



## SHORT-TERM DISABILITY GUIDELINES FOR REGULAR CONTRACT EMPLOYEES

### WHAT ARE SHORT TERM DISABILITY BENEFITS FOR?

Short-term disability benefits pay a percentage of an employee's salary if the employee becomes **temporarily** disabled, meaning that the employee is not able to work for a **short period of time** due to sickness or injury (excluding on-the-job injuries, which are covered by worker's compensation insurance) and the employee is unable to perform the essential functions and responsibilities of the employee's position.

Short-term disability benefits are also intended to serve as an income "bridge" during the period a claim has been submitted for long-term disability benefits for employees deemed totally and continuously disabled (no longer able to work at all or ever) by their physician/specialist.

By making application for short-term and/or long-term disability benefits, the employee acknowledges that the employee cannot perform the essential functions of the position with or without reasonable accommodation.

### 1. DEFINITION

Short-term disability (STD) benefits are available in case of a diagnosed physical or mental disability that extends beyond the employee's accumulated sick and vacation/personal leave days **during the first four (4) months of disability calculated from the last day the employee worked.**

For purposes of this program, disability is defined as the inability of the regular contract employee, as a result of extended physical or mental illness or bodily injury, to perform the essential functions of his/her job with or without reasonable accommodation.

**All disabilities for purposes of short-term or long-term disabilities must have an ICD-10 or a DSM-IV-TR diagnosis.**

A claim for STD benefits is approved only if the objective medical information provided substantiates a period of disability according to clinical guidelines. A Board-Certified medical specialist of the District's choice may further evaluate a claim for short-term disability benefits if:

- An anticipated disability duration exceeds clinical guidelines;
- The treatment protocols vary from those usually seen; or
- The provider's plan of care does not include a timely return to work.

The District may request medical records or contact the physician(s) directly. Further, the District may seek independent medical verification of the disability. Prospects for recuperation shall not be grounds for denial of STD benefits.

## 2. ELIGIBILITY FOR SHORT-TERM DISABILITY BENEFITS

The District offers short- and long-term disability (LTD) as a bundled package.

### A. Regular Contract Teachers

Participation in the District sponsored STD/LTD program is optional. Rather, contract teachers who elect coverage under the plan are assessed a monthly premium rate for coverage.

Upon election to participate at time of hire, LTD coverage is effective following 90 calendar days of contract employment. Upon election after an annual open enrollment period, coverage is effective contingent upon medical underwriting by the carrier. Provisional contract teachers are not eligible to participate in STD benefits.

### B. Regular Contract Classified, Secretarial and Administrative Employees

Participation in the STD/LTD program is provided for classified, secretarial and administrative employees. LTD coverage is effective following 90 calendar days of contract employment. Provisional contract employees are not eligible to participate in STD benefits.

## 3. PRE-EXISTING CONDITIONS

The STD program does not provide for coverage for disability resulting from or related to any pre-existing condition. For purposes of this memorandum, a pre-existing condition is a condition (except pregnancy) occurring or present prior to an employee's effective date of coverage for which medical advice, diagnosis, care or treatment was received from or recommended by a physician.

## 4. BEGINNING DATE OF SHORT-TERM DISABILITY BENEFITS

STD benefits will be paid only after ALL accrued sick leave and vacation/personal leave days have been used and after a waiting period without pay. The length of the waiting period without pay depends upon the number of unused sick leave and vacations/personal leave days the employee is able to apply to the disability involved. The length of the waiting period without pay shall be determined by the following formula:

Sick Leave & Vacation/Personal Leave Days Applied To This Short-Term Disability	Waiting Period – Contract Days Without Pay
0 – 5.9	10
6.0 – 10.9	8
11.0 – 15.9	6
16.0 – 20.9	4
21.0 – 40.9	2
41.0 or more	0

## 5. HOW TO APPLY FOR SHORT-TERM DISABILITY BENEFITS

As soon as the employee knows that the employee will be away from work for more than the accrued sick leave and/or personal leave days:

- **Supervisor Notification:** The employee must notify his or her immediate supervisor of the intent to make a claim for STD benefits.
- **Make a Claim:** To receive STD payments, the Granite School District STD claim form must be completed and submitted to the District Human Resource Benefits Office.

- **Physician/Specialist Statement:** The employee must attach a physician's statement (Diagnosis and Functional Limitations Form) detailing the condition/illness that renders the employee disabled to the STD claim form. This statement must contain the employee's anticipated return to work date.

Information about the area of a physician's specialization must be clearly stated on the DFL that is provided for STD consideration.

If the claim is denied, the employee will be sent a letter detailing the reason for the denial.

## **6. MEDICAL VERIFICATION & RECERTIFICATION**

A current Diagnosis and Functional Limitations Form (DFL) must be completed by the attending physician/specialist and be on file with the District Human Resource Benefits Office for the time period covered by the claim for STD benefits. This form must be kept current and renewed every thirty(30) calendar days during the employee's STD absence. One fifteen (15) day "grace period" will be extended per STD claim for recertification purposes.

