Requesting a Family Medical Leave or Short-Term Disability Claim

UnitedHealthcare is committed to supporting you during your absence and helping you achieve a timely and healthy return to work. This guide will assist you in making a request for scheduled or unscheduled absences. This process applies to short-term disability (STD), the Family Medical Leave Act, and related state or company specific leave policies. Please review the following information carefully.

Follow These Simple Steps

1. Notify your manager or supervisor of your absence from work.
2. Using the Information Checklist, gather information about your absence. Have this information ready when you call us. If someone makes the call for you, he or she will need to provide this information on your behalf.
3. Call us toll free at 1-866-556-8298. Hours of operation are Monday through Friday, 8:00 a.m. – 6:00 p.m. ET.
4. If your absence from work is due to your own health condition, please sign and date the included Authorization Form. Give your physician the signed and dated form. Please also fax a copy of the signed, dated form to us at 1-866-334-0985.

What Happens Next

Every absence is unique and next steps can differ depending upon the type of claim or leave request. When you contact us at 1-866-556-8298 and we learn more about your specific request, we will guide you through the process, answer any questions and tell you what to expect next. You have our commitment to be responsive and supportive during your time away from work.

Information Checklist

Please have the following information ready when you call:

- ☐ Employer's name and location
- ☐ Your full name and Social Security number
- ☐ Your complete address and phone number
- ☐ Date of birth
- ☐ Marital status and number of dependents
- ☐ Occupation or job title
- ☐ Supervisor's name and phone number
- ☐ Last day you worked and first day you were absent from work
- ☐ Date you expect to return to work (if you know), or the actual date (if you have already returned to work at the time you call)
- ☐ If the absence or claim is due to your own health condition, please have the following information available:
  - Description of medical condition, including any relevant dates of injury or if it is work related
  - Physician's name, address and phone number
  - Dates of your first visit, your most recent visit, and your next scheduled visit with your physician for this condition

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How to Request Family Medical Leave or a STD Claim

1. Notify your supervisor or manager of your absence from work.
2. Gather information about your absence. Review the Information Checklist for guidance.
3. Call UnitedHealthcare at 866-556-8298.
4. Complete and fax any necessary forms to UnitedHealthcare at 866-334-0985.

Hours of operation are Monday through Friday, 8:00 a.m. – 6:00 p.m. ET

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Authorization to Release Information

Please be aware: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony, and may be subject to imprisonment, fines, and civil damages. **California:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of Insurance within the department of regulatory agencies. **Florida:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Kentucky:** Any person who knowingly, and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime. **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

By my signature below, I demonstrate my informed consent and authorization to allow my health care provider(s)/attending physician(s) named in Part I and II to release, disclose and communicate to my employer or employer representative, such health care records and information concerning my current medical condition(s) as is or may be necessary to support my request for a leave of absence and disability benefits and/or any additional benefits my employer or employer representative may provide. I further authorize my employer or employer representative to contact my health care provider directly for the purposes of clarification and verification of the authenticity of information on this form. This authorization shall be valid for one (1) year from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of Employer-provided benefits. I understand that information disclosed to my employer or employer representative may be subject to additional disclosure and not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The information shall not be released to my immediate supervisor.

Employee's Signature: _____ Date: _____

Employee's Name (please print): _____ Telephone Number: _____

If the employee does not sign this authorization and the employee fails to obtain clarification of incomplete or inconsistent responses upon request, the employee's leave may be denied. 29 C.F.R. §825.307(a). You have a right to obtain a copy of this authorization after you sign it.

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C.§§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. §825.313.

UnitedHealthcare Disability products are provided by UnitedHealthcare Insurance Company; and in California by Unimerica Life Insurance Company; and in New York by Unimerica Life Insurance Company of New York. In New York, it is provided on Form LASD-POL-ADD/DIS NY (05/03). In Texas, it is provided on Form LASD-POL-TX (05/03) or Form UHCLD-POL 2/2008-TX. UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Life Insurance Company in Milwaukee, WI; Unimerica Life Insurance Company of New York in New York, NY. Some products vary by state or may not be available in all states.