Claim for Benefits

Instructions: Please complete all sections thoroughly and mail original to:

Tompkins County Personnel Department
125 East Court Street
Ithaca, NY 14850

(607) 274-5526 phone
(607) 274-5401 fax

To be completed by Physician ONLY

Tompkins County is eager to work with employees and their physicians to facilitate a return to full-time or part-time work, with or without reasonable accommodation. Your participation in this process is critical and welcome. Your recommendations for a successful and speedy return-to-work will be greatly appreciated. Thank you.

This patient has authorized the release of medical information regarding the following disability claim.

1. Claimant's Name: _____ _____
   first last
2. Claimant's Symptoms: _____
3. Medical Findings and Diagnosis: _____
4. Is surgery indicated? ☐ yes ☐ no
   If yes, what kind of surgery? _____
   What date? ____/____/____
5. Record of medical treatment:

	month	day	year
a. Date you first treated for this injury/illness and the related absence from work:			
b. Most recent treatment date:			
c. Date claimant unable to perform regular duties because of this injury/illness:			
d. Date claimant can perform regular duty:			

○Is claimant able to perform light duty? ☐ no ☐ yes If yes, when? ____/____/____

○Please suggest restrictions or accommodations of light duty (job description provided upon request):

_____

○Is claimant able to work part-time? ☐ yes ☐ no
If yes, how many hours per week? _____ hrs/week

○Next scheduled appointment with this patient: _____

6. In your opinion, is the illness or injury arising out of and in the course of employment? ☐ no ☐ yes
7. If yes, have you filed a C4/C48 with our carrier EM Risk Management at PO Box 325 Syracuse, NY 13206? ☐ no ☐ yes
8. Physician's name (please print): _____
   Office address: _____
9. Physician's Signature: _____ Date: _____

Claim for Benefits

M/C & WC

Instructions: Both sides of this claim form are to be completed whenever a Tompkins County Management, Confidential or White Collar employee requests payment for absence due to illness or injury. Requests for paid disability must be made by submitting a completed claim form to Personnel no later than 9:30 AM Monday following the end of the pay period in which disability is requested. A faxed copy will be accepted in an emergency, however, the original claim form must be received within five working days. The first three working days of any period of inability to work must be covered by another fringe unless it is caused by scheduled or emergency surgery, or emergency hospitalization. For any additional occurrence of the same illness in the same year, the first day of inability to work must be covered by another fringe. Untimely receipt of a claim form will void a claim for benefits. **Claim forms must be submitted for every pay period that disability is claimed.** In no instance will disability be granted for periods prior to a doctor's visit.

To be completed by Employee Only

1. Name: _____ _____
   first last
2. Date of birth: ____/____/____ Social Security Number: _____-_____-_____
3. Address: _____
   City: _____ State: _____ Zip Code: _____
4. Telephone Number: _____
5. Job Title: _____ Department: _____

6. Date of Injury/Illness: _____/_____/_____
   Date you became unable to work:
   _____/_____/_____
7. Date you saw a doctor regarding this claim: _____/_____/_____
8. Current work schedule: shift: _____
   hours per week: _____
   regular days off: _____

Nature of Illness/Injury (how, where and when did it occur):
_____
_____
_____
_____
_____
_____

9. What benefits are you claiming? (check all that apply):
   - ☐ Wages, salary or disability
   - ☐ Damages for personal injury
   - ☐ Workers' compensation benefits
   - ☐ Unemployment Insurance Benefits
   - ☐ No fault automobile insurance benefits

10. Since your injury/illness have you worked for any other employer or have you been self employed?
    ☐ yes ☐ no
    If yes, please indicate date:
    _____/_____/_____
    Name of Employer: _____
    _____

11. I hereby claim benefits and certify that for the period covered by this claim I was disabled, and that the foregoing statements, including any accompanying statements, are true and complete. Further, I authorize the disclosure of any medically necessary information between my employer and medical provider.

Signature: _____ Date: ____/____/____

10/2011