ☐ Yes ☐ My Workers' Compensation claim is currently being disputed

Is your claim related to an illness ☐ No ☐ Yes If yes, Date symptoms first appeared: _____

Please list all symptoms associated with your claim: _____

_____

Date you ceased work: _____ Have you returned to work? ☐ No ☐ Yes If yes, date returned: _____ ☐ Full-time ☐ Part-time

If you have returned to work part time please indicate the number of hours: _____ per day _____ days per week

Continued on Reverse Side

Name_____ DOB _____

CLAIM INFORMATION CONTINUED

When do you plan to return to your job either on a full-time or part-time basis? Please explain in detail: _____

_____

Please describe the primary tasks of your occupation: _____

_____

Has your doctor provided work restrictions? ☐ No ☐ Yes If yes, please describe: _____

_____

Can you return to your job or another job with your current employer if accommodations were made? ☐ No ☐ Yes If yes, please describe the accommodation needs: _____

_____

Are there any concerns you have about returning to work? ☐ No ☐ Yes If yes, please describe: _____

_____

MEDICAL INFORMATION

Please provide us with a brief description of your condition(s). Describe any physical and/or psychiatric/psychological limitations related to your return to work: _____

_____

Date first treated for this condition: _____ Name of physician that provided initial treatment: _____

Have you ever had the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of doctor:

_____

Name Street Address

_____

City State Zip Phone

Have you ever been hospitalized for the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of hospital:

_____

Name Street Address

_____

City State Zip Phone

If claim is related to Pregnancy: Expected date of delivery:_____ Actual Date of Delivery:_____ ☐ Vaginal ☐ C-Section

Were / are there any complications associated with your pregnancy? ☐ No ☐ Yes If yes, please describe: _____

_____

OTHER INCOME BENEFITS / FEDERAL TAXES

Your monthly benefit may be affected by other income benefits received. We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	☐ No	☐ Yes	Social Security Disability or Retirement	☐ No	☐ Yes	Unemployment Benefits	☐ No	☐ Yes
Vacation/Bonus Pay	☐ No	☐ Yes	Retirement Benefits	☐ No	☐ Yes	Other Income Benefits	☐ No	☐ Yes
Automobile No-Fault	☐ No	☐ Yes	Short Term Disability	☐ No	☐ Yes	Workers' Compensation	☐ No	☐ Yes

CA, HI, NJ, NY, RI State Disability / Paid Leave ☐ No ☐ Yes

If you have been awarded any of the above other income benefits, please list the type of benefit, benefit amount, frequency of payment, and benefit effective date:

_____

_____

Have you tried any type of other work since the date your ceased work, as noted above? (either for this employer, another employer or through self-employment) ☐ No ☐ Yes if yes, provide name and address of employer, type of work, when employment began and number of hours worked per week: _____

_____

If your employer pays any portion of the premium or premiums are withheld from your pay on a pre-tax basis, you may elect to have Federal Income Tax withheld from each payment. State taxes can also be withheld in IA, IN, MN and WI. Do you want amounts withheld for Federal or State tax purposes? ☐ No ☐ Yes

If Yes you must indicate a percentage that you would like to have withheld from your benefit payment: Federal % _____ State % _____

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature _____ **Date**_____

Madison National Life
a Horace Mann company

P.O. BOX 305 ADDISON, TX 75001-0305
Telephone: 800-356-9601 Fax: 608-830-2701

REIMBURSEMENT AGREEMENT
GROUP DISABILITY INSURANCE BENEFIT
(Please read carefully)

