Email: to all Associate December 4, 2017

verizon

Introducing Sedgwick

On January 1, 2018, we're changing our disability vendor from MetLife to Sedgwick. Sedgwick is a major claims administration provider with 50 years of experience.

sedgwick

Here's what will happen

For current and new claims filed through Dec 31, 2107:

- Continue to work with MetLife.
- Claims will be automatically transferred to Sedgwick.
- If you have an open claim, Sedgwick will send you a letter in mid-December confirming transfer of your claim and outlining any additional actions you might need to take.

For claims beginning Jan 1, 2018:

- Initiate disability claims with Sedgwick.
- Use the existing phone number to file a disability claim: 800.638.4228.
- Use the new fax number for supporting disability documents: 859.264.4384.
- Information about Sedgwick will be posted on About You on Jan 1.
- Requirements for initiating disability claims remain the same.

sedgwick

P.O. Box 14192, Lexington, KY 40512-4192
Telephone: 800-638-4228 Facsimile: 859-264-4384 Email: myclaimdocs@sedgwick.com

Attending Physician Statement for Behavioral Health
To be completed by physician

Patient's Name: **Date of Birth:**

Claim Number: **Medical Due Date:**

The patient's current disability plan requires that medical information indicate an inability to perform the essential duties of his/her own job. Patient's occupation: _____

Have you recommended to your patient to stay home from work? ☐ Yes ☐ No If yes, effective what date?_____

Please provide your rationale for recommending the patient stay home from work _____

Can your patient return to work with accommodations? ☐ Yes ☐ No If yes, effective what date? _____

Please describe accommodations:_____

_____

Your patient will be released to work full duty on: _____

DIAGNOSIS

Primary: ICD Code: _____ Description: _____

Secondary: ICD Code: _____ Description: _____

COGNITIVE FUNCTIONING EVALUATION

Applied focus and concentration in session for periods of:

☐ 30 to 50 minutes ☐ 15 to 30 minutes ☐ 5 to 10 minutes ☐ less than 5 minutes

Expressed his/her current circumstances and responded to direct questions appropriately: ☐ Yes ☐ No

If no, was redirection needed? ☐ Yes ☐ No Please describe:_____

Reasoning and/or judgment: ☐ Within normal limits ☐ Impaired If impaired, please describe:_____

Delusional ideations evident: ☐ Yes ☐ No If yes, please describe:_____

Hallucinations reported: ☐ Yes ☐ No If yes, please describe:_____

Memory functions: Four unrelated words after five minutes: _____ Other testing results: _____

Able to perform five operations of Serial 7's or 3's: ☐ Yes ☐ No Exam findings: _____

Able to follow direction and verbalize directions given during exam? ☐ Yes ☐ No If no, please describe:_____

Able to read a narrative paragraph from a magazine or newspaper and report the main concept/idea of the passage: ☐ Yes ☐ No

EMOTIONAL FUNCTION AND BEHAVIORAL OBSERVATIONS

Date of last exam: _____Behaviors and emotional state observed during exam: _____

_____

Able to spontaneously compose her/himself: ☐ Yes ☐ No If no, please explain:_____

Psychomotor activity and ability to apply effort: ☐ Unremarkable ☐ Impaired If impaired, describe: _____

Presented with appropriate dress and hygiene in session: ☐ Yes ☐ No If no, please describe:_____

Impulse control: ☐Physical abusive behavior ☐ Verbal abusive behavior ☐Substance abuse/addiction
☐Alcohol abuse/addiction ☐Manic Behavior

Speech: ☐ Slurred ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over productive ☐ Under productive
☐ Other (please describe)_____

Risk to self/others:

SUICIDAL IDEATIONS ☐ Yes ☐ No Plan reported: ☐ Yes ☐ No If yes, please explain:_____

HOMICIDAL IDEATIONS ☐ Yes ☐ No Plan reported: ☐ Yes ☐ No If yes, please explain:_____

Able to report reasons for not harming self/others: ☐ Yes ☐ No If no, please explain:_____

Contracted for safety: ☐ Yes ☐ No If no, please explain:_____

PATIENT SELF REPORT OF ACTIVITIES OF DAILY LIVING

Is the patient currently performing any of the following? ☐ Volunteer work ☐ Works at a lesser demanding job ☐ Attending school ☐ No work activities in any capacity ☐ Self-employment

Has the patient conceptualized the following areas as barriers in returning to work:

☐ Increase in work demands ☐ Conflicts with supervisor ☐ Anticipation of relapse

☐ Recent unfavorable work evaluation ☐ Dissatisfaction with the job ☐ Other (please specify)_____

