KGI KECK GRADUATE INSTITUTE

Application for Disability (VDI) Benefits

Plan & Benefit Information

This application packet is for filing a claim for disability benefits through the Voluntary Disability Insurance (VDI) Plan of The Claremont Colleges. The VDI plan is intended as a wage loss replacement benefit for eligible employees (see below) and is not a leave entitlement. These forms must be fully completed by you and your treating doctor as indicated and returned to Human Resources or TCCS Disability Administration ***as soon as possible*** to determine your eligibility to receive disability pay benefits.

Eligibility: All employees are covered by the plan on the effective date of hire unless coverage is rejected in writing. If you do not participate in the voluntary disability programs (VDI and PFL), you must participate in the state disability program.

Qualifying Reason: An employee with a serious health condition and unable to perform their job.

> Serious Health Condition Definition: An illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, or at home. This includes any period of incapacity (e.g., inability to work, attend school, or perform other regular daily activities) or any subsequent treatment in connection with such inpatient care, or continuing treatment by a physician or practitioner.

Maximum Benefit: Up to 52 weeks or the maximum benefit amount allowed for the claim, whichever comes first, and may be paid over a 12-month period. PFL benefits are paid on a 7-day calendar week per the California Employment Development Department (EDD). Note: VDI payments are not subject to federal or state taxes.

Waiting Period Waived: Effective January 1, 2025, the 7-day waiting period no longer applies to ALL VDI and PFL claims.

Base Period: The amount of the *basic weekly benefit* depends on the total wages paid to you during a 12-month base period. As shown below, the month in which your claim begins determines which 12-month period is used.

If your claim begins in:	**The base period is the preceding:**
January, February, or March	October 1 – September 30
April, May, or June	January 1 – December 31
July, August, or September	April 1 – March 31
October, November, or December	July 1 – June 30

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Forms and Instructions

Notify Your Supervisor and Human Resources

As soon as possible, contact your supervisor and your Human Resources office to request a medical leave of absence and provide a note from your treating doctor placing you off work. Submit this request before you start your leave, or within 24 hours for emergency leaves.

VDI Benefits Application Forms

Employee Claim
Complete this form to provide information about your disability and to request ("claim") your benefits.

Authorization to Furnish Medical Information and Declaration of Disability
Complete this form to give us permission to receive your medical information from your healthcare provider on the *Medical Certification*. As required, on this form you will also declare you are disabled for the period of your claim.

Supplementation (Staff) and Coverage of Benefits Deductions
Complete this form to let us know if you want to supplement your VDI pay with your available sick and vacation hours, provided you first exhaust all sick hours before using vacation hours (for staff). On this form, you also state if you authorize your benefits deductions for your insurance plans to be taken from your VDI pay or if you will make payments directly to TCCS Benefits Administration.

Note: When an employee is receiving payments under the VDI plan, and supplementing their VDI payments, their vacation and sick time balances have been exhausted, they will no longer receive any contributions into the 403(b) plan since VDI payments are not eligible to be placed into any 403(b) plan.

Therefore, contributions to your 403(B)-retirement plan will not be deducted from your VDI payments, nor will KGI make contributions on your behalf since the college contributions are based on wages, including vacation and sick pay, but excluding VDI benefits.

Medical Certification (Completed by Your Doctor)
Give this form to your treating healthcare provider (doctor) for completion to certify your claim.

Important: All forms must be ***fully completed and received*** by Human Resources or the TCCS Disability Office before eligibility can be determined. Incomplete or late forms will delay your benefits. Once we determine your eligibility, we will send you a letter with your weekly benefit amount and will process payments in accordance with KGI's payroll schedule.

Questions or Need Assistance? Contact Human Resources at HR@kgi.edu or (909) 607-7853 or TCCS Disability Administration at disability@claremont.edu or (909) 621-8847. If you have any questions regarding your institution's leave of absence policies, please contact Human Resources at HR@kgi.edu or (909) 607-7853.

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Employee Claim Form

Important: To avoid delaying your VDI pay benefits, complete all the items on this form that apply to your claim.

1. First Name:_____ 2. Middle Initial(s): _____ 3. Last Name: _____

4. Home Address: _____ 5. Phone: _____

6. Email: _____ 7. Workday ID #: _____ 8. Last 4 of SSN: __ __ __ __

9. Date of Birth: _____ 10. Position Title: _____

11. TCC Institution: _____ 12. Department: _____

13. What date did your **disability start**? _____ 14. What was the last date you worked? _____

15. Have you recovered from your disability? ☐ Yes ☐ No

16. Describe what regular work duties (e.g., sitting, walking, typing, lifting, etc.) you cannot perform due to your disability:

_____

17. Was this disability caused by your work? ☐ Yes ☐ No (go to the *Acknowledgement and Certification* section)

18. Describe how your disability(ies) occurred from your work: _____

_____

19. Are you claiming Workers' Compensation benefits for any injuries or illnesses during any period covered by this claim?

☐ Yes ☐ No

20. Are you receiving Workers' Compensation benefits for any injuries or illnesses during any period covered by this claim?

☐ Yes ☐ No

Acknowledgement and Certification

I hereby claim benefits and certify that for the period covered by this claim I was unemployed and disabled, that the foregoing statements including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize my attending physician, practitioner, or hospital to furnish and disclose all facts concerning my disability that are within their knowledge and allow inspection of and provide copies of any medical records concerning my disability that are under their control.

I understand and acknowledge that under Section 2101 of the California Unemployment Insurance Code, it is a misdemeanor to willfully make a false statement or knowingly conceal a material fact to obtain the payment of any benefits, such misdemeanor being punishable by imprisonment not exceeding six (6) months or by a fine not exceeding $500 or both.

Employee Signature: _____ **Date**: _____

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

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Authorization to Furnish Medical Information and Declaration of Disability

Important: Read this form carefully. To avoid delaying your VDI pay benefits, complete all the items on this form.

First Name:_____ Last Name: _____

Last 4 of your SSN: __ __ __ __ Date of Birth: _____ Date Disability Begins: _____

TCC Institution (Employer): _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or carrier to furnish and disclose to *The Claremont Colleges Services Disability Administration Office* all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control. I understand that *The Claremont Colleges Services Disability Administration Office* may disclose information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected by this rule. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for five (5) years from the date received by *The Claremont Colleges Services Disability Administration Office* or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent recovery of monies to which it is legally entitled.

Employee Signature: _____ Date: _____
If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

Declaration of Disability

By my signature on this claim statement, I claim disability benefits and certify that for the period covered by this claim I was disabled and unable to work. I understand that willfully making a false statement or concealing a material fact to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to then best of my knowledge and belief true, correct, and complete.

By my signature on this claim statement, I authorized *The Claremont Colleges Services Disability Administration Office* and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the *Health Insurance Portability and Accountability Act (HIPAA) Authorization* portion of this form. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of five (5) years from the date of my signature or the effective date of the claim, whichever is later.

Employee Signature:_____ Date: _____
If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature:_____ Address: _____

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Supplementation (Staff) and Coverage of Benefits Premiums

First Name:_____ Last Name: _____

Date Disability Begins: _____ TCC Institution: _____

Staff: Authorization of Supplementation (not applicable to Faculty)

If you are eligible for voluntary disability insurance (VDI) payments, they will provide approximately 70% or 90% of your base wages. Your accrued sick leave (hours) can be used to supplement your VDI pay up to 90% of your base salary. If your sick hours exhaust, you can allow the use of your available vacation hours to supplement your VDI pay during your leave.

☐ **I authorize the use of my accrued time off ("accruals") as follows:**

(Indicate if you wish to allow the use of "all" or a specific number of hours.)

Sick hours: _____ **Vacation hours**: _____

I understand that while I receive sufficient pay from my accruals, payroll deductions for my insurance benefits (i.e., medical, dental, vision, retirement, etc.) will continue. If my accruals exhaust or are not sufficient to cover my deductions, I must either allow the use of my VDI pay to cover benefit premiums (see below) OR I must make premium payments directly to TCCS Benefits Administration.