When Madison National Life Insurance Company, Inc. ("MNL") has made benefit payments to you in excess of the amount required by the provisions of this policy, or during periods of time for which you subsequently receive retroactive benefits from any source that may offset your benefits under the group policy, you must, in a timely manner, reimburse MNL for such payments, including duplicate or erroneous payments. In addition and upon request, you must execute and deliver to MNL such documents as may be required and do whatever else is necessary to secure our rights to recover any excess, duplicate, or erroneous payments. Such reimbursement will be due and payable immediately upon our notification to and demand of you. Or, at our option, the subsequent payment of benefits or the refund of any premium owed you by MNL may be reduced or refused as a setoff and applied toward such reimbursement. If you delay in notifying MNL of your receipt of a reimbursable income benefit or in making reimbursement to MNL, MNL will have the right to charge interest at a reasonable rate on the delinquent amount owed to MNL. Our acceptance of premium and other fees, or our providing or paying disability benefits, does not constitute a waiver of our right to enforce the provisions of this agreement and/or the group policy in the future. The provisions of this agreement are in addition to, and not in lieu of, any other rights or remedies available to MNL at law or in equity.

Agreement

If my application for group disability insurance benefits is approved, in consideration of the payment of benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described and provided for in the group policy, I hereby agree to reimburse Madison National Life Insurance Company, Inc. for any and all overpayments made to me under the group disability plan provided by employer. I understand that MNL agrees to make payment in this manner in consideration of my agreement to promptly notify MNL of the amounts and effective dates of any such benefits. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators or assigns under the applicable group policy may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the applicable policy.

With respect to any group life insurance coverage provided me by MNL and in consideration of the foregoing, I hereby assign to MNL, as creditor beneficiary, an amount of such group life insurance equal to the amount of any overpayment which may be outstanding under any applicable group disability policy at the time of death.

In witness of the above, the parties hereto have caused this Agreement to be executed, as of the date indicated.

_____
Printed Name of Claimant

_____
Signature of Claimant

_____
Date Of Signature

_____
Signature of Spouse

Or

_____
Witness (must be over age 18)

The following Fraud Warning applies to these states: **Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Utah, Vermont, Wisconsin and Wyoming.**

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATE SPECIFIC FRAUD WARNINGS

ALABAMA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA WARNING: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, LOUISIANA & WEST VIRGINIA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

DELAWARE & IDAHO WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MASSACHUSETTS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.

MINNESOTA WARNING: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE, VIRGINIA & WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

TEXAS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in the state prison.

Madison National Life
a Horace Mann company

P.O. BOX 305 ADDISON, TX 75001-0305
Telephone: 800-356-9601 Fax: 608-830-2701

Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization, but if you do not Madison National Life Insurance may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization form will be accepted.

Name (print): _____ **Date of birth:** _____ **Telephone number:** _____

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

2) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

3) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

4) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

5) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

to: **Madison National Life Insurance Company (address, telephone and fax number documented above)**

This form serves as an authorization for Madison National Life Insurance to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2015 through two years from the date of the signature on this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2015 through two years from the date of the signature on this form.

Also this form provides Madison National Life Insurance the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (e.g., Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance for the review of my claim for benefits. I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance at any point during the review of my claim or during any appeals that may take place as explained above. I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature _____ **Date** _____

Macomb Intermediate School District
44001 Garfield Road • Clinton Township, MI • 48038-1100 • 586/228-3300

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(Including paper, oral and electronic information)

I, _____ authorize and direct any and all treating physicians, medical / health care providers and facilities to release information contained in my patient records, that may relate to my disability claim or services on _____, and to disclose any such information to authorized representatives of my employer, the Macomb Intermediate School District (MISD) and its third party disability claim administrators, Cannon Cochran Mgmt Services, Inc (CCMSI), FSA Administration (WEX), and/or Madison National Life Insurance Company (MNL) and affiliates.

This authorization specifically includes, but is not limited to, all medical, dental, hospital, clinical, employment, insurance claims, vocational records, and information. The information received may disclose privileged alcohol/drug treatment and mental health information. This authorization allows the MISD and claim administrators to release the above-mentioned information and records to each other.

This medical release is valid during the pendency of my 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 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 eligibility for benefits. 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 eligibility for 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 signing this authorization is voluntary. However, failure to provide a signed copy of this medical release may prevent MISD and its third-party claim administrators from processing my benefits.

