FRISCO I.S.D.
FMLA WORKSHEET INSTRUCTIONS

You will need the following to complete this worksheet:

1. Employee verification letter
2. Current paystub
3. Current school year contract calendar

Any yellow cell requires you to insert information. The spread sheet will do the calculations for you.

Definitions:

1. Days of absence is the total number of working days you will miss regardless of if they will be counted as state, local or extended leave days.
2. Daily rate of pay is your annual salary divided by your contract days
3. Days worked is the actual number of days you have worked during your contract.
4. Annual salary is found on your employee verification letter.
5. Pay periods should equal 12 unless you began in the middle of a contract year.
6. Checks received is the number of salary checks received during the current contract period.
7. You can enter the number of state, local and extended leave days listed on your check stub. Don't forget to subtract any anticipated usage from this number to arrive at an available balance at the beginning of your leave.
8. The extended leave daily rate is your daily rate less $80 if a professional or $40 if not a professional.
9. Leave pay checks are the number of pay checks you will receive while on leave.
10. Stipends can be found on your employee verification letter. Simply divide that number by 12 or by the number of pay periods in your contract year if you begin in the middle of a contract year.
11. Return to work compensation - add the number of days you will work after you return from leave. Then insert the number of paychecks you will receive after returning. This will be your new gross salary figure.
12. Check figure 1 should be the total number of days in your contract. Check figure 2 should be the total number of paychecks you will receive during your contract. This figure should never exceed 12.

FRISCO ISD APPLICATION FOR FAMILY AND MEDICAL LEAVE

Name ____ SS# ______________________

Campus/Location______________________________

Dates: Begin____________________ End____________________

Injury/Illness causing the absences____

____

____

Physician_____________________________________ Phone _____________________

Employee Signature ____

Apply as soon as possible (within 30 days) to avoid pay disruption or benefit loss.
Eligibility is not determined until doctor's statement is received.

This section to be completed by ATTENDING PHYSICIAN:

Earliest treatment or diagnosis da~~te (to the best of your knowled~~ge ____________

Related pre-existing conditions ____

For all surgeries: Could recommended surgery be scheduled during extended school breaks such as summer or winter break without being detrimental to this patient's health?

Yes _____ No _____

Anticipated treatments/therapy after initial release for work: _______________________

____

This patient was/will be unable to work from _____________ through ______________

Physician's signature _________________________________ Date _______________

Return to Frisco ISD, Human Resources Office
6942 Maple St., Frisco, TX or fax 469-633-6001

White-Human Resource Yellow-Payroll Pink-Employee

FRISCO ISD
FMLA WORKSHEET

Name of Employee:		Jane Doe					
Social Security Number		123-45-6789					
Campus Location		Your Campus					
Job Title:	Teacher		Code:	104			
Days to work to complete annual contract:			187				
Days absence:	57	Cost of Absence			$7,247.57		
Beginning Date:	8/9/2006		Check Figure #1		187	Check Figure #3	$34,052.43
Ending Date:	12/21/2006		Check Figure #2		12	Check Figure #4	$34,052.43

FMLA Leave Compensation

$220.86	Daily Rate of Pay		
92	Days Worked (or possible days worked)		
$20,318.72	AMOUNT EARNED		
$41,300.00	Annual Salary		
12	Pay Periods		
$3,441.67	MONTHLY PAY		
5	Checks Received	Sept'06 - Jan'07	
$17,208.35	AMOUNT PAID		
$20,318.72	Amount Earned		
$17,208.35	Amount Paid		
$3,110.37	SEVERANCE PAY DUE TO EMPLOYEE		
$0.00	Dock Hours		
$0.00	Dock Days		$220.86
$1,987.70	State days	9	$220.86 06-07
$1,987.70	Local days	9	$220.86 06-07
$0.00	Sick Leave Bank *		$220.86
$1,365.80	Extended Leave	10	$136.58
$8,451.57	TOTAL DUE TO EMPLOYEE		
$8,451.57	FMLA Pay		
3	Leave Paychecks		
$2,817.19	GROSS PAY PER PERIOD		Feb'07 - Apr'07
	Stipends:		
$83.33	Master's Degree		
$2,900.52	TOTAL PAY PER PERIOD		