OR

☐ **I choose NOT to supplement my VDI pay with my available sick time, and therefore, neither vacation ("accruals").**

I understand that by not authorizing the use of my accruals, I will only receive disability pay, if I am eligible. To continue my coverage for my elected insurance benefits (e.g., medical, dental, vision, retirement, etc.) I must allow deductions for my benefit premiums from my VDI pay (see below) OR I must make cash payments directly to TCCS Benefits Administration.

Authorization of Coverage of Benefit Premiums

California regulations allow you to use a portion of your voluntary disability insurance (VDI) payment to cover all or part of the employee portion of the premiums for the benefit insurance plans in which you are currently enrolled (e.g., medical, dental, vision, retirement, etc.). To allow the use of your VDI payments to cover your benefit premiums, you must provide a written authorization.

☐ **YES, I authorize deducting my benefit premiums from my VDI payments.**

I understand these premium deductions will continue until I terminate them, reach my maximum VDI benefit amount or leave of absence time, or until I return to work, for a maximum of up to 12 months. I understand I can terminate or change these deductions at any time while receiving VDI payments (see Stopping Benefit Deductions below). I understand that benefits deductions from VDI payments can only be taken after taxes.

☐ **NO, I do NOT authorize deducting my benefit premiums from my VDI payments and understand I must make timely payments by personal check, cashier's check, or money order for my premiums to TCCS Benefits Administration.** Please contact Benefits Administration for detailed instructions: BenReps@claremont.edu or (909) 621-8151.

Stopping Benefits: If you wish to stop coverage on an after-tax benefit plan (e.g., life insurance) or would like to inquire if special approval is available to stop coverage on a current pre-tax benefit plan while on a leave of absence, submit your request in writing to TCCS Benefits Administration at BenReps@claremont.edu, or by mail, fax, or in person.

Legally Incompetent VDI Recipients: If the disability benefit recipient has been declared legally incompetent, the spouse of the recipient, in the absence of any other legally authorized representative, shall have the right to continue or cancel the authorization to use VDI payments for benefits premiums coverage.

Employee Signature: _____ Date: _____

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature:_____ Address: _____

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

***IMPORTANT NOTE:** The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) and the federal Genetic Information Nondiscrimination Act of 2008 (GINA) prohibit employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by law. **To comply, we are asking that you not provide any genetic information when responding to this request for medical information.** "Genetic information," as defined by CalGINA and GINA, includes information about the individual's or the individual's family member's medical history, genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic information" does not include information about an individual's sex or age.

SECTION I - EMPLOYER

Company Name _____

Company Contact _____

Attach a copy of the employee's job description and the essential job functions of the employee's position to this form.

Instructions for the employee: The law permits us to require that you submit a timely, complete and sufficient medical certification to support your request for FMLA/CFRA leave to care for yourself or a covered family member with a serious health condition. If requested by your employer, your response is required to obtain the benefit of Family and Medical Leave Act (FMLA)/California Family Rights Act (CFRA) protections. Failure to provide a complete and sufficient medical certification may result in a denial of your request. You have **15 calendar days** to return this form to the company. If extenuating circumstances prevent you from returning this certification in a timely manner, please contact _____ .

_____ _____

Employee Name | Employee Contact Number

If the request is to care for a family member:

_____

Name of the family member/patient for whom you will provide care

Relationship of family member to you:

- ☐ Child (if the child is under the age of 18, or over the age of 18, if the child is incapable of self-care due to a physical or mental disability), parent or spouse. **(CFRA only, FMLA only or CFRA/FMLA depending on eligibility and leave availability)**
- ☐ Child (if the child is an adult capable of self-care), parent-in-law, grandparent, grandchild, sibling, domestic partner or someone else with a blood or family-like relationship with the employee ("designated person"). **(CFRA only)**

If the request is to care for a family member, please complete Attachment B and **provide to the health care provider**, not your employer.

I certify that the information I have provided is true and correct.

_____ _____

Employee Signature | Date

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

SECTION II - HEALTH CARE PROVIDER

I**nstructions for the Health Care Provider:** The employee listed above has requested leave under the FMLA/CFRA to care for himself/herself or for your patient who is a family member or "designated person" listed above. Please answer fully and completely all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. Limit your responses solely to the condition for which the patient needs leave. Please be sure to sign the form. **PLEASE DO NOT DISCLOSE THE UNDERLYING DIAGNOSIS, INCLUDING ANY GENETIC INFORMATION*, WITHOUT THE CONSENT OF THE PATIENT.** Do not provide information about genetic tests, as defined in 29 CFR 1653.3 (f), genetic services, as defined in 29 CFR 1635.3 (e), or genetic information, as defined by CalGINA or GINA. Please be sure to sign the form.

1. Date medical condition or need for treatment commenced: _____

2. Probable duration of medical condition or need for treatment: _____

3. *Attachment A: Definitions* describes what is meant by a "serious health condition" under both the federal FMLA and California CFRA. Does the patient's condition qualify as a serious health condition?

   ☐ Yes ☐ No

4. If the certification is for the serious health condition of the employee, please answer the following:

   a. Is the employee able to perform work of any kind?

      ☐ Yes ☐ No (If "no" skip next question)

   b. Is the employee unable to perform any one or more of the essential functions of the employee's position? (Please answer after reviewing the attached job description provided by the employee that includes the essential functions of the employee's position.)

      ☐ Yes ☐ No

      If yes, to 4b, please identify the job functions the employee is unable to perform.

      _____

      _____

5. If the certification is for the care of the employee's family member or "designated person," please answer the following:

   a. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation needs or the provision of physical or psychological care?

      ☐ Yes ☐ No

   b. After review of the signed *Employee's Statement Regarding Seriously Ill Family Member* (Attachment B), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

      ☐ Yes ☐ No

6. Estimate the period of time the employee will need care or during which the employee's presence would be beneficial to participate in care for the employee's family member:

   _____

***** See the "Important Note" on page 1 of this form. CalGINA and GINA prohibit employers from obtaining genetic information. **To comply, we are asking that you not provide any genetic information when responding to this request for medical information.**

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

7. Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule:

Yes No

☐ ☐ Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee, family member or "designated person"?

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

☐ ☐ Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee, family member or "designated person"?

If yes, please indicate the part-time or reduced work schedule the employee needs:

_____ hour(s) per day; _____ day(s) per week, from _____ through _____

☐ ☐ Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment and the time required for each appointment, including any recovery period:

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per appointment/treatment

_____ _____
Signature of Health Care Provider Date

_____ _____
Signature of Employee Date

Physician or Practitioner Information:

_____
Physician's or Practitioner's Name

_____
Business Address

_____ ____ _____-_____
City State Zip

(____) ____-_____
Telephone

RETURN THIS FORM TO THE PATIENT. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.

Form adapted for California use from CFRA Regulations (2 CCR sec. 11097) and CRD-E11P-ENG (1/23) and U.S. Department of Labor WH-380-E and WH-380-F Revised June 2020 (OMB Control Number 1235-0003 Expires: 06/30/2026)

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

Attachment A: Definitions

A "serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, domestic partner, or someone else with a blood or family-like relationship with the employee ("designated person") of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

HOSPITAL CARE

Inpatient care in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a health care facility formally admits the person to the facility with the expectation that the person will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

ABSENCE PLUS TREATMENT

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

1. Treatment two or more times by a health care provider (for FMLA only, the two treatments must occur within 30 days ***), by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
2. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

For FMLA only, the employee's first treatment must occur within 7 days of first day of incapacity. ***

PREGNANCY

Any period of incapacity due to pregnancy or for prenatal care.
(Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.)

CHRONIC CONDITIONS REQUIRING TREATMENT

A chronic condition, which:

1. Requires periodic visits (for FMLA ONLY, periodic means at least two times per year ***) for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

*** California law does not include these time limitations. If a leave is FMLA/CFRA, follow the California law without these time limitations.