If you are disabled and unable to work due to illness or injury disability income coverage provides you weekly benefit payments through your payroll deduction. The insurance company works closely with you and your physicians to approve your claim and help you recuperate, for an easier transition back to work.

**HOW TO INITIATE YOUR DISABILITY CLAIM**

☐ **STEP 1:** CONTACT YOUR MANAGER AND YOUR HUMAN RESOURCE REPRESENTATIVE to discuss your leave, verify your Short Term Disability eligibility, and find out if you have a benefit waiting period.

☐ **STEP 2:** COMPLETE THE REQUEST FOR FAMILY OR MEDICAL LEAVE

Return this to Human Resources. Be sure to complete all fields. You do not need to complete the section on using any accrued, unused paid leave as your benefit is 100% salary replacement.

☐ **STEP 3:** CONTACT THE INSURANCE COMPANY (THE HARTFORD) TO INITIATE YOUR CLAIM.

Follow the instructions on the flyer on filing a claim.

☐ **STEP 4:** THE HARTFORD WILL REVIEW YOUR CLAIM AND CONTACT YOU.

If your absence is approved, the benefit specialist at THE HARTFORD will determine the estimated claim duration and send you a written notification regarding the status of your claim.

If THE HARTFORD is unable to retrieve your medical information directly from your health care provider your disability claim will remain in a pended status and you will receive written notification.

**Key Note:** If you continue your leave of absence past the approved benefit duration please contact THE HARTFORD immediately.

☐ **STEP 5:** THE HARTFORD WILL CONTACT YOUR EMPLOYER.

Once your benefit is approved SNC will pay your Short Term Disability benefit through your normal payroll checks.

**Key Note:** Your Earnings (Disability Pay) may be delayed if you do not follow the step-by-step claim instructions.
Your disability program is managed by The Hartford, a leader in disability and leave services. It’s a user-friendly benefit that helps provide essential support services while you’re away from your workplace.

St Norbert College
Policy #697340

THE HARTFORD MAKES IT EASY TO FILE A CLAIM. JUST FOLLOW THESE STEPS.

STEP 1
Know when it's time to file
If you're absent from work, we can advise you on when to file your claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

STEP 2
Have this information ready
- Name, address, and other key identification information.
- Name of your department and last day of active full-time work.
- Your manager's or HR representative's name and phone number.
- The nature of your claim.
- Your treating physician's name, address, and phone and fax numbers.

STEP 3
Make the call or file online
With your information handy, call The Hartford at 1-877-543-7052. Or file online at WWW.THEHARTFORDATWORK.COM, or by using the My Benefits at The Hartford mobile claims app (see more information on the next page). You'll be assisted by a caring professional who'll take your information, answer your questions and file your claim.

TO FILE A CLAIM:
1-877-543-7052
Policy #697340
WWW.THEHARTFORDATWORK.COM
If you're absent from work, we can advise you on when to file your claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

continued
FILE YOUR CLAIM FASTER BY USING THE MOBILE APP!

The My Benefits at The Hartford claims app allows you to file your claim faster from your mobile device. You can also view your status, payment details and more! Download the app for free today from Apple® and Google Play™ stores.

GET SUPPORTIVE ASSISTANCE

Even after your claim has been filed, we may be in touch to check your progress, answer questions or obtain additional information from you. Our goal is to offer a smooth and hassle free experience until you return to work. Feel free to also call us with anything that's on your mind. We're here to help.

RELAX AND STAY POSITIVE

You have the assurance of our knowledge, experience and understanding of what you are going through. We're with you all the way, so you can receive the benefits you qualify for and get back to your life.

QUICK FACTS

The Hartford's goal is to help get you through your time away from work with dignity and assist you in any way we can. Keep the card below in a safe place for future use. We'll be there when you need us.

Prepare. Protect. Prevail.™

When you call The Hartford will ask you to provide:

- Name, address, and other key identification information.
- Name of your department and last day of active full-time work.
- Your manager's or HR representative's name and phone number.
- The nature of your claim.
- Your treating physician's name, address, and phone and fax numbers.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT. ©2017 The Hartford Financial Services Group, Inc. All rights reserved. Disability Form Series includes GBD-1000, GBD-1200, or state equivalent. The policy number is 697340. 5894298 08/17

(Please cut here and keep in your wallet.)
ST. NORBERT COLLEGE

EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee Printed Name: ________________________.

I am requesting leave under St. Norbert's Family and Medical Leave policy. I anticipate that this leave will begin on ________________ and that the leave will end on ________________.

The reason for the leave is as follows: (CHECK ONE)

☐ Birth of my child. Due date is: ________________.

☐ Adoption of a child or foster care placement of child. Adoption or foster care date is: ________________.

☐ Care for my child, spouse, domestic partner, parent of the spouse or domestic partner, or parent with a serious health condition.

Name of affected family member: ________________________.

Relationship to me: ________________________.

☐ My own serious health condition.

☐ Military exigency related to my family member's military service or call to military service.

Name of service member: ________________ Relationship: ________________.

☐ Care for my family member with a serious injury or illness incurred during military service.

Name of service member: ________________ Relationship: ________________.

☐ do not want to use any accrued, unused paid leave during my unpaid FMLA leave.

(Indicate below the type and amount of paid leave that you wish to use, if any.) ________________________.

My regular work schedule is as follows (identify the days of the week and the starting and stopping times you are normally scheduled to work and any overtime hours, if any, you are frequently assigned to work): ________________________.

If I am a salaried employee, my average weekly work hours are ______ per week.

I understand that I or my family member may be required to provide a Medical Certification from a health care provider or other Certifications to support this request. I understand that I may also be required to provide my employer with clarifications or more information in relation to my request. I understand that providing any false or misleading information will result in disciplinary action, up to and including termination.

Dated this ______ day of ______________, 20____.

______________________________
Employee Signature

Instructions to Employee:

1. Please return this Form to: St. Norbert College Human Resources Department

2. A request for FMLA leave must be provided at least 30 days prior to the start of any foreseeable leave needs. If the leave is unforeseeable, the request must be made as soon as possible.