*** INSTRUCTIONS***

REPORT BY EMPLOYER OF LEAVE STATUS FOR EMPLOYEE (Half sheet)

Employer completes. Actual dates are to be recorded by the Timekeeper.

PRELIMINARY STATEMENT OF DISABILITY

Employee completes. If injury or illness is not related to work, please complete designated section.

Maternity benefits will be considered same as an illness. Non-occupational illness, including maternity, a seven (7) day waiting period is applied. No waiting period applied for Injury. After completing your section, signature and date is REQUIRED before process begins.

IF WORK RELATED CONDITION, INQUIRE WITH THE WORKERS' COMPENSATION PROGRAM AT 928-871-6389

The bottom section, after the employee's signature, will be completed by the Employee Benefits Program or Enterprise Representative on behalf of the Employer.

ATTENDING PHYSICIAN'S STATEMENT OF ACCIDENT OR ILLESS

Doctor completes. If section incomplete, claim will be sent back to you for completion.

NOTE: For maternity claims, it is the responsibility of the employee to add a newborn to their policy at their discretion within thirty-one (31) days from the date of birth to allow coverage for the child from the date of birth. Otherwise, Open Enrollment Period would apply. Please contact our office to inquire.

W-2 will be issued at the end of the benefit year for tax purposes.
Unpaid Premiums will be collected on the first payroll the employee receives once returned to work.

Revised 01/2019

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APPLICATION SUBMISSION BY:

In Person:

Administration Building One, Second Floor
Window Rock, AZ

Mail to:

Navajo Nation Employee Benefits Program
PO Box 1360
Window Rock, AZ 86515

Fax to:

(928) 871-6408, call to verify receipt

Scan and Email to: benefitsdocs@navajo-nsn.gov

Loleta Jim, Insurance Claims Analyst, or Michelle Yazzie, Insurance Claims Analyst
loletakjim@navajo-nsn.gov or michelleyazzie@navajo-nsn.gov

For Navajo Nation employees, Family Medical Leave (FMLA) applications are available at the NN Department of Personnel Management office and require a separate application process for employment purposes.
www.dpm.navajo-nsn.gov

(Inter-office Use Only)

Total Paid _____

# of Days_____

(Inter-Office Use Only)

_____ Opened

_____ Closed

_____Reopened

_____ Closed

Navajo Nation Employee Benefits Program

Report by Employer of Leave Status for Employee

Member ID _____ (Inter-Office Use Only)

Employee's Name_____ Social Security No_____

Mailing Address_____ City_____ State_____ Zip_____

Date Last Worked_____ Date Returned to Work_____

Date Sick Leave Exhausted_____

(*If Sick Leave is not accrued, date would be the same date as Date Last Worked.)*

Date Employee is anticipated to return to work?_____

Employee must be totally disabled, be under a physician's care for the disability, exhaust sick leave hours, and satisfy all provisions and requirements for filing a claim. A seven (7) day waiting period applies for all non-occupational illness/maternity; no waiting period for a non-occupational injury. All information is subject to verification.

Dept/Prog_____ Dept No_____

Completed by (Print Name)_____ Tele No_____ Date_____

*A copy of the Official timesheet and a current Job Description must be attached for the insured employee'

10/15

NAVAJO NATION EMPLOYEE BENEFIT PLAN
PRELIMINARY STATEMENT OF DISABILITY-STD

THIS SECTION TO BE COMPLETED BY EMPLOYEE (Please Print)			Plan Number 710000	
Full Name (Last, First, M.I.)			Social Security No.	Date of Birth
Mailing Address			Employer	Home Phone ( )
City	State	Zip	Email	
Occupation			Gender ☐ Male ☐ Female	Type of Disability ☐ Accident ☐ Illness ☐ Maternity

Describe how and where accident occurred or list symptoms of illness.

