Human Resources Department

190 Sailstar Drive NW, Cass Lake, MN 56633 • (218) 335-3698 Phone • (218) 335-3697 Fax • llbobenefits@llojibwe.net

Important Information Regarding Leave of Absences
Including Short-Term Disability Benefits

*It is **your** responsibility to speak to your supervisor, apply for leave, submit the required paperwork, follow-up with LLBO benefits and other applicable benefit providers, and submit a return to work form.*

Short-term disability

Short term disability insurance pays you a portion of your salary if you cannot work because of a disabling illness, injury, or pregnancy. Benefits are payable for up to 26 weeks as long as you remain totally disabled - this is dependent on a physician's statement and The Hartford's approval. Medical documentation will be required.

Information about applying for short-term disability benefits:

- You must notify your supervisor in writing
- Your supervisor will initiate a PAF, that includes your notice, for benefits and payroll
- You must contact The Hartford directly to apply for short-term disability benefits. This can be done over the phone or online.
- You must ensure the proper medical justification/documentation is submitted directly to The Hartford for their review.
- The Hartford will contact you directly about your case. You must ensure that you provide your current contact information.
- *LLBO benefits staff does not determine your eligibility for short-term disability benefits.*
- You must submit a return to work statement, from your physician, to your supervisor so they are aware of the date and any limitations you may have. The supervisor is responsible for submitting the return to work form with a PAF to HR to reinstate your employment status to active.

LLBO Family Medical Leave (FML)

If you were approved for a leave of absence under LLBO Family Medical Leave or Short-Term Disability, the LLBO will pay your Health Insurance premiums for a maximum of twelve weeks within a rolling twelve-month period. During your approved FML, you remain responsible for payments of any voluntary coverage(s). If you have not returned to work when your FML expires, your benefits will end on the last

day of the month and you will be eligible to continue coverage by paying the full cost of the insurance through COBRA.

Non-FML Leave of Absence

If you do not qualify for LLBO FML and are on an approved non-paid leave of absence, your benefits will terminate on the last day of the month in which your leave started and you will be eligible to continue coverage by paying the full cost of the insurance through COBRA. When you return from your leave of absence you will be eligible for benefits to begin the first of the month after your return date.

The Hartford Voluntary Life Insurance Coverage Continuation

While you are on an un-paid leave of absence, your voluntary life insurance through the Hartford will end on the last day of the month in which your leave started unless you pay your premium payments while you are on your leave of absence.

If you have not returned to work when your FML or leave of absence expires, your voluntary life will terminate on the last day of the month and you will be eligible to continue coverage by paying the full cost of the insurance through COBRA, converting it to an individual whole life policy or request a "Waiver of Premium".

UNUM Voluntary Benefits

While you are on an un-paid leave of absence, your UNUM voluntary benefits will end on the last day of the month in which your leave started unless you pay your premium payments while you are on your leave of absence. Contact Unum directly for instructions to make your premium payments for the UNUM voluntary benefits.

COBRA

You have the option to continue your health, dental and life coverage by paying the full cost of the insurance to our COBRA administrator ThrivePass. ThrivePass will send COBRA application and payment instructions once benefits have terminated.

Return from Leave / Insurance Reinstatement Procedures

It is your responsibility to notify the Benefits Office within 30 days of your return to work in order to reinstate your benefits. Failure to do so will mean you will have to wait until the next annual Open Enrollment period.

Benefit Providers Contact Information

The Hartford: (800) 549-6514
ThrivePass: (866) 855-2844
Unum: (866) 679-3054
BlueLink TPA (800) 262-0820
Delta Dental (800) 553-9536
Ascensus (888) 652-8086
LLBO: llbobenefits@llojibwe.net Phone (218) 335-3698

FILE A CLAIM WITH CONFIDENCE

Leech Lake Band of Ojibwe
Policy Number: 697221

Your disability program is managed by The Hartford.

THE HARTFORD MAKES IT EASY TO FILE A CLAIM

Step 1: Know when it's time to file a claim.

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

Step 2: Have this information ready.

- Name, address and other key identification information.
- Name of your department and last full day of active work.
- The nature of your claim or leave request.
- Your treating physician's name, address, phone and fax numbers.

Step 3: Make the call or file online. With your information handy, call The Hartford at **1-800-549-6514**. Or file online at WWW.THEHARTFORD.COM/MYBENEFITS. You'll be assisted by a caring professional who'll take your information, answer your questions and file your claim or process your leave request.

TO FILE A CLAIM

1-800-549-6514

Policy #: 697221
WWW.THEHARTFORD.COM/MYBENEFITS

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

continued

GET SUPPORTIVE ASSISTANCE

Even after your claim has been filed, we may be in touch to check your progress, answer questions or obtain additional information from you. Our goal is to offer a smooth and hassle-free experience until you return to work. Feel free to also call us with anything that's on your mind. We're here to help.

RELAX AND STAY POSITIVE

You have the assurance of our knowledge, experience and understanding of what you are going through. We're with you all the way, so you can receive the benefits you qualify for and get back to your life.

QUICK FACTS

The Hartford's goal is to help get you through your time away from work with dignity and assist you in any way we can. Keep the card below in a safe place for future use. We'll be there when you need us.

THEHARTFORD.COM/GROUPBENEFITS

(Please cut here and keep in your wallet.)

WHEN YOU CALL THE HARTFORD WILL ASK YOU TO PROVIDE:

- Name, address and other key identification information.
- Name of your department and last full day of active work.
- The nature of your claim or leave request.
- Your treating physician's name, address, and phone and fax numbers.