Employee Signature: _____ Date: _____

Date of Birth: _____ SSN # (*Last 4 digits*) _____

Witnessed by: _____ Date: _____

Madison National
Life Insurance Company
Independence Holding Group

www.madisonlife.com

Authorization Agreement for Direct Deposit

I (we) authorize Madison National Life Insurance Company hereinafter called the COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our):

(select one) ☐ Checking Account ☐ Savings Account

indicated below and the depository names below, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

Depository Name: _____ Branch: _____

Complete Mailing Address of your Financial Institution:

Street Name or P.O. Box: _____

City: _____ State: _____ Zip Code_____

Transit ABA #: _____ Account #: _____

This authority is to remain in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it.

Name: _____
Please Print Name

Date of Birth: _____

Claim Number: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

(Both parties must sign on a joint account)

FOR DEPOSITS TO A CHECKING ACCOUNT PLEASE ATTACH A VOIDED CHECK.

FOR DEPOSTITS TO A SAVINGS ACCOUNT PLEASE ATTACH A DEPOSIT SLIP.

GIVE FORMS TO YOUR DOCTOR TO FILL OUT

MADISON NATIONAL LIFE

Highly recommend that you also

PROVIDE

Medical Records

From **each of your treating physicians** to help expedite the review of your claim. **Lack of medical records will result in a delay (up to a month) in the review of your claim.**

Madison National Life
a Horace Mann company

P.O. BOX 305 ADDISON, TX 75001-0305
Telephone: 800-356-9601 Fax: 608-830-2701

ATTENDING PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

Thorough completion of this form will provide the information necessary to allow us to work closely with your patient and his/her employer to develop a plan which will promote a return to work. This form must be completed by a physician. Medical records are required in association with this claim as noted on the bottom of the second page of this document. Lack of medical records will result in a delay in the processing of this claim.

Name of patient:_____ Date of birth:_____

Address:_____
Street City State Zip

A. DIAGNOSIS / HISTORY

Primary diagnosis:_____ ICD-10 code:_____
Secondary diagnosis: _____ ICD-10 code:_____
Other diagnoses and ICD codes related to this claim:_____

Symptoms:_____

Is the condition primarily related to: ☐ Employment ☐ Illness ☐ Mental Disorder ☐ Alcohol or Drug Dependence ☐ MVA ☐ Pregnancy ☐ Injury

Date patient became unable to work due to this impairment? Month_____ Day_____ Year_____

Anticipated length of Disability ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12 months or more

Date your patient can return to work: Part time:_____ Full time:_____
OR unable to determine, due to:_____ Follow up in: _____

Patient's Height: _____ Patient's Weight: _____ BP:_____ Patient's Dominant Hand: ☐ Right ☐ Left
Date symptoms first appeared:_____ Date of first visit to you for this condition:_____
Date of most recent visit:_____ Date of next visit:_____
Has your patient ever had the same or similar condition? ☐ No ☐ Yes If yes, indicate when and describe:_____

Was the patient referred to you from another physician? ☐ No ☐ Yes If yes, indicate name of physician and their treatment facility: _____

B. TREATMENT PLAN

Planned course of treatment (please include expected duration, surgeries, therapy, etc.):_____

Treatment complicated by: ☐ Employer / Employee conflict ☐ Significant emotional or behavioral disorder
☐ Alcohol or Drug Dependence ☐ MVA ☐ Other _____

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper):_____

Frequency with which you see your patient: ☐ Weekly ☐ Monthly ☐ PRN ☐ Other:_____
Has your patient been referred to other doctors or therapy programs (P.T., O.T., psychotherapy)? ☐ No ☐ Yes If yes please indicate to whom and dates:

If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? For example, have you had contact with the patient's employer regarding possible job modifications or gradual return to work? ☐ No ☐ Yes If yes, please describe the return to work plan:_____

C. HOSPITALIZATION: (If not hospitalized please proceed to next section.)

If patient was hospitalized, please provide dates: Admitted_____ Discharged_____
Admitting diagnosis:_____ ICD-10 code:_____
Discharge diagnosis:_____ ICD-10 code:_____
Name of hospital:_____ Name of doctor seen at hospital:_____
Address:_____
Street City State Zip Code

D. SURGERY: (If surgery was not performed or is not anticipated to be necessary in the future please proceed to next section.)