Has the patient expressed or are you aware that she/he is experiencing any psychosocial stressors? ☐ Yes ☐ No If yes, please describe:_____

Significant weight changes: ☐ Yes ☐ No Current weight:_____ Previous weight:_____Date of previous weight:_____

Significant appetite changes: ☐ Yes ☐ No If yes, please describe diet:_____

Significant sleep disturbance: ☐ wakes more than twice per night ☐ sleeps less 4 hours or less ☐ sleeps 12 hours or more

Are any of the above weight, appetite, or sleep disturbances related to medication side effects? ☐ Yes ☐ No If yes, please describe:_____

Panic attacks: ☐ Yes ☐ No If yes, please specify below:

- Frequency of panic attacks:_____
- Duration of panic attacks:_____
- Symptoms experienced during panic attacks:_____

Socialization problems: ☐ Yes ☐ No If yes, please describe:_____

Is patient able to: Clean/maintain residence: ☐ Yes ☐ No Perform routine shopping: ☐ Yes ☐ No

Pay bills: ☐ Yes ☐ No Operate motor vehicle: ☐ Yes ☐ No

If no to any of these above, please explain:_____

TREATMENT

Date initiated care: _____

Inpatient care: Dates of hospitalization: _____ Partial hospitalization programs: Dates of care: _____

Intensive outpatient (IOP): Start date: _____ End date: _____

Days per weeks: _____ Hours per day: _____

Outpatient psychotherapy: Frequency: _____ Date of next visit: _____

Medication management: Frequency: _____ Date of next visit: _____

Current medications/changes in medication-list all medications and identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Medication	Date prescribed	Adjusted Medication	Date Adjusted
				Yes ☐ No ☐		Yes ☐ No ☐	
				Yes ☐ No ☐		Yes ☐ No ☐	
				Yes ☐ No ☐		Yes ☐ No ☐	

Medication side effects: ☐ Yes ☐ No If yes, please describe:_____

Attach if relevant all office notes, history & physical, results of x-rays, laboratory tests, MRI Reports, etc.

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Telephone Number: _____ Physician/Provider Printed Name: _____

Fax Number: _____ Physician/Provider Specialty: _____

Date Completed: _____ Physician/Provider Signature: _____

sedgwick
P.O. Box 14192, Lexington, KY 40512-1192
Telephone: 800-638-4228 Facsimile: 859-264-4384 Email: myclaimdocs@sedgwick.com

Attending Physician Statement
To be completed by physician

Patient's Name: **Date of Birth:**

Claim Number: **Medical Due Date:**

1. Objective findings: HT: WT: BP: TEMP: PULSE: RESP:
2. Patient's Complaints: _____
3. Your Diagnosis: (list all disabling diagnoses including all ICD codes)
   Primary: ICD Code: _____ Description: _____
   Secondary: ICD Code: _____ Description: _____
4. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. _____
5. When was patient first diagnosed with this condition? ____/____/____
   List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
				Yes ☐ No ☐	Yes ☐ No ☐	____/____/____
				Yes ☐ No ☐	Yes ☐ No ☐	____/____/____
				Yes ☐ No ☐	Yes ☐ No ☐	____/____/____
				Yes ☐ No ☐	Yes ☐ No ☐	____/____/____

6. Is this condition the result of an injury? Yes ☐ No ☐ Is this condition work related? Yes ☐ No ☐ If yes, provide date and description of event: _____
   List all co-morbid conditions: _____
7. If patient is pregnant, indicate estimated date of delivery ____/____/____
8. Is a C-Section planned? Yes ☐ No ☐ If yes, date scheduled: ____/____/____
9. Give all dates of treatments by you during this period of disability; also indicate date of follow up visit: _____
10. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):

11. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? Yes ☐ No ☐

    If Yes: ☐ Emergency Room visit ☐ Hospitalization ☐ 23 hour admission

    Name and address of hospital or facility _____

    _____

    Date of admission: ____/____/____ Date of discharge: ____/____/____

    Indicate treatment provided: _____

12. Has any surgical procedure related to current disability been performed or is any anticipated? Yes ☐ No ☐

    List the name of the procedure: _____

    CPT code: _____

    Date of procedure: ____/____/____

13. Has patient been referred to other physician(s)/specialist? Yes ☐ No ☐ If yes, provide physician name, specialty, and telephone number. _____