Return to Work Compensation

4/2/2007	State Days	1
	Local Days	1
$220.86	Daily Rate of Pay	
38	Days worked	
$8,392.51	AMOUNT EARNED	
$8,392.51	Amount Earned	
4	Pay Periods	
$2,098.13	GROSS PAY PER PERIOD	
	Stipends:	
$83.33	Master's	
$2,181.46	TOTAL PAY PER PERIOD	
	May'07 - Aug'07	

State days (06-07): 4
Local days (06-07): 4

July 2006 — 0

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

August 2006 — 17

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

September 2006 — 20

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

October 2006 — 21

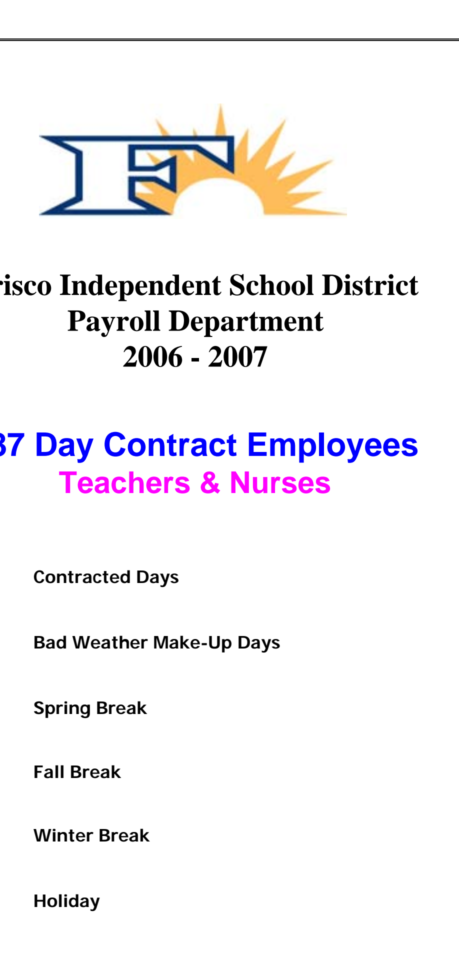
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

November 2006 — 19

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December 2006 — 15

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						



Frisco Independent School District
Payroll Department
2006 - 2007

187 Day Contract Employees
Teachers & Nurses

- Contracted Days
- Bad Weather Make-Up Days
- Spring Break
- Fall Break
- Winter Break
- Holiday

January 2007 — 20

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February 2007 — 20

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28			

March 2007 — 17

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April 2007 — 19

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May 2007 — 19

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

June 2007 — 0

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

July 2007 — 0

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FRISCO INDEPENDENT SCHOOL DISTRICT
Payroll Department
Revised 06-12-06

PAYROLL BEGINNINGS, CLOSINGS, AND PAYCHECKS ISSUED
2006 – 2007

The payroll beginning and closing dates listed below are used to record absences for professional and auxiliary employees and to pay a substitute teacher if applicable. Crossing Guards are paid hourly by timecard according to the dates listed below. These dates are also used for auxiliary employees in order to pay approved overtime and to record compensation time accrued or used for the pay date referenced.

- ***If you begin work on your assigned start date with FISD***, your yearly salary is divided among 12 equal payments.
- ***If you begin work after the start date for your job assignment***, an adjusted yearly salary is computed and divided among the payments left in the school year.

Lifeguards, cafeteria cashiers, and employees that work less than 20 hours per week are paid hourly by timecard. This group of employees will be paid semi- monthly for the hours worked.

MONTH	PAYROLL BEGINNING & CLOSING DATES	CHECKS ISSUED
SEPT.	07-17-06 THRU 08-13-06	09-15-06
OCT.	08-14-06 THRU 09-10-06	10-13-06
NOV.	09-11-06 THRU 10-15-06	11-15-06
DEC.	10-16-06 THRU 11-12-06	12-15-06
JAN.	11-13-06 THRU 12-10-06	01-12-07
FEB.	12-11-06 THRU 01-14-07	02-15-07
MARCH	01-15-07 THRU 02-11-07	03-09-07
APRIL	02-12-07 THRU 03-11-07	04-13-07
MAY	03-12-07 THRU 04-15-07	05-15-07
JUNE	04-16-07 THRU 05-13-07	06-15-07
JULY	05-14-07 THRU 06-17-07	07-13-07
AUG.	06-18-07 THRU 07-15-07	08-15-07