Was surgery performed? ☐ No ☐ Yes If yes, indicate procedure and date of surgery: _____

Is surgery planned? ☐ No ☐ Yes If yes, indicate planned procedure and anticipated date:_____

Name of Patient:______________________________ Date of Birth:______________

E. PREGNANCY: (If patient is not pregnant please proceed to next section.)

If disability is related to pregnancy, please provide the following: LMP______________ First obstetric visit:______________

Expected date of delivery:______________ Actual date of delivery: ______________ Type: ☐ C-Section ☐ Vaginal

Have there been complications resulting in disability prior to delivery? ☐ No ☐ Yes If yes indicate the type of complication:______________

F. ASSESSMENT

Describe your patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

Has your patient reached maximum medical improvement? ☐ No ☐ Yes

If your patient has not reached maximum medical improvement, when do you expect a fundamental or marked change in his/her condition?

☐ Never ☐ Condition expected to regress ☐ Condition expected to improve, State anticipated date______________ ☐ Unable to determine

Is confinement to bed or home medically required? ☐ No ☐ Yes. If yes, please indicate duration of confinement. ______________

G. RESTRICTIONS AND LIMITATIONS

If physical or psychiatric limitations exist, how long do you feel that these limitations will last?______________

Has your patient provided a self-report of his/her job tasks? ☐ No ☐ Yes

Based on your knowledge of your patient's job, what reasonable work or job site modifications could the employer make to assist him/her to return to work?

____

Level of functional impairment:

In a work day, given two breaks and a meal break, your patient can:

Lift (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+

Carry (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+

Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently (how frequently)______________

If allowed positional changes, patient can: (please circle one for each)

Sit: 8 7 6 5 4 3 2 1 0 (hrs)

Stand: 8 7 6 5 4 3 2 1 0 (hrs)

Walk: 8 7 6 5 4 3 2 1 0 (hrs)

Alternately sit/stand : 8 7 6 5 4 3 2 1 0 (hrs)

If the total number of days that the patient can work during a week is limited, please specify the number of days the claimant can work per week. ______________

Patient can work with arms in the following positions:

Right arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes

Left arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes

Patient can use arms/hands for repetitive action such as:

Right arm: Gross movements ☐ No ☐ Yes Pushing & pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Left arm: Gross movements ☐ No ☐ Yes Pushing & pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Patient can use his/her head and neck in:

Flexion ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Extension ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Rotation ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Mental Impairment (if applicable)

Please define "stress" as it applies to this claimant: ______________

What stress and problems in interpersonal relations has this claimant had on the job? ______________

____

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations. (No limitations.)

☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations. (Slight limitations.)

☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. (Moderate limitations.)

☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked limitations.)

☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment. (Severe limitations.)

Remarks: ______________

What obstacles prevent a return to work?______________

Would you like assistance in developing a return to work plan? ☐ No ☐ Yes

Would you recommend vocational rehabilitation services (assignment of a case manager to assist your patient and the employer in return to work planning, or to provide assistance in finding a new job, or in designing a retaining plan which would allow a return to work)? ☐ No ☐ Yes

Comments:______________

PLEASE READ CAREFULLY

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

I have received and read the fraud warning statements provided with this form.

Physician's signature: ______________ **Date:** ______________

Physician's name (please print):______________ Specialty:______________

Address: ______________ City:______________ State:________ Zip code:____________

Phone number: ______________ **Medical record department fax number:**______________

The following Fraud Warning applies to these states: **Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Utah, Vermont, Wisconsin and Wyoming.**

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATE SPECIFIC FRAUD WARNINGS

ALABAMA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA WARNING: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, LOUISIANA & WEST VIRGINIA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

DELAWARE & IDAHO WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MASSACHUSETTS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.

MINNESOTA WARNING: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE, VIRGINIA & WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

TEXAS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in the state prison.