**Benefit payments shall not be retroactive for any period of time an employee fails to make timely written application or provide other required recertification information.**

**The District is not responsible to remind employees of the requirement to provide a new DFL every 30-calendar days.**

No STD benefit payment will be paid for any period of disability during which the employee is not under the regular care and attendance of a physician.

The District reserves the right to have an independent physician of its choice examine the employee.

STD benefits may be denied by the District upon recommendation of a District-appointed physician. Any disputes between the District's physician and the employee's physician shall be resolved by a mutually agreed upon third physician.

At any period during the duration of an STD claim, the District may assess vocational rehabilitation potential and, if appropriate, refer the file to a vocational rehabilitation specialist chosen by the District.

## **7. AMOUNT OF PAYMENT**

The payment to the employee shall be 80% of contract salary not to exceed a period of 4 months. Benefits will only be paid for days within that four-month period designated by the Board as working days for the employee involved.

## **8. HOW SHORT TERM DISABILITY BENEFITS ARE RECEIVED**

STD payments begin after the application is approved, after ALL accrued sick leave and vacation/personal leave days are exhausted and after the applicable waiting period without pay.

The employee receives payment according to the regular payroll schedule for that employee.

At the end of the period indicated by the physician/specialist on the claim form, STD payments will be withheld until updated medical information is received from the physician/specialist.

## **9. MAXIMUM BENEFIT**

Paid STD benefits shall not exceed 120 days in any five-year period.

## 10. CONTINUANCE OF DISABILITY AT THE LTD “ELIMINATION PERIOD” MIDPOINT

The LTD “Elimination Period” is the first 120 consecutive days of any one period of total disability calculated from the employees last day worked.

To be considered for LTD benefits, an employee must submit a claim for LTD benefits *prior* to the cessation of paid STD benefits. The LTD carrier is the sole determinate of eligibility and acceptance or denial of any LTD claim submitted.

**FAILURE TO INITIATE A CLAIM TO THE LTD CARRIER FOR CONSIDERATION OF LTD BENEFITS PRIOR TO THE CESSATION OF PAID STD BENEFITS MAY RESULT IN TERMINATION OF EMPLOYMENT**  
(see FAILURE TO RETURN TO WORK below).

## 12. RETURNING TO WORK

When a temporary disability has ended, the employee must present medical certification to the District Human Resource Benefits Office releasing the employee to return to work. The District reserves the right to seek independent medical verification of the employee’s ability to return to work.

## 13. FAILURE TO RETURN TO WORK

- Failure to return to work as determined and attested to by the employee’s treating physician **on the date specified** on the DFL form **will result in termination of employment.**
- Failure to return to work after ceasing to provide requisite medical recertification **will result in termination of employment.**
- Failure to return to work when the maximum 120-day duration of STD benefits has been reached **without having made application for LTD benefits on or before the LTD “Elimination Period” will result in termination of employment.**

## 14. EMPLOYEE STATUS

Employees who are approved for STD benefits:

- Do not accrue sick leave or vacation/personal leave
- Do not accrue seniority (years of service advancement on salary schedule, (etc.)
- Are covered by medical and basic life insurance programs

## 15. FAMILY AND MEDICAL LEAVE ACT (FMLA)

FMLA leave runs concurrently with STD leave.

Employees working for the District who have been employed for at least one (1) year and have worked at least 1,250 hours during the year preceding the request for leave are provided up to 12 weeks of job protected, unpaid leave for one or more of the following reasons:

- The birth and care of a newborn child of the employee;

- Placement with the employee of a child for adoption or foster care;
- Care for an immediate family member (spouse, child or parent) with a serious health condition; or
- Medical leave when the employee is unable to perform his or her job duties because of a serious health condition

Dr. Stephen F. Ronnenkamp  
Superintendent



**Granite School District**  
**Short-Term Disability Claim Form**

STD Claimant's Name				Social Security #	
Street/Mailing Address			City	State	Zip
Home Phone Number ( )			Date of Contract Hire		
Is this condition due to: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness		Is this disability related to your employment? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you ever had the same or similar condition in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes" provide date(s):			I am a: <input type="checkbox"/> Teacher <input type="checkbox"/> Classified <input type="checkbox"/> Secretary <input type="checkbox"/> Administrator		
Describe the injury incurred (what, how, where, when) OR the nature and the medical diagnosis of the sickness and when it began:					
Last Day Employee Reported To Work:			Projected Date of Return To Work: (You MUST provide date)		