Form W-4 (2006)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $850 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2006. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . **A** ______

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

. . **B** ______

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . **C** ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . . **D** ______

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** ______

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** ______
(**Note.** Do **not** include child support payments. See **Pub. 503,** Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be less than $55,000 ($82,000 if married), enter "2" for each eligible child.
- If your total income will be between $55,000 and $84,000 ($82,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children. **G** ______

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ______

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $35,000 ($25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2006

1 Type or print your first name and middle initial.	Last name	2 Your social security number

Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card.** ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $ ______

7 I claim exemption from withholding for 2006, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ **7** ______

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(Form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2006 tax return.

1 Enter an estimate of your 2006 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2006, you may have to reduce your itemized deductions if your income is over $150,500 ($75,250 if married filing separately). See *Worksheet 3* in Pub. 919 for details.) . . . 1 $______

2 Enter: { $10,300 if married filing jointly or qualifying widow(er); $ 7,550 if head of household; $ 5,150 if single or married filing separately } . . . . 2 $______

3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter “-0-” . . . . 3 $______

4 Enter an estimate of your 2006 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 $______

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 7* in Pub. 919) . 5 $______

6 Enter an estimate of your 2006 nonwage income (such as dividends or interest) . . . . 6 $______

7 **Subtract** line 6 from line 5. Enter the result, but not less than “-0-” . . . . 7 $______

8 **Divide** the amount on line 7 by $3,300 and enter the result here. Drop any fraction . . . . 8 ______

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . . 9 ______

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . 10 ______

Two-Earner/Two-Job Worksheet (See *Two earners/two jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 ______

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here . . . . 2 ______

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . 3 ______

Note. If line 1 is *less than* line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . 4 ______

5 Enter the number from line 1 of this worksheet . . . . 5 ______

6 **Subtract** line 5 from line 4 . . . . 6 ______

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $______

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $______

9 Divide line 8 by the number of pay periods remaining in 2006. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2005. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . 9 $

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly						All Others	
If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $42,000	$0 - $4,500	0	$42,001 and over	32,001 - 38,000	6	$0 - $6,000	0
	4,501 - 9,000	1		38,001 - 46,000	7	6,001 - 12,000	1
	9,001 - 18,000	2		46,001 - 55,000	8	12,001 - 19,000	2
	18,001 and over	3		55,001 - 60,000	9	19,001 - 26,000	3
				60,001 - 65,000	10	26,001 - 35,000	4
$42,001 and over	$0 - $4,500	0		65,001 - 75,000	11	35,001 - 50,000	5
	4,501 - 9,000	1		75,001 - 95,000	12	50,001 - 65,000	6
	9,001 - 18,000	2		95,001 - 105,000	13	65,001 - 80,000	7
	18,001 - 22,000	3		105,001 - 120,000	14	80,001 - 90,000	8
	22,001 - 26,000	4		120,001 and over	15	90,001 - 120,000	9
	26,001 - 32,000	5				120,001 and over	10

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $60,000	$500	$0 - $30,000	$500
60,001 - 115,000	830	30,001 - 75,000	830
115,001 - 165,000	920	75,001 - 145,000	920
165,001 - 290,000	1,090	145,001 - 330,000	1,090
290,001 and over	1,160	330,001 and over	1,160

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

EDUCATOR SALARY PROTECTION PLAN DISABILITY CLAIM FORM

Claim Questions: 800.527.4572 **Tax Questions:** 800.845.2290

For use with policies issued by the following UnumProvident Corporation ["UnumProvident"] subsidiaries:

Unum Life Insurance Company of America Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Please mail or fax this form to:
Educator Salary Protection Plan
2121 N. Glenville Drive
Richardson, TX 75082
Fax To: 972.881.2251

This form must be completed by the Attending Physician, the Employee, and the Employer, and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

The employee is responsible for completion of all portions of this form without expense to the UnumProvident Corporation subsidiaries.

INSTRUCTIONS:

A. **Attending Physician's Statement:** This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form.

B. **Claimant's Statement:** This section must be completed by you, the employee. To avoid delay in evaluating your claim, advise your physician(s) to attach copies of medical records and test results.