    _____

14. List specific functional limitations of Activities of Daily Living (ADL's): _____

    _____

    _____

    _____

15. Has patient been given any driving restrictions for this disability period? Yes ☐ No ☐

    If yes please describe: _____

16. Based on your personal knowledge and treatment, how long has the patient been totally disabled by this sickness and prevented from working? From ____/____/____ to and including ____/____/____

17. Has the patient recovered sufficiently to return to work? Yes ☐ No ☐

    If yes, give the date the patient was able to return to work ____/____/____

    If no, in your opinion when, may work be resumed? (please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months, the total duration of disability. ____/____/____

    _____

18. Has the patient recovered sufficiently to return to restricted work? Yes ☐ No ☐

    If yes, indicate date restrictions begin: ____/____/____ date restrictions end: ____/____/____

    Restriction (s) required: _____

    _____

    _____

Attach if relevant all office notes, history & physical, results of x-rays, laboratory tests, MRI Reports, etc.

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Telephone Number: _____ Physician Printed Name: _____

Fax Number: _____ Physician Specialty: _____

Date Completed: _____ Physician Signature: _____

MEDICAL AUTHORIZATION

I authorize any physicians, nurses and hospitals to communicate my individually identifiable medical or health information by any means, including written or telephonic communications or by direct interview, whether or not I am present during, or notified of, such communications, and I hereby authorize Sedgwick Claims Management Services, Inc. (Sedgwick) to initiate and conduct such communications whether or not I am present or have received notice thereof. I understand that the information about me that I authorize to be used or disclosed may be re-disclosed in accordance with the terms of this Authorization by the recipient thereof and may no longer be protected by federal or state privacy laws or regulations.

What information is covered by this authorization? This authorization applies to all medical, health, psychological, and/or psychiatric information, records and reports, including information regarding pre-existing health or medical conditions or illnesses (a) that are in existence while this authorization is valid (see Item 3) and (b) that are related to my workers' compensation claim or, my claim for disability benefits under my employers short and long term disability plans (which may include assisting me in returning to work).

My information to be disclosed may include, but is not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health care providers. If directly related to my claimed condition or illness, this information may include information on HIV test results, HIV, AIDS, psychiatric information, or information related to drug or alcohol abuse.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member, or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Who may disclose and receive information under this authorization?

A. Any person or facility that attends, treats, or examines me, is to make this information available to Sedgwick or any of its agents, representatives, or independent contractors; and

B. When relevant to my claim, Sedgwick may re-disclose (without my further authorization) any and all of my individually identifiable medical or health information (whether obtained pursuant to this authorization or otherwise from any person or entity) to any of the following: (a) Any person or facility that attends, treats, or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits; (c) My employer and its affiliates and their representatives, independent contractors, and service providers that may receive any such information from my employer to the extent permitted by federal or state law; (d) service providers for my long term disability or

workers' compensation claim; or (e) The Social Security Administration or a social security or vocational rehabilitation vendor. Sedgwick may use my information obtained pursuant to this authorization in any other claim matter that Sedgwick may administer or handle related to me.

How long is this authorization valid? This authorization is valid during the duration of my claims and any future related claims, unless a different period is required under applicable federal or state law. **(Release in connection with a claim for benefits for health insurance may not remain valid longer than the term of coverage of the policy; or for the duration of the claim for all other insurance claims.)**

Revocation of this authorization. Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying Sedgwick, in writing, of my revocation and that my revocation shall be effective upon Sedgwick's receipt of my notice of revocation. I also understand that my revocation of this authorization will not have any effect on any actions taken by Sedgwick before it receives my revocation.

Processing of claims. I understand that this authorization is generally necessary for the processing of my claim. Failure to sign this authorization will likely impair or impede the processing of my claim.

Refusal to sign. I further understand my health care providers will not condition my treatment, payment, enrollment, or eligibility on my refusal to sign this authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Printed Name of Patient or Patient's Representative	Representative's Relationship to Patient, if applicable

Claim Number	Last 4 Digits of Patient's SSN	Patient's Date of Birth

Signature of Patient or Patient's Representative	Date Signed

Sedgwick Claims Management Services, Inc.
PO BOX 14192
Lexington, KY 40512-4192

<Today>

<EmployeeName>
<AddressBookAddress1> <AddressBookAddress2>
<AddressBookCity>, <AddressBookState> <AddressBookPostalCode>

Re: A Change in the Disability Administrator for Verizon
Claim Number: <ClaimNumber>

Important information regarding your Long-Term Disability Claim

We're contacting you about changes in the administration of your Long-Term Disability Claim. Starting **January 1, 2018,** Verizon is standardizing, simplifying and improving the claims administration process with a new vendor. We're excited to have Sedgwick, a best-in-class provider of claims administration services with 50 years of experience, join the Verizon team to administer Long-Term Disability claims.