This card is not proof of insurance.

The Hartford® is the Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

Disability Form Series includes GBD-1000, GBD-1200, or state equivalent. The policy number is 697221.

CA20030005326539

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Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

Attending Physician's Statement – Initial

To be completed by the Provider (The patient is responsible for any expense related to the completion of this form)

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Condition

Patient's condition is a result of: ☐ Illness ☐ Injury ☐ Pregnancy

If illness or injury, is condition related to: ☐ Work Activity ☐ Motor Vehicle Accident ☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery? __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

Condition onset: __/__/____ (MM DD YYYY)

Date you first treated this patient: __/__/____ (MM DD YYYY)

First day recommended out of work: __/__/____ (MM DD YYYY)

Office visit to complete this form: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

Projected return to work date: __/__/____ (MM DD YYYY)

Disabling Diagnosis(es) and Impact to Function

ICD-10 Code
Please provide most specific codes:

|__||__||__|.|__||__||__||__| and |__||__||__|.|__||__||__||__|

Description of corresponding symptoms

Please provide most specific code possible, one character per block, up to two code entries possible. Ex.: |X|#|#|.|#|#|#|#|

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other ____________

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| and |__||__||__||__||__|

Please provide most specific code possible, one number per block, up to two code entries possible. Ex.: |#|#|#|#|#|

☐ Referral to a specialist Type: ________________________ Contact Info: ________________________________

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: ____

☐ Prescription medications Name(s): ____
☐ Impacting function? ☐ Yes ☐ No If yes, why? ____________________________________

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

Attending Physician's Statement – Initial

To be completed by the Provider (The patient is responsible for any expense related to the completion of this form)

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____ (MM DD YYYY)

In a workday the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, enter time for each section below	
				Hours at one time	Total hours in a workday
Sit	☐	or	☐	|___|	|___|
Stand	☐	or	☐	|___|	|___|
Walk	☐	or	☐	|___|	|___|

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N	Activity Ability	Right/Left	C	F	O	N
☐ Drive	☐	☐	☐	☐	☐ Squat / Kneel		☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐	Hand Dominance	☐ R ☐ L				
☐ Climb	☐	☐	☐	☐	☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐ Gross Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Max lift	____LBS	____LBS	____LBS	____LBS	☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Max Carry	____LBS	____LBS	____LBS	____LBS	☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray __/__/____ (MM DD YYYY) ☐ MRI __/__/____ (MM DD YYYY) ☐ CT __/__/____ (MM DD YYYY) ☐ EKG __/__/____ (MM DD YYYY)

☐ ECHO __/__/____ (MM DD YYYY) ☐ EMG __/__/____ (MM DD YYYY) ☐ Lab Work __/__/____ (MM DD YYYY)

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____ (MM DD YYYY)

Provider Details

Provider Name: ______________________________
Specialty: ______________________________
EIN Number: ______________________________
License Number: ______________________________

Email: ________________________
Phone: (___) ___ - ____
Fax: (___) ___ - ____

Provider Signature:
____

Date:
__/__/____ (MM DD YYYY)

Human Resources • Benefits Department
190 Sailstar Drive NW, Cass Lake, MN 56633
(218) 335-3698 Phone • (218) 335-8232 Fax

PLEASE NOTE: This form must be returned within 72 hours of doctor visit.

Return to Work Form

Employee Name: ______________________ Social Security #: ______________________

Division: ______________________ Department: ______________________

Program: ______________________ Position: ______________________

If accident, date of injury: ______________________

The following must be completed by attending physician

Date of visit: ______________________

Describe disability condition/diagnosis and course of treatment *(please be detailed)*:

____

____

____

____

Can patient return to work without restrictions? ☐ Yes ☐ No

if yes, date patient can return to work: ______________________

If patient cannot return to work, what is the anticipated return date: ______________________

If patient cannot return to work, please list reasons:

____

____

____

____

If patient can return to work with restrictions, please answer the following questions:

Return to work date: ______________________

In an 8 hour work day, can patient:

	Yes	No	If yes, maximum number of hours
Stand			
Walk			
Sit			

Does the patient have lifting restrictions? ☐ Yes ☐ No

If yes, please indicate maximum weight lifting restrictions: ______________________

Please list any other restriction that may apply to lifting, i.e.: carrying, pushing or pulling of objects:

____

____

____

Return to Work Form Continued

In an 8 hour work day patient may *(check all that apply)*:

	Not at all	Occasionally	Frequently
Bend/stoop			
Squat/kneel			
Reach			
Twist			
Climb stairs			
Sweep/mop			
Vacuum			
Stretch			
	(0-33%)	(33-66%)	(66-100%)

In an 8 hour work day patient may use repetitive motion with his/her hands *(check all that apply)*:

	Not at all	Occasionally	Frequently
Gripping objects			
Carrying objects			
Lifting small objects			
Writing/typing			
Pushing/pulling			
Fine manipulation			
	(0-33%)	(33-66%)	(66-100%)

List any other work restrictions and/or limitations that may apply:

____

____

____

____

The above restrictions/limitations are in effect until: ____________________

Does the patient require follow up care? ☐ Yes ☐ No

If yes, date of next scheduled appointment: ____________________

Additional Comments:

____

____

____

____

Physicians Signature ____________________ Date ____________________

Physicians Name *(please print)* ____________________ Phone Number ____________________

Clinic Address ____