C. **Direct Deposit Request:** This section must be completed by you, the employee, if you wish to have your Long Term Disability and/or your Individual Disability benefits deposited directly into your bank account.

D. **Employment Statement:** The employer must complete this form.

Authorization: Sign and date this form. Provide a copy of the signed and dated form to your attending physician.

Please enclose any additional information that you feel will assist us in evaluating this claim.

CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Fraud Warning for California Residents

For your protection, California law requires the following to appear:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning for Colorado Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning for District of Columbia, Maine, Tennessee and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Fraud Statement for New York Residents

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

EDUCATOR SALARY PROTECTION PLAN DISABILITY CLAIM FORM

Mail to: 2121 N. Glenville Drive, Richardson, TX 75082
Claim Questions: 800.527.4572 **Fax To:** 972.881.2251

A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number	Date of Birth	Social Security Number
Employer Name			Employer Telephone Number

Instructions: If this claim is related to normal pregnancy, complete the Normal Pregnancy section. For all other claims, including complicated pregnancy, complete the All Other Conditions section. **In all situations, you must complete the signature block at the bottom of this form.**

Normal Pregnancy

1. Expected Delivery Date: | If Delivered, Actual Delivery Date: | Type of Delivery ☐ Vaginal ☐ C-Section

2. Date First Unable to Work | Dates Hospitalized

3. Has patient been released to work in her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No
If not, when should the patient be able to return to work? Full Time Part Time

All Other Conditions

1. Diagnosis - Please include the primary diagnosis and list any secondary conditions.

Diagnosis (including any complications) include **ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number**

2. Date First Unable to Work | Dates Hospitalized

3. Has patient been released to work in his/her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No
If not, when should the patient be able to return to work? Full Time Part Time

4. Is this disability related to the patient's employment? ☐ Yes ☐ No ☐ Unknown

5. Has patient ever had the same or a similar condition? ☐ Yes ☐ No If yes, when?

6. Date of first visit for this illness or injury – When did symptoms first appear or accident happen?

7. Nature of treatment (including surgery and medications prescribed) | Name of Surgical Procedure | Date of Surgery

8. If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

RESTRICTIONS (What the patient should not do)

LIMITATIONS (What the patient cannot do)

Date restrictions and limitations began.

9. Referring physician or other treating physicians (names, addresses, telephone numbers):

Please include copies of all applicable office notes and test results.

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Print or Type Name		Degree	Medical Specialty
Street Address			Telephone Number
City	State	ZIP Code	Fax
Signature of Physician			Date

SSN or Employer's ID Number: | Are you, the physician, related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

EDUCATOR SALARY PROTECTION PLAN DISABILITY CLAIM FORM

Mail to: 2121 N. Glenville Drive, Richardson, TX 75082
Claim Questions: 800.527.4572 **Fax To:** 972.881.2251

B. EMPLOYEE'S STATEMENT (PLEASE PRINT)

1. Claimant's Name (as printed on your Social Security Card) | Home Telephone Number | Date of Birth ☐ Male ☐ Female | Social Security Number

Home Address (Street, City, State, ZIP)

The state in which you work | Preferred e-mail address where you can be reached

2. Employer Name | Policy Number

3. Occupation | **4.** List the duties of your occupation at the time of your disability (grade taught, etc.)

5. How does your injury or sickness impede your ability to do your occupational duties?

6. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | If you are married, spouse's name | Spouse's Date of Birth | Is spouse employed? ☐ Yes ☐ No

7. Is this disability due to ☐ Motor Vehicle Accident ☐ Other Accident ☐ Sickness ☐ Work-related Injury/Sickness ☐ Pregnancy

For any accident related claim, describe the injury (what, how, where, when).

8. Date Last Worked | Number of Hours Worked on Date Last Worked

9. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.

If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

Social Security/Retirement ☐ Yes ☐ No | Social Security/Disability ☐ Yes ☐ No | State Disability ☐ Yes ☐ No

Have you filed for Sabbatical Leave? ☐ Yes ☐ No
Do you intend to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
Date Payment Began

Teacher's Retirement ☐ Yes ☐ No | Pension/Disability ☐ Yes ☐ No | Unemployment ☐ Yes ☐ No

Teacher's Retirement System - Disability ☐ Yes ☐ No
Public Employee Retirement ☐ Yes ☐ No
Public Employee Disability ☐ Yes ☐ No

Other (Include Individual Disability or Group Disability Benefits) ☐ Yes ☐ No

10. Number of Regular Sick Days Accumulated ____________

11. Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No
Do you intend filing a Workers' Compenation Claim? ☐ Yes ☐ No
If filed has it been approved? ☐ Yes ☐ No
Amount Date Payment Began

12. If benefits are approved, do you want these benefits to be automatically deposited into your bank account? ☐ Yes ☐ No If yes, please completed the Direct Deposit Request of this form and return it to us along with this completed claim form.

13a. Have you ever been employed by any other school(s) or District(s)? ☐ Yes ☐ No

13b. Please list name(s) of school(s)/District(s) and years employed.

14. Information about physicians and hospitals **NOTE: TO AVOID DELAY IN PROCESSING YOUR CLAIM, ADVISE YOUR DOCTOR(S) TO ATTACH COPIES OF MEDICAL RECORDS AND TEST RESULTS**

First medical attention for the current disability was given by (complete below):

Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to

List all other physicians and hospitals you have seen for this condition:

Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to
Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to
Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to
Hospital		
Address (Street, City, State, Zip)		Dates of Confinement to

Have you ever had the same or a similar condition in the past?
☐ Yes ☐ No If yes, complete the following concerning your past treatment:

Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen to
Hospital		
Address (Street, City, State, Zip)		Dates of Confinement to

List your dependent children who are under age 25 (attach additional sheets if necessary).

Name	Date of Birth	Attending School?
		☐ Yes ☐ No
		☐ Yes ☐ No

I have read and understand the fraud notices listed on the instruction page of this form.

The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

________________________________ ________________________
Signature Date

EDUCATOR SALARY PROTECTION PLAN DISABILITY CLAIM FORM

Mail to: 2121 N. Glenville Drive, Richardson, TX 75082
Claim Questions: 800.527.4572 **Fax To:** 972.881.2251

C. DIRECT DEPOSIT REQUEST

If your claim is approved, we are pleased to offer you the security and convenience of having your monthly benefit check deposited electronically to your bank account. Direct Deposit means no more mail delays or trips to the bank to cash your check.

- **How does direct deposit work?**
  Each month, our bank will transfer your benefit payment directly into your bank account. We recommend this payment option because it is predictable, safe and convenient. This is the same system enjoyed by over 15 million Social Security recipients.

- **How do I sign up?**
  Complete the below section of this form and forward to us. Be sure to print the information clearly. You may want to verify your account and transit/routing numbers with your bank to avoid delays.

- **How soon can my direct deposits begin?**
  To ensure accuracy, your Direct Deposit will begin within 30 days of our notification to your bank. This means you may still receive checks by mail after you send in your request. Once Direct Deposit processing begins, your funds will be deposited into your bank account on the second business day after the day your benefit payment is processed.

- **What if I have questions?**
  Call our Customer Service direct deposit line at 800-413-7671. This toll-free number is available Monday through Friday from 8:00 A.M. to 4:00 P.M. EST.

- **What happens if I am out of town when the benefit payment is due?**
  Your deposit is in your account. You may access it anytime after it is deposited.

- **What if I change banks?**
  Simply call and we will send a request form for your completion or you can provide us with the new bank information in writing. You may receive a paper check in the mail for one payment while we process your change request.

- **Can I change my mind?**
  Yes. You can start or stop Direct Deposit at any time. Just write and tell us.

- **Now what?**
  We will transfer your benefits directly to your bank every month. No more waiting for the mailman, standing in line at the bank, or remembering to send us a change of address each time you establish a temporary residence.

Social Security Number: ______________________

Name: ______________________

Address: ______________________

____

Tel #: (   ) ______________________

I authorize UnumProvident to deposit my Benefit payments to the bank shown here.

