



**CHIEF EXECUTIVE OFFICE
Risk Management Division**

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Management Short Term Disability Claim Statement

One of the management employee benefits is a self-insured limited income protection plan. This plan provides that if you are temporarily unable to work due to illness or injury (other than job related illness or injury which is already covered by Workers' Compensation) the county will continue paying 50% of your monthly salary for up to twelve months starting on the 31st day of disability.

To be eligible for the benefit, an employee must file this form with Risk Mgmt. It must be completed and returned to Risk Mgmt. within 30 days of the "first day of disability". A Department Head may file a claim on behalf of an eligible employee.

The employee must attach to this claim form, medical proof that the illness or injury is disabling to the point where the employee cannot continue on the job. Medical proof in the form of a statement from a physician or psychiatrist is subject to independent verification by a county paid medical examination.

To be completed by Employee

Full Name of employee (please print)	<input type="checkbox"/> male	Date of Birth
	<input type="checkbox"/> female	
		Occupation
Nature of sickness or injury (if due to accident, explain when, where and how it happened)	Date of first medical treatment for this condition	
	Date on which you were first unable to work because of this condition	

My 30 day waiting period will be from _____ to _____

If you have recovered or returned to work, give date	If still totally disabled, when do you expect to return to work?
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Names and addresses of physician who have been consulted because of this condition

Name	Address
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Have you been confined to a hospital for this disability? Yes No If yes, please complete

Name of Hospital	Address	from	through
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I hereby authorize any physician, hospital or other institution or person to furnish County of Stanislaus or its authorized representative, any information which they may request concerning my medical history or any examination, treatment, or prescriptions I may have received. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Employee or / Department Head _____

◆ When you have completed this form, please return to Risk Mgmt. along with Attending Physician's Statement