Rogers C. Anderson
Williamson County Mayor

Benefits

Gina Crawford
Director

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 the weekly $200.00 disability benefit 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 the weekly $200.00 disability benefit for the remainder of the **6 months** allowed under the program.

☐ I choose to use **all available sick time**, **then the $200.00 weekly** disability benefit 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 **jaimew@williamson-tn.org**

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.

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.

Name: _____
Social Security Number: ____-___-____
Date of Birth: _____/_____/_____
Telephone: (____)_____-_____
Location/Dept.:_____

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: _____

Part B – Physician's Statement
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. First seen for this condition/diagnosis _____
b. Was employee first seen in
   Office ___ Hospital ___ or Other ___ for this condition?
   If other please explains: _____
c. If hospitalized, name of facility_____
   Admittance date_____ Discharge date_____
d. Is patient still under your care for this condition? Yes___ No___
e. If no, who is treating physician?
   _____
f. Based on diagnosis indicated in question 1. above, is patient totally disabled and unable to work? Yes___ No___
g. If yes, please supply dates of disability (unable to work)
   From_____ Thru_____

Physician Remarks:

_____
_____
_____
_____

Note to Physician: Please be sure to fill out all of # 3, especially item (g.) and sign.