

## I. Benefits and Instructions

### A. Administration

The State of Florida Group Disability Income Plan (Plan) is established pursuant to Section 110.123(3)(b) to provide short-term replacement of a portion of an Employee's income if he or she becomes unable to work because of a covered Sickness or Injury.

People First administers the State Group Disability Income Plan. For additional information or assistance, call the People First Service Center (People First) at (866) 663-4735. TTY users call (866) 221-0268.

### B. Definitions

**Active Work** or **Actively at Work** – an Employee's performance of job duties in the place and manner normally performed on a continuing basis.

**Agency** – as defined in Section 110.123(2)(h), F.S.

**Anniversary Date** – the annual date upon which an Employee receives sick and annual leave credits.

**Basic Daily Earnings** – the Employee's biweekly or monthly base pay on the date of Total Disability (exclusive of bonuses, commissions, additives, and similar compensation), annualized and then divided by 364 days.

**Employee** – an individual holding a salaried Senior Management Service (SMS) or Selected Exempt Service (SES) position created according to Part III and Part V of Chapter 110, F.S., with an Agency or an individual who has been appointed to a position that is authorized to receive SMS or SES benefits according to Section 110.205(2), F.S.

**Injury** – an incident of accidental bodily damage.

**Physician** – a physician licensed to practice in the clinical area for which medical care is being provided and licensed to practice by the state in which the Employee is assigned to work.

**Sickness** – an illness or disease, including pregnancy, childbirth, miscarriage or related complications.

**Total Disability** – a condition in which an Employee, under the direct care of a Physician, is completely unable due to Sickness or Injury to perform every duty pertaining to Active Work and is not engaged in any other occupation.

### C. Eligibility and Enrollment

All active Employees are eligible for the Plan and enrollment in the Plan is automatic upon an Employee's appointment to an eligible position.

An Employee is allowed to refuse coverage by submitting a written refusal to the Agency human resource office. An Employee who previously refused coverage is allowed to apply for enrollment by submitting a written request to People First only during Open Enrollment.

### D. Exclusions

Benefits are not payable for any period in which a participant is not under the direct and continuous care of a Physician or for any Total Disability caused by intentional self-inflicted injuries.

### E. Effective Date of Coverage

Coverage is effective on the date of an Employee's appointment to an eligible position, unless the Employee is disabled or under a Physician's care due to Sickness or Injury and not Actively at Work on that date. Coverage for such Employees will be effective on the date they resume Active Work.

The effective date of coverage of an Employee who previously refused coverage and then chooses to enroll will be January 1 of the following year, unless the Employee is disabled or under a Physician's care on account of Sickness or Injury and not Actively at Work on that date. Then the effective date will be the date the Employee is Actively at Work.

### F. Cost

The state pays the entire cost of participation in the Plan for enrolled Employees on active payroll and approved medical leave unless the Employee is receiving Plan benefits.

### G. Benefits

If an Employee, while covered under the Plan and as a result of Sickness or Injury, is diagnosed with a Total Disability, the Plan will pay biweekly benefits to the Employee for the period of the Total Disability up to a maximum of 364 days, as long as the Employee has no available leave balance and the Employee files a claim in accordance with section H.

Benefits are payable from the first benefit day of any one continuous period of the Total Disability in the

amount of 65 percent of the Employee's Basic Daily Earnings subject to the following:

- a. The "first benefit day" is the latter of:
  1. The 31<sup>st</sup> day of continuous Total Disability; or
  2. The date following the day that an Employee exhausts all accumulated leave credits, including leave accrued on the Employee's Anniversary Date.
- b. Benefits paid under the Plan will be reduced by any of the following benefits paid or payable. Upon becoming qualified or upon receipt of these benefits, the Employee must immediately provide written notice to People First:
  1. Any Workers' Compensation Act or similar legislation; and
  2. Primary and family benefits under the Social Security Act; and
  3. Regular or disability retirement benefits under the State of Florida Retirement System; and
  4. For state holiday pay; and
  5. For personal holiday leave when accrued on July 1 of each year.
- c. Benefits paid under the Plan will be suspended until all leave accrued on the Anniversary Date or from a sick leave pool are exhausted.
- d. For the calculation of a benefit reduction, each day of Total Disability is 1/30 of a month. If any of the income benefits listed above are paid in a lump sum, this sum will apply to the period of time for which the sum was given. If this period cannot be obtained from the provider of the lump sum payment, People First reserves the right to estimate the applicable period based upon all available data.
- e. Successive periods of Total Disability separated by less than one work week of continuous Active Work with the Agency will be considered one continuous period of Total Disability unless the later Total Disability is due to causes entirely unrelated to the causes of the previous Total Disability and commences after returning to Active Work for at least one full day.
- f. Plan benefits will be suspended at the time an Employee accrues or is credited with any leave credits and will recommence on the date following the day that an Employee exhausts all leave credits.

## H. Filing a Claim for Plan Benefits

When the Employee meets the definition of Total Disability, the Employee and the Agency are required to complete section A of the State Group Disability Income Plan Claim Form (see III); a Physician providing medical care to the Employee must complete section B, the Attending Physician's Statement. The Employee must submit the State Group Disability Income Plan Claim Form to People First within 90 days of the onset of Total Disability, even if ineligible to receive benefit payment. Failure to submit all sections of the completed form within 90 days of the onset of Total Disability while the Employee holds an SMS or SES position will result in a denial of Plan benefits for that period of Total Disability.

To continue receiving benefits, the Employee must resubmit to People First every 60 days all sections of the State Group Disability Income Plan Claim Form, recertifying that other income as described on the form is not being received by the Employee. The resubmitted Attending Physician's Statement section must be based on the Physician's reevaluation of the Total Disability. The 60 days will be measured from and include the signature date of the previously completed Attending Physician's statement.

## I. Termination of Benefits

Enrollment in the Plan and payments of benefits automatically terminates on the date an Employee terminates employment with the state, on the date the Plan terminates, or on the last day of the month in which People First receives a signed waiver of coverage, whichever occurs first.

For Employees who leave SMS or SES positions but continue state employment, coverage will extend through the last day of the month for which contributions to the Plan are paid in full.

# State Group Disability Income Plan Certificate



## II. Calculation of Benefits

The following worksheet may be used to estimate the Plan benefit.

### Step 1: Annualize Salary<sup>1</sup>

a. Employees paid biweekly multiply their gross biweekly pay amount times 26.1.

$$\begin{array}{r} \$ \underline{\hspace{2cm}} \\ \text{biweekly pay} \end{array} \times 26.1 = \$ \underline{\hspace{2cm}} \\ \text{annual salary}$$

b. Employees paid monthly multiply their gross monthly pay times 12.

$$\begin{array}{r} \$ \underline{\hspace{2cm}} \\ \text{monthly pay} \end{array} \times 12 = \$ \underline{\hspace{2cm}} \\ \text{annual salary}$$

### Step 2: Determine Basic Daily Earnings

Divide annual salary by 364 benefit days to determine Basic Daily Earnings.

$$\begin{array}{r} \$ \underline{\hspace{2cm}} \\ \text{annual salary} \end{array} \div 364 = \$ \underline{\hspace{2cm}} \\ \text{Basic Daily Earnings}$$

### Step 3: Estimate Daily Benefit

Multiply the Basic Daily Earnings by 65% to estimate the daily benefit.

$$\begin{array}{r} \$ \underline{\hspace{2cm}} \\ \text{Basic Daily Earnings} \end{array} \times .65 = \$ \underline{\hspace{2cm}} \\ \text{daily benefit}$$

**Reminder: the benefit will be reduced if you are receiving other disability benefits as described in section G above.**

<sup>1</sup>Salary is the monthly base pay, which does not include bonuses, additives, commissions, etc.

### III. State Group Disability Income Plan Claim Form A. Employee and Agency



**Employee Information - All Fields Required:**

People First ID: 

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First Name: 

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Last Name: 

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Complete Mailing Address: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Male: \_\_\_\_      Female: \_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_      Home Phone: (\_\_\_\_) \_\_\_\_\_

1. I have been unable to work because of this disability since: \_\_\_\_/\_\_\_\_/\_\_\_\_
  - a. I returned to work on a part-time basis on: \_\_\_\_/\_\_\_\_/\_\_\_\_
  - b. I returned to work on a full-time basis on: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Date of your accident or the date you first noticed symptoms of your illness: \_\_\_\_/\_\_\_\_/\_\_\_\_
  - a. Is your accident or illness related to your occupation? Yes \_\_\_\_ No \_\_\_\_
  - b. If Yes, explain: \_\_\_\_\_
3. Describe how and where the accident occurred or describe the first symptoms of your illness. \_\_\_\_\_
4. Date you were first treated for your illness or injury: \_\_\_\_/\_\_\_\_/\_\_\_\_
 

Treated by: Hospital's Name/Address: \_\_\_\_\_

Doctor's Name/Address: \_\_\_\_\_
5. Have you ever had the same or similar condition in the past? Yes \_\_\_\_ No \_\_\_\_
 

Treated by: Hospital's Name/Address: \_\_\_\_\_

Doctor's Name/Address: \_\_\_\_\_

6. Are you receiving, or are you eligible to receive, income from any of the following sources?

Yes	No	Benefits	Weekly Income	Date Income Began/Begins	Date Ended/Ends
		a. Worker's Compensation Benefits			
		b. Retirement or Disability Benefits under the State of Florida Retirement System			
		c. Primary and/or Family Benefits under the Social Security Act			

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or their person who has attended me or examined me, or any company or government agency to furnish People First, or their representative, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this form will be as valid as the original. I also understand that I must immediately contact People First or their representative, upon approval for or receipt of payment of any of the above benefits

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Employer Information - To be Completed by Agency Human Resource Office - All Fields Required:**

Date of Hire	Effective Date of Insurance	Last Day Worked	Reason for Stopping Work	Date Returned to Work	Occupation at Time of Disability

1. Is the employee entitled to benefits by virtue of employment? Yes \_\_\_\_ No \_\_\_\_
  2. Biweekly earnings at time of disability: \$ \_\_\_\_\_
  3. Employee is eligible for accumulated accident/sick leave time as of date of disability for \_\_\_\_ weeks and \_\_\_\_ days, ending on \_\_\_\_\_
  4. State Regular or Disability Retirement Benefit \$ \_\_\_\_\_ per week.
  5. Worker's Compensation Benefits \$ \_\_\_\_\_ per week
- Name & Address of Employer: \_\_\_\_\_
- Title: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_
- Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

A person who knowingly files a statement of claim containing any false, incomplete or misleading information maybe guilty of a crime and subject to criminal prosecution.

**Send Parts A and B of this form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314 or fax to (800) 422-3128  
You must resubmit the completed form to People First every 60 days of your Total Disability**

**III. State Group Disability Income Plan Claim Form-**  
**B. Attending Physician's Statement**



- Parts A and B of this form must be resubmitted every 60 days based on the Physician's reevaluation of your Total Disability.
- Please mail form to People First Service Center, PO Box 6830, Tallahassee, FL 32314 or fax to (800) 422-3128.
- If you have questions, please call (866) 663-4735.

**Employee Information - All Fields Required**

People First ID: 

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First Name: 

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Last Name: 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Complete Mailing Address: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

**Physician(s) complete remaining sections - Please Print - All Fields Required**

**1. History**

- (a) Height: \_\_\_\_\_ Weight: \_\_\_\_\_
- (b) Date symptoms first appeared or accident happened: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_
- (c) Date patient ceased work because of disability: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_
- (d) Has patient ever had same or similar condition? No Yes, state when and describe.

