Catholic Diocese of Cleveland

CATHOLIC DIOCESE OF CLEVELAND
WEEKLY DISABILITY/MATERNITY BENEFITS CLAIM FORM

1404 EAST NINTH STREET, EIGHTH FLOOR • CLEVELAND, OH 44114-1722
216-696-6525 EXT. 5040 • FAX 216-621-9622 • hbo@dioceseofcleveland.org

PLEASE RETURN TO THE DIOCESE BENEFITS OFFICE UPON COMPLETION

TO BE COMPLETED BY EMPLOYER

Employee Name _____ Last 4 Digits Of SS# _____

Title _____ _ Hourly _ Salary Current Rate Of Pay _____ Effective Date _____

Reg. Work Year Annual Salary/52 = $ _____ *or* Teacher Work Year Annual Salary/43 = $ _____

Accrual Balances: Sick_____ Vacation_____ Other_____

Academic/Contract Start Date: _____ Year End/Last Work Day: _____

Date Last Worked _____ Expected Date Return To Work _____ Injured On Job? Yes (explain) No

Explanation: _____

_____

Will sick and other PTO balances be paid? Yes No Date through which sick pay will be paid by employer _____

If your church or institution has 50 or more employees, was the employee provided FMLA paperwork? Yes No

Is FMLA paper work returned Yes No N/A

Name of Employer (Church or Institution) _____

Address _____

Date _____ Authorized Name (Print) _____

Authorized Signature _____ Phone _____

THE FORM MUST BE SUBMITTED WITH TWO (2) MOST RECENT PAY STUBS AND A SCREEN SHOT OF PTO BALANCES IF NOT INCLUDED ON THE PAY STUB

TO BE COMPLETED BY EMPLOYEE

Name _____

Address _____

Telephone _____ Date of Birth _____ _ Male Female

Beginning of Maternity Disability If disabled due to accident, how, when, where did it occur (explain)

_____

_____

Do you expect payment from other sources because of this accident (insurance, legal action, etc.)? Yes No

I certify that the information provided is complete and accurate. I authorize any physician, healthcare provider, hospital, or other institution that has provided care to me to release any and all relevant information to The Catholic Diocese Group Life and Benefits Office or its authorized representative. A photocopy or electronic copy of this authorization shall be considered as valid as the original. I understand that FICA tax will be withheld from any benefits paid and that disability benefits are subject to Federal Income Tax.

DATE _____ EMPLOYEE SIGNATURE _____

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis _____

_____

Hospitalized? Yes _ No If yes: From _____ To _____

Pregnancy? Yes No If yes: Due Date _____

Date patient first consulted you for the disability condition (omit for pregnancy) _____

Patient disabled and unable to work? From _____ to _____

Date patient has or should be able to return to work _____

Physician's name (print) _____

Physician's (signature) _____ Date _____

Address _____

Telephone _____ Fax _____

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INSTRUCTIONS FOR COMPLETING THE DISABILITY/MATERNITY WEEKLY CLAIM FORM

1. PARISH / EMPLOYER SECTION

Complete the 'TO BE COMPLETED BY EMPLOYER' portion of the form:

- Fill in all requested information about the employee (name, last 4 of SSN, title, pay rate, effective date,work year salary calculation, accrual balances, last day worked, expected return date, etc.).
- Indicate if the injury occurred on the job and whether PTO balances will be paid.
- Confirm if FMLA paperwork has been provided and whether it was returned.
- Provide authorized name, signature, date, phone number, and parish/institution address.

ATTACH:

- Two most recent pay stubs
- Screenshot of PTO balances (if not shown on pay stub)
- FMLA forms (if applicable)

2. EMPLOYEE SECTION

Complete the 'TO BE COMPLETED BY EMPLOYEE' portion of the form:

- Fill in personal information (name, address, phone, date of birth, gender).
- Indicate whether the leave is for maternity or disability and provide accident details if applicable.
- Answer whether you expect payment from other sources.
- Read and sign the authorization statement.
- Date and sign where indicated.

3. PHYSICIAN SECTION

Complete the 'ATTENDING PHYSICIAN'S STATEMENT' portion of the form:

- Provide diagnosis.
- State if hospitalized (include dates).
- If pregnancy, list due date.
- For disability, give date first consulted, period unable to work, and projected return-to-work date.
- Print name, sign, date, and provide contact information (phone, address, fax/email).

4. SUBMISSION

Weekly Disability/Maternity Benefits Claim Forms should be submitted as soon as possible for an upcoming maternity and within twenty-one (21) days of an illness or injury.

Once all three sections are complete and required attachments are included, submit the form and documents to:

Catholic Diocese of Cleveland – Benefits Office
1404 East Ninth Street, 8th Floor
Cleveland, OH 44114-1722
Fax: 216-621-9622
Email: hbo@dioceseofcleveland.org