Complete if your claim is for an accident:	Complete if your claim is for an illness or maternity:
Date accident occurred_____	Date symptoms first noticed_____
How and Where? _____	Date first treated_____
Date symptoms first noticed_____	List symptoms of illness_____
Date first treated_____	_____

Have you had same or similar conditions in the past? ☐ Yes ☐ No	If so, when?	Doctor name and address	Hospital name and address
Is your injury or illness related to your work? ☐ Yes ☐ No		Date claim filed with Workers' Compensation Program	

If Workers' Compensation denied your claim, attach copies of denial letter, original claim filed, and Employee's Claim Petition

I have been unable to work because of the disablity since (m/d/yr):	☐ I returned to work Part Time on (m/d/yr)	☐ I returned to work Full Time on (m/d/yr)
Date first treated for illness or injury	Doctor name and address	Hospital name and address

Describe any other income you are receiving or are eligible to receive as a result of your disability: (Examples: Social Security, Workers' Compensation, State Disability, Pension Disability, etc.)

Describe Source	Amount of Income	Date Income Began	Date Income Ended

If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purpose? ☐ Yes ☐ No (W2 will be provided for benefits paid)

If "yes", enter amount $_____ (Amount per week $20.00 minimum)

_____ Signature (required)

AUTHORIZATION TO RELEASE INFORMATION- Must be signed and dated to validate the claim.

To: Any licensed physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, employer, or consumer reporting agency.

(1) I authorize you to release the following to Verdegard Administrators, LLC., their reinsurers, or any consumer reporting agency on their behalf for purposes of determining disability benefits: full information, including copies of records, concerning medical examinations, history and treatment, occupation, income, and financial status.

(2) I have a right to receive a copy of this authorization upon request. A photocopy of this authorization shall be considered as valid as the original.

This authorization shall be valid for a period of one year from the date of signature.

DATE_____ SIGNATURE OF EMPLOYEE_____

THIS SECTION TO BE COMPLETED BY EMPLOYER (Please Print)

Employee's Name	Last Day Worked	Reason for Stopping Work	Date Returned Full Time	Date Returned Part Time

Date Hired	Occupation at Time of Disability	Work Schedule at Time of Disability Days/wk: Hrs/day:	Basic Annual Earnings as of Last Day Worked $

By any Employer-Employee, Labor Management, Union Welfare Plan or any State Disability, will (or has) Employee file(d) for Unemployment Compensation or for Disability provided? ☐ Yes ☐ No If yes, please specify:	Is Employee eligible for Workers' Compensation? Amount $ Carrier ☐ Yes ☐No

Employer Address

Telephone	Title	Date	Signature

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY 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 INSURANCE ACT, WHICH IS A CRIME.

Revised 09/2024

ATTENDING PHYSICIAN'S STATEMENT OF ACCIDENT OR ILLNESS

1. Patient's Name

Date of Birth

2. Nature of injury or illness (Describe complications, if any):

3. When did accident happen or symptoms first appear? (m/d/yr)

4. When did patient first consult you for this condition? (m/d/yr)

5. Is condition due to injury or sickness arising out of patient's employment?
☐ Yes ☐ No If yes, explain:

6. Has patient ever had same or similar condition?
☐ Yes ☐ No If yes, state when and describe:

7. Describe any other disease or infirmity affecting present condition:

8. Date and nature of surgical or obstetrical procedure, if any. Describe fully:

9. Give dates of treatment:

OFFICE_____
HOME_____
HOSPITAL_____

10. If patient is hospitalized give name and address:

HOSPITAL_____
ADDRESS_____
CITY, STATE, ZIP_____
Date admitted_____ Date Discharged_____

11. How long was or will patient be continuously totally disabled. (Unable to work)?

From_____Through_____
(m/d/y) (m/d/y)

12. If due to pregnancy: ☐ Natural birth ☐ C-section

LMP Date_____EDC Date_____

Date Delivered:_____
Complications, if any:

13. Is this patient competent to endorse checks and direct the proceeds with a clear understanding of the nature of his/her acts? Comments.

☐Yes ☐No

(*As defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1 - No limitation on functional capacity; capable of heavy work* No Restrictions. (0-10%)
- ☐ Class 2 - Medium manual activity* (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
- ☐ Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary*) activity. (60-70%)
- ☐ Class 5 - Severe limitation or functional capacity; incapable of minimum (sedentary*) activity (75-100%)

REMARKS:

Attending Physician's Name (Please Print)

Signature

Mailing Address

City

State

Zip

Telephone
( )

Date

Degree

Revised 09/2024