Southeastern Pennsylvania Transportation Authority

BENEFITS DEPARTMENT

1234 Market Street, 6th Floor
Philadelphia, PA 19107

SICK BENEFITS APPLICATION

Part 1: 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) _____

Do you have a Workers' Compensation Claim pending? Yes_____ No_____

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 provider and approval by AmeriHealth Casualty.

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 three (3) 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.*

Please have your health care provider COMPLETE THE REVERSE SIDE OF THIS FORM. All questions must be answered or benefits may be delayed. Take the completed application to your LOCATION MANAGER who will approve Part II and forward to appropriate individuals. ***Only If confined or otherwise incapacitated, should you forward the completed form to*** SEPTA Benefits Department, 1234 Market Street, 6TH Floor, Philadelphia, PA 19107.

Employee's Signature: _____ **Date:** _____

Part II: TO BE COMPLETED BY EMPLOYEE'S LOCATION

Date application received: _____ **Last date employee worked:** _____

First day off for current illness: _____ **Return to work date if known:** _____

Current Days Off: _____

Date: _____ **Director:** _____

Upon receipt of this form please fax to SEPTA Benefits (215) 580-7185 and AmeriHealth Casualty (215) 587-1284

PART III: TO BE COMPLETED BY HEALTH CARE PROVIDER (Please type or print)

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. If you have any questions, you may contact SEPTA Medical (phone numbers are listed below).

ICD-9 Codes/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:** _____

City/State/Zip Code: _____ **Signature:** _____

Telephone: _____

PART IV: TO BE COMPLETED BY SEPTA WORKERS COMPENSATION DEPARTMENT

Approved: _____ **Disapproved:** _____ **Date:** _____

Manager's Signature: _____

Sick Benefits Effective: _____

Benefits Approved To: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Return Form to: **Location Manager for completion:** *Failure to do so may delay benefits* (Return form to Human Resources only if hospitalized or completely incapacitated)	**Contact Information**: Human Resources Benefits Clerk (215) 580-7116 Family Medical Leave Administrator (215) 580-7021 AmeriHealth Casualty 1-800-587-1211