- \* All disabilities for purposes of short-term or long-term disabilities must have an ICD-10 or a DSM-IV-TR diagnosis.
- \* Information about the area of specialization of your physician should clearly be stated on the required District Diagnosis and Functional Limitations Form (DFL) and returned with this claim form for short-term disability benefits.
- \* Granite may seek independent medical verification of your disability.
- \* Short-term disability benefits will be paid only after ALL accrued sick leave and vacation/personal leave days have been used and after a waiting period without pay. The length of the waiting period without pay depends upon the number of unused sick leave and vacation/personal leave days the employee is able to apply to the short-term disability involved. The length of the waiting period without pay shall be determined by the following formula:

Sick Leave & Personal Leave Days Applied To This Short-Term Disability	Waiting Period Contract Days Without Pay
0 – 5.9	10
6.0 – 10.9	8
11.0 – 15.9	6
16.0 – 20.9	4
21.0 – 40.9	2
41.0 or more	0

**With my signature, I acknowledge the following:**

- I have received, read and understand Administrative Memorandum #112 outlining the STD guidelines for regular contract employees.
- I am required submit a current Diagnosis and Functional Limitations (DFL) Form (completed by my attending physician/specialist) with this application in order for my initial STD application to be recognized.
- I have notified my immediate supervisor of my intent to make a claim for STD benefits and together, we have discussed the potential duration of my absence.
- **It is my responsibility to provide the District Human Resource Benefits Office with renewed DFL every thirty (30) calendar days during my absence from work due to a short-term disability. The District is not responsible to remind me of the requirement to provide a new DFL every 30-calendar days.**
- I understand that STD benefits will not be paid beyond four (4) calendar months calculated from the last day I worked and I will only be paid for days within that four-month period designated by the Board as working days.
- I hereby acknowledge that I may experience, as a result of the short-term disability waiting period, some contract days without pay that are not reimbursable under the short-term disability plan.
- With this claim for short-term disability benefits, that I hereby acknowledge that I cannot perform the essential functions of my position with or without reasonable accommodation.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Immediate Supervisor Signature

\_\_\_\_\_  
Date



# DIAGNOSIS & FUNCTIONAL LIMITATIONS FORM

Granite School District Fax Number:

**646-4319**

## TO THE EMPLOYEE:

For continuing absence, additional forms must be submitted as per leave policy or when requested by your principal, supervisor, or the Human Resource Office. By making application for short-term and/or long-term disability benefits, you acknowledge that you cannot perform the essential functions of your job with or without reasonable accommodation. Your signature on this form certifies the accuracy of the information contained herein. Your signature also authorizes the release, to the District, of medical information regarding your diagnosis. Failure to provide this form in a proper and timely manner could result in loss of leave benefits and/or disciplinary action.

Social Security Number:	Full Name (Last, First, Middle Initial):	Phone Number
Street Address:	City :	State: Zip Code:
Work Location:	Current Position:	
<b>Describe how and where accident occurred or describe the onset and nature of your illness here:</b>		
<b>I, the undersigned, authorize the release of any and all reports to Granite School District.</b>		<b>My last actual day worked is / was:</b>
Employee's Signature	Date	

## ATTENDING PHYSICIAN'S STATEMENT

<b>DIAGNOSIS</b>		
ICD-10 / DSM-IV Diagnosis and Code Number:	If pregnancy, est. delivery date:	Subjective Symptoms:
	Delivery Type: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	
Objective Findings (including current X-rays, EKG's, laboratory data and any clinical findings):		
<b>TREATMENT</b>		
Date of first visit:	Date of last examination:	Frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
Nature of treatment (including medications prescribed, surgery, etc.):		
<b>ABILITY TO WORK</b>		
If the patient has demonstrated a loss of function, please provide restrictions and limitations <b>and the date they began</b> below:		
Restrictions (What the patient SHOULD NOT do)		
Limitations (What the patient CANNOT do)		
<b>PROGRESS</b>		
Is patient: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Hospital Confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> House Confined	Has patient been hospital confined: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , confined from _____ to _____ Name & address of hospital _____	
Has patient: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed		
Comments:		
<b>PROGNOSIS</b>		
Patient is:		
<input type="checkbox"/> Disabled short-term / temporarily	<input type="checkbox"/> own occupation	<input type="checkbox"/> any other occupation
<input type="checkbox"/> Disabled long-term / totally disabled	<input type="checkbox"/> own occupation	<input type="checkbox"/> any other occupation
Date patient became disabled due to present illness/injury:	<b>Expected date of return to work: (ESTIMATIONS NOT ACCEPTABLE)</b>	
When do you expect a fundamental or marked change in the future? <input type="checkbox"/> 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> Never    This applies to: <input type="checkbox"/> own job <input type="checkbox"/> any job		
Name of Attending Physician:	Area of Medical Specialty:	
Phone Number:	Fax Number:	Office Hours:
Street Address:	City or Town:	State: Zip Code:
Physician's Signature:	Date:	

*Any Additional Physician Comments On Reverse Side of Form*