



WILLIAMSON COUNTY GOVERNMENT

Name: _____
Social Security Number: _____
Date of Birth: _____
Telephone: _____
Location/Dept: _____

Williamson County Government Temporary Disability Program Application

Full time employees who are unable to perform the tasks of their jobs for seven consecutive calendar days due to non-job related illness, injury or condition will be covered under Williamson County’s Disability Program.

An employee who qualifies for this program must use all available sick time for each day of absence before the Williamson County Disability Program begins. If the employee does not have enough sick time to cover the seven (7) day waiting period, the employee may choose to use vacation time or simply allowed unpaid time off. This Program will begin on the eighth (8th) day of disability and provides coverage for up to six (6) months.

Please indicate type of disability continuation once all available sick time has been used. (Check the)

I choose to use **all available sick time, vacation time,** then **all available rollover time** credited to retirement (up to 60 days). Once all time available in rollover (retirement) account has been exhausted, then \$5.00 per hour (up to \$200.00 weekly) disability payment will be received for the remainder of the 6 months allowed under the program.

I choose to use **all available sick time,** then **all available rollover time** credited to retirement (up to 60 days). Once all time available in rollover (retirement) account has been exhausted, then \$5.00 per hour (up to \$200.00 weekly) disability payment will be received for the remainder of the 6 months allowed under the program.

I choose to use **all available sick time,** then \$5.00 per hour (up to \$200.00 weekly) disability payment will be paid for up to 6 months allowed under the program.

Please Note: Election of disability continuation cannot be changed once processed.

Before payment can be processed the following must be on file with the Benefits Department:

- Payroll Change Notice (PCN) from supervisor
- Authorization to Disclose Health Information Form
- Temporary Disability Benefit Application

All pages must be completed in full and returned to the Benefits Department to avoid delay in payment of the Williamson County Temporary Disability Program Benefit. Fax to (615) 790-5876 or email to gina.crawford@williamsoncounty-tn.gov

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee Signature: _____ Date: _____

Separate periods of disability, resulting from the **same or related condition** and not separated by at least **“ninety (90)”** days are considered a continuation of the prior disability. An employee who returns to a short term disability status for the same or related condition within **“fourteen (14)”** days of returning to work would be allowed to access the balance of his/her original rollover sick time without an additional waiting period



Employee Name: _____

Date of Birth: ____/____/____

Last 4 of social security number _____

Williamson County Government Temporary Disability Program Application

Contact Gina Crawford with questions regarding completion of this form at gina.crawford@williamsoncounty-tn.gov or at (615)790-5600.

Return completed form to Williamson County Benefits Department, attention Gina Crawford by email gina.crawford@williamsoncounty-tn.gov or fax to (615)790-5876.

To avoid a delay in payment of the temporary disability benefit, this form must be completed in full.

Authorization to release information: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signature of Employee: _____

Date: _____

Physician Statement

Physician Information:

Physician Name (Print and Sign)

Physician Address

Telephone #

1. Diagnosis, please supply diagnosis code and given name of diagnosis

2. Is condition due to injury or sickness arising out of employment? Yes ___ No ___

3. Date of Treatment

a. Date first seen for this condition/diagnosis _____

b. Is patient still under your care for this condition? Yes___ No___

c. If no, who is the treating physician? _____

d. Based on diagnosis indicated in question 1 above, is patient totally disabled and unable to work?
Yes___ No___

e. If yes, please provide dates of disability (unable to work) From_____ Thru_____

Physician Remarks:

