

## STAY-AT-WORK PROGRAM

**Standard Insurance Company (The Standard)** is offering the Stay-at Work (SAW) program to help employees who may be affected by an illness or medical condition.

**The guiding belief of the program** is that work is important and valuable:

- Promotes one's self-support and independence,
- Gives a sense of purpose and invigoration, and
- Contributes to the socioeconomic development of society.

**Lisa Angeles, RN, BSN, CCM** is the onsite case manager for The Standard to provide these services to employees of the State of Missouri. These services could include meeting with your managers or staff to discuss employees who are likely to benefit from the program, and coordinate and provide the appropriate services.

**Who can benefit from case management?** When an employee is not able to work because of a medical condition, significant costs—both human and financial—often result. With assistance, employees might be able to avoid filing a disability claim "stay-at-work," or return to work sooner if they have already filed a claim. Some triggers for referral include:

- History of frequent absences due to illness—either physical or psychological
- Exhibit performance problems that may be a result of a medical condition, and/or may have filed a claim and need accommodations to return to work.
- ADA accommodation
- Workers' Compensation
- Chronic illness or disease

**Examples of accommodations include:**

- Sit/stand work station for those who need to change positions during the day
- Ergonomic chair
- Lifting device
- Graduated schedule going from part time to full time
- Special shoes to help those who have problems with prolonged standing/walking
- Modification of job tasks
- Each employee's situation is unique. Each deserves and will receive individualized, respectful attention to their difficulties.

**Consultations:** Wednesday, 9 a.m. to 2 p.m., or by appointment  
**Place:** MOSERS, 907 Wildwood Drive, South Conference room,  
or at an alternate location  
**Phone:** 314-846-5043  
**Cell Phone:** 314-591-2806  
**Email:** langeles@stubbe.com

## STAY-AT-WORK FORM

|   |                     |                                  |              |
|---|---------------------|----------------------------------|--------------|
| Contract #:   |                     | Group #:                         |              |
| Employer/Dept:                                      |                     | Employer Contact Name/Job Title: |              |
| E-Mail:   | Phone:              | Fax:                             |              |
| Worksite Address:                                   |                     | Worksite Address (if different): |              |
| Employee Name:                                      | Home Phone:         | Work Phone:                      |              |
| Home Address:                                       |                     |                                  |              |
| SSAN:   | DOB:                | Hire Date:                       | Salary:      |
| Job Title & Description of Essential Job Functions: |                     | Supervisor/Job Title:            |              |
|   |                     | Supervisor's Phone:              |              |
| Medical Condition:                                  | Cause of Condition: | Work Related?<br>Yes/No          |              |
| Limitations/Restrictions:                           |                     |                                  |              |
| Treating Physician:                                 | Phone:              | Fax:                             |              |
| Proposed Intervention:                              |                     |                                  |              |
| Potential Vendor:                                   |                     | Vendor Address:                  |              |
| Vendor Contact Name/Job Title:                      |                     | Phone:                           | Fed Tax ID#: |

**Documents needed for consideration:**

1. Medical records which documents the diagnosis and describes the symptoms.
2. A letter from the treating physician that describes how the disabling condition is preventing the employee from carrying out the material duties of his/her job, and what specific accommodations are recommended.
3. A letter in the employee's own words that describes how the disabling condition is preventing him/her from carrying out the material duties of his/her job. The letter should mention any barriers in the workplace such as mobility, workstation layout, inappropriate chair, overhead reaching required etc.
4. Depending on the nature of the employer's insurance program, the employee may or may not be required to disclose their specific medical condition to the employer. However, to receive accommodation, they will always be required to provide the employer with a physician's statement of his/her limitations and restrictions. The physician may also recommend a particular type of accommodation.
5. The employee must sign an Authorization to Obtain Information form to allow the Nurse Case Manager/Vocational Case Manager to contact their treating physician, employer etc. to obtain clarification for consideration of this request.

02/03/10

## Authorization to Obtain and Release Information

I **AUTHORIZE THESE PERSONS** having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.*).

**TO GIVE THIS INFORMATION:**

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

**TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").**

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 2. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) \_\_\_\_\_ Social Security No. \_\_\_\_\_

Signature of Claimant/Representative \_\_\_\_\_ Date \_\_\_\_\_

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

## **Authorization to Obtain and Release Information**

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Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. The Standard Benefit Administrators performs claims administration services for Standard Insurance Company. An absence manager may be hired by your employer and may be one of The Companies.

### **FOR RESIDENTS OF NEW MEXICO**

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

|       |          |
|-------|----------|
| Name: | Analyst: |
| SS#:  | Group:   |

**PART A. TO BE COMPLETED BY PATIENT**

Please answer both 1. and 2.

1. I verify my medical condition prevents me from working on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (today's date)

2.  I returned to work on \_\_\_\_\_ (check all that apply)  my job  another job  self-employed  
 I expect to return to work on \_\_\_\_\_  part-time - number of hours: \_\_\_\_\_

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Signature \_\_\_\_\_ Phone No. \_\_\_\_\_ Date \_\_\_\_\_

The patient is responsible for the completion of this form without expense to Standard Insurance Company.

**PART B. TO BE COMPLETED BY PHYSICIAN**

**DEAR DOCTOR:**  
 The purpose of this form is to help us determine whether the clinical condition of your patient is disabling. We need to document functional impairment. Please include laboratory data and results of special tests (X-rays, CAT scan, EKG, etc.) Please attach copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes, and narrative reports.

1. Primary diagnosis: ( \_\_\_\_\_ )  
I.C.D. code  
 Secondary diagnosis: ( \_\_\_\_\_ )  
I.C.D. code

2. Date of patient's initial visit: \_\_\_\_\_ Frequency of visits:  Weekly  Monthly  
 Date of most recent visit: \_\_\_\_\_  Other (specify) \_\_\_\_\_

3. Patient's condition since last report to The Standard (or date of first visit) whichever is later: Current Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ BP. \_\_\_\_\_  
 (Please check one)  Recovered  Improved  Unchanged  Regressed

4. Describe patient's current physical, mental and cognitive limitations and work activity restrictions: \_\_\_\_\_

5. Is this patient competent to manage insurance benefits? Yes No  
 If no, is the patient competent to appoint someone to help manage the insurance benefits? Yes No

6. Planned course of treatment (include expected duration, surgeries, etc.): \_\_\_\_\_

7. Medications prescribed: dosage, frequency, dates of prescription(s): \_\_\_\_\_

8. If patient was recently hospitalized, Name of hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Admitted: \_\_\_\_\_ Discharged: \_\_\_\_\_ (Please attach operative reports and discharge summary)

9. When do you anticipate the patient can return to work? If part-time, how many hours weekly? \_\_\_\_\_  
 Anticipated date: \_\_\_\_\_, or,  Unable to determine, follow up in \_\_\_\_\_ months

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

Other physicians being consulted: \_\_\_\_\_

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

|                                  |          |                         |           |
|----------------------------------|----------|-------------------------|-----------|
| Physician's Signature:           |          | Date:                   |           |
| Physician's Name (please print): |          | Specialty:              |           |
| Address:                         | City:    | State:                  | Zip Code: |
| Phone No.:                       | Fax No.: | Physician's Tax ID No.: |           |

When both parts A and B have been completed, return to the address indicated above.