Here's what you need to know

All of your claim information has automatically transferred from MetLife to Sedgwick; however, MetLife will continue to manage your claim and you should contact them as needed through December 31, 2017. Sedgwick will review your claim and will contact you directly with any questions or requests for additional information to help ensure an effective and efficient transition of your claim. Please note, effective January 1, 2018:

- The contact number will remain as 800-638-4228.
- The fax number is changing to 859-264-4384.
- For approved claims, your LTD payment will be sent from Sedgwick using your existing payment information.

Here's what you need to do

Please review the table below and, as soon as possible after January **1, 2018,** complete the actions that correspond with the status of your Long-Term Disability claim. Please return all requested forms to Sedgwick in a timely manner as it is important to help ensure effective claim processing during this transition.

Claim Status	Actions Required
Pending	Return the enclosed Medical Authorization
Approved and an extension is required	Return the enclosed Medical Authorization
Approved and an extension is NOT required	Nothing further is needed at this time

You can help to expedite claim handling during the transition by completing the Medical Authorization form online at www.claimlookup.com/VZ.

We're here to help

At Sedgwick, we're excited to serve you and are committed to supporting you during your time away from work. I Starting **January 1, 2018,** you'll be able to use these enhanced tools for a better claim administration experience.

- Opt into receiving email messages and text claim-alerts
- Access Sedgwick's self-service system, viaOne Express at www.claimlookup.com/VZ to:
    - Obtain your claim information
    - Upload documents
    - Electronically sign medical authorizations
    - Update your email and/or text preferences

Please be sure to include your claim number in all correspondence with Sedgwick to ensure we can provide you with the best service possible. If you have any questions, please contact Sedgwick at 800-638-4228, Monday through Friday, 8:00 a.m. - 9:00 p.m. Eastern Time.
We're here to help and look forward to serving and supporting you starting **January 1** regarding your claim, so please do contact us as needed. Thank you.

Sincerely,

Sedgwick Disability Specialist

Sedgwick Claims Management Services, Inc.
PO BOX 14192
Lexington, KY 40512-4192

<Today>

<EmployeeName>
<AddressBookAddress1> <AddressBookAddress2>
<AddressBookCity>, <AddressBookState> <AddressBookPostalCode>

Re: A Change in the Disability Administrator for Verizon Associates
Claim Number: <ClaimNumber>

Important information regarding your Short-Term Disability Claim

We're contacting you about changes in the administration of your Short-Term Disability Claim. Starting **January 1, 2018**, Verizon is standardizing, simplifying and improving the claims administration process with a new vendor. We're excited to have Sedgwick, a best-in-class provider of claims administration services with 50 years of experience, join the Verizon team to administer Short-Term Disability and Statutory Disability.

Here's what you need to know

All of your claim information has automatically transferred from MetLife to Sedgwick; however, MetLife will continue to manage your claim through December 31, 2017. Sedgwick will review your claim and contact you directly with any questions or requests for additional information to help ensure an effective and efficient transition of your claim.

- The contact number will remain as 800-638-4228.
- The fax number is changing to 859-264-4384.

Here's what you need to do

As soon as possible after **January 1, 2018**, please review the table below and complete the required actions that correspond with the status of your Short-Term Disability claim. Please return all requested forms to Sedgwick in a timely manner as it is important to help ensure effective processing of your claim during this transition.

Claim Status	Actions Required
Pending	Return the enclosed Medical Authorization and Attending Physician Statement
Approved and an extension is required	Return the enclosed Medical Authorization and Attending Physician Statement
Approved and an extension is NOT required	Contact your supervisor to discuss your return to work at the end of your approval period
Seeking to return to work with a workplace arrangement or accommodation	Contact the Workplace Accommodations Team at 877-635-1231 Return the enclosed Medical Authorization and

	the Attending Physician Statement

You can help to expedite claim handling during the transition by completing the Medical Authorization form online at www.claimlookup.com/VZ.

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Please be sure to include your claim number in all correspondence with Sedgwick to ensure we can provide you with the best service possible. If you have any questions, please contact Sedgwick at 800-638-4228, Monday through Friday, 8:00 a.m. - 9:00 p.m. Eastern Time.
We're here to help and look forward to serving and supporting you starting **January 1** regarding your claim, so please do contact us as needed. Thank you.

Sincerely,

Sedgwick Disability Specialist