Southeastern Pennsylvania Transportation Authority

BENEFITS DEPARTMENT

1234 Market Street, 6th Floor
Philadelphia, PA 19107

SICK BENEFITS APPLICATION

(For TWU-234 & SMART 1594 Employees Only)

PART I: TO BE COMPLETED BY EMPLOYEE

Name:______________________________ **Account Number:**____________________

Address:_______________________ **City:**____________ **State:**__________ **Zip:**__________

Home Phone:__________________ **Location** (Depot, Department, Shop, etc):____________________

Position:_________________________ **Date of Hire:** (month/day/year____________________

Nature of Problem: (Auto Accident, slips, falls, illness, etc.)______________________________

HAVE YOU FILED A WORKER'S COMP CLAIM FOR THIS INJURY/SICKNESS YES__________NO__________

ARE YOU CURRENTLY RECEIVING WORKERS COMP BENEFITS RELATING TO THIS INJURY/SICKNESS YES________NO ________

IF YES WHAT IS THE AMOUNT OF WORKERS COMP BENEFIT YOU ARE RECEIVING? $____________________

FMLA ELIGIBILITY: By applying for Sick Benefits, you have notified us of a potential FMLA qualifying event.

You are possibly eligible for FMLA leave. The leave time will be counted against your 12-week entitlement and will run concurrently with your sick leave. This leave is being **PROVISIONALLY** designated pending receipt of certification from your health care provided and approval by WorkPartners

Please be advised approval for Sick Benefits does not guarantee approval for FMLA leave.

I understand that benefits shall commence the fourth day of illness, provided that the Authority receives this request within the first five (5) days of illness, and will be in accordance with SEPTA Sick Benefit Regulations. Sick benefits paid to me, as the result of a 3rd party suit will, in compliance with the Labor Agreement, be reimbursed to the Authority I also understand this form is to be completed fully and accurately by my treating Health Care provider. I agree that SEPTA Medical Department, or its designated medical representative, may contact my treating health care provider to obtain clarification of the information provided on this form.

Employee's Signature:____________________________ **Date:** __________________________

Please have your Health Care Provider complete PART II of this form. All questions must be answered, or benefits may be delayed. All requests for sick benefits must be made in writing and must be received by the Division Superintendent or Department Head. If the employee is hospitalized and unable to submit the Sick Benefits Application on or before the fifth (5th) calendar day of illness, the employee may submit the request no later than five (5) calendar days following the date of discharge from the hospital. Any requests not so received will become effective for benefits only on and from the date received.

PART II: TO BE COMPLETED BY HEALTH CARE PROVIDER (PLEASE TYPE OR PRINT)

(COMPLETED PART II MUST BE RETURNED TO PATIENT)

The named employee is applying for monetary Sick Benefits due to his/her inability to perform his/her duties with SEPTA. Please complete the following questions in full so that we may authenticate our employee's eligibility to receive Sick Benefits.

Diagnosis (Primary Cause of Illness):____

____

State the approximate date the condition commenced, and the probable duration of the condition.

Date absence began: _____/_____/_____ **Duration:**____________________

Date employee can return to work - Full Time: _____/_____/_____ **Part Time:**_____/_____/_____

Date of first visit for current illness:__________________ **Date of most recent treatment:**__________________

is he/she confined to: Home:_______ **Institution:**_______ **Name of Institution:**__________________

Treatment (including prescriptions, physical therapy, etc.)____

____

____

Surgery:

Contemplated _______**Yes** _______ **No** **If Yes, Please Give Date(s)**____________________

Performed _______**Yes** _______ **No** **If Yes, Please Give Date(s)**____________________

Provider Name:
(Please print Legibly) ____________________ **License #**____________________

Address: ____________________ **Date:**____________________

Telephone: ____________________ **Signature:**____________________

PART III: TO BE COMPLETED BY EMPLOYEE'S LOCATION FOR APPROVAL

(Part III MUST BE COMPLETED BY EMPLOYEE'S LOCATION PRIOR TO SUBMITTING THE SICK APPLICATION TO BENEFITS DEPARTMENT

Date Application Received:____________________**Last date employee worked:** __________

First day of current illness: ____________________ **Return to work date if known:** __________

Sick Leave Balance: __________

Director's Phone # ____________________ **Current days off:** ____________________

Date:__________ **Director (Print Name):**______________ **Director (Signature):**______________

Director:

Upon receipt of this form please fax SEPTA Benefits (215) 580-7185 or email benefits@septa.org and WORKPARTNERS at SEPTALOA@workpartners.com

PART IV: REVIEW BY SEPTA'S ABSENCE MANAGER SIGNATURE ______________**Date** ______________

<u>Employee:</u> Complete PART I and have Health Care Provider complete PART II Then submit application to Superintendent or Department Head for approval (PART III) <u>Director:</u> Forward to WP at SEPTALOA@workpartners.com and Benefits Fax (215) 580-7185 or email benefits@septa.org	Contact information: SEPTA Sick Benefits Department Phone (215) 580-7116, FAX (215) 580-7185/benefits@septa.org WorkPartners (FMLA): (844) 860-9305 / SEPTALOA@workpartners.com