(e) Is condition due to injury or sickness arising from patient's employment? No Yes Unknown

(f) Names and addresses of other treating physicians, if known.  
 Name \_\_\_\_\_ Address \_\_\_\_\_  
 Name \_\_\_\_\_ Address \_\_\_\_\_  
 Name \_\_\_\_\_ Address \_\_\_\_\_

**2. Diagnosis**

- (a) Date of last examination: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_
- (b) ICD diagnostic code (mandatory): \_\_\_\_\_
- (c) Diagnosis (including any complications): \_\_\_\_\_
- (d) Subjective symptoms: \_\_\_\_\_

(e) Objective findings (including **current** X-rays, EKGs, laboratory data and any clinical findings):  
 (1.) Clinical Findings:  
  
 (2.) Diagnostic Studies and Results:

- (f) If disability is due to pregnancy, the expected delivery date is: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_
- (g) Other disease or infirmity affecting present condition: \_\_\_\_\_

# State Group Disability Income Plan Claim Form - Attending Physician's Statement cont.

## 3. Dates of Treatment

(a) Date of first visit: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_

(b) Date of last visit: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_

(c) Frequency of visits:  Weekly  Monthly  Other (specify) \_\_\_\_\_

## 4. Nature of Treatment

(a) Type and dates of treatment:

(b) Prescribed medications:

(c) Surgical procedures and dates:

## 5. Progress

(a) Patient has:  Recovered  Improved  Stabilized  Retrogressed

(b) Patient is currently:  Ambulatory  House confined  Bed confined  Hospital confined

(c) Has patient been hospital confined?  No  Yes, give name and address of hospital \_\_\_\_\_

Confined from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ through \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## 6. Cardiac (If applicable)

(a) Functional capacity:  Class 1 - No limitation  Class 3 - Marked limitation

Class 2 - Slight limitation  Class 4 - Complete limitation

(b) Blood Pressure reading at last visit: \_\_\_\_\_ / \_\_\_\_\_  
Systolic Diastolic

## 7. Limitations

(a) What are patient's present capabilities?

(b) What are the present limitations (physical and/or mental)?

(c) What restrictions are placed on the patient?

## 8. Physical Impairment as defined in Federal Dictionary of Occupational Titles

Class 1 - No limitation of functional capacity, capable of heavy work. No restrictions. (0-10%)

Class 2 - Medium manual activity. (15-30%)

Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)

Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)

Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

Remarks: \_\_\_\_\_

# State Group Disability Income Plan Claim Form - Attending Physician's Statement cont.

## 9. Mental/Nervous Impairment (If applicable)

Define "stress" as it applies to this patient.

- 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.

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof?  No  Yes

## 10. Prognosis

(a) What is the patient's prognosis?

- Guarded  Good  Fair  Poor  Other

(b) Is patient totally disabled for current job?  Yes  No For any other job?  Yes  No

(c) When do you feel patient's maximum medical improvement will be reached?

- 1 Month  1-3 Months  6-9 Months  1 year or longer

(d) What is the estimated date of the patient's return to work?

- Current job \_\_\_\_\_  Any other job \_\_\_\_\_  No return expected

## 11. Rehabilitation

(a) Is patient a suitable candidate for further rehabilitation services?

Current job

Any other job

(i.e., cardiopulmonary program, speech therapy, etc)

Yes  No

Yes  No

(b) When could trial employment commence? (FT=full-time, PT=part-time) \_\_\_\_/\_\_\_\_/\_\_\_\_  FT  PT

\_\_\_\_/\_\_\_\_/\_\_\_\_  FT  PT

(c) Would vocational counseling and/or retraining be recommended?

Yes  No

Yes  No

Attending Physician's Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Attending Physician's Signature: \_\_\_\_\_ Phone Number: \_\_\_\_\_

License Number: \_\_\_\_\_ State where License Issued: \_\_\_\_\_

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

A person, who knowingly files a statement of claim containing any false, incomplete or misleading information maybe guilty of a crime and subject to criminal prosecution.