Signed ______________ Date: ______________

Name of Bank ______________________

City ______________ State ________ Zip ________

Phone (   ) ______________________

Type of Account ☐ Checking ☐ Savings

Account Number ______________________

Transit/Routing Number* ☐☐☐☐☐☐☐☐☐

*Checking (Attach a Voided Check)

*Savings (Contact Bank/Credit Union for Transit/Routing Number)

EDUCATOR SALARY PROTECTION PLAN DISABILITY CLAIM FORM

Mail to: 2121 N. Glenville Drive, Richardson, TX 75082
Claim Questions: 800.527.4572 **Fax To:** 972.881.2251

D. EMPLOYER STATEMENT (PLEASE PRINT)

To be completed by Employer

1. Employer Name

Employer's Phone Number ( )

Employer Address (Street, City, State, ZIP)

Policy Numbers

Division Number

2. Claimant's Name

Claimant's Address (Street, City, State, ZIP)

Social Security Number	Date of Hire	Effective Date of LTD Insurance	Employee's Work Schedule at Time Last Worked _______Days per week _______Hours per day

Average monthly earnings in effect at last annual enrollment date $_________________
Please refer to your contract for your earnings definition.
Has the claimant's employment been terminated? ☐ Yes ☐ No If yes, please provide termination date

3. Has claimant returned to work? ☐ Yes ☐ No If yes, date ☐ Full Time ☐ Part Time Hours Per Week

4. Job Title/Major Job Duties **(Please attach a copy of claimant's job description)**
Is the Employee also a Coach? ☐ Yes ☐ No

5. Date last worked prior to claim

6. Number of hours worked that day

7. Date paid through For ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick Pay

8. Does this employee contribute to FICA? ☐ Yes ☐ No Medicare SSDI: ☐ Yes ☐ No Medicare: ☐ Yes ☐ No

9. Are you as the employer able to accommodate the employee's restrictions and limitations, if appropriate, for an early return to work? (i.e. job modification, part time, etc.) Please elaborate.

10. Employee's immediate supervisor: Name_________________________________Title_____________________Telephone Number______________________
Please submit a copy of employee's job description if expected to be out of work for more than 6 weeks.

11. How was the LTD premium paid for the plan year in which the disability occurred?
☐ Pre-tax _______ % paid by Employer
☐ Post-tax _______ % paid by Employee **Please call 1-800-845-2290 for tax related questions**

12. Is employee eligible for:

	Yes	No	If yes	WEEKLY	MONTHLY	Date Benefits Begin Date	Date Benefits Through Date
Teacher's Retirement System-Disability	☐	☐	$__________	☐	☐	____________	____________
Teacher's Retirement	☐	☐	$__________	☐	☐	____________	____________
Social Security/Retirement	☐	☐	$__________	☐	☐	____________	____________
Social Security Disability	☐	☐	$__________	☐	☐	____________	____________
Other Benefits	☐	☐	$__________	☐	☐	____________	____________
Workers' Compensation	☐	☐	$__________	☐	☐	____________	____________
Has Workers' Compensation claim been filed?	☐	☐	If Workers' Compensation Claim has been denied, please submit a copy of the denial with this claim.				

Has the employee filed for Sabbatical Leave? ☐ Yes ☐ No
Is employee eligible to file? ☐ Yes ☐ No
If filed, has it been approved? ☐ Yes ☐ No
Date Payment Began

13. Will (or has) the employee filed for disability benefits provided by any employer, employee, labor management, state disability or union welfare plant? ☐ Yes ☐ No

If yes,
Weekly Amount $________________ Date ___________________

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form

Employer's Taxpayer ID Number (EIN) or Public Employer Social Security Number. If you have neither, please explain

Telephone Number ( )

Title of Person Completing Form

E-mail Address

Fax Number ( )

Signature

Date Signed

EDUCATOR SALARY PROTECTION PLAN
EMPLOYEE'S AUTHORIZATION

Mail to: 2121 N. Glenville Drive, Richardson, TX 75082
Claim Questions: 800.527.4572 **Fax To:** 972.881.2251

FOR EMPLOYEE TO COMPLETE

NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, its insurance subsidiaries* and duly authorized representatives ("UnumProvident"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

______________________________	______________________________
(Claimant Signature)	(Date Signed)
______________________________	______________________________
(Print Name)	(Social Security Number)

I signed on behalf of the claimant as __________________(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following UnumProvident insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.