Dear Mr./Ms./Dr. NAME:

York is the Third-Party Claims Administrator for the University of Michigan Long-Term Disability (LTD) Program. Please find the necessary forms enclosed that you will need to complete to apply for benefits under the LTD Plan. Please note both a Faculty/Staff Member Signature and Witness Signature is required on all forms, and missing signatures may cause a delay in the process.

The LTD application forms should be returned to York within fifteen (15) calendar days of the date of this letter. Failure to return the forms may cause your claim to be denied. You may fax the forms to York at (866) 229-4474 or mail them to:

York
University of Michigan LTD
PO Box 620
Howell, MI 48844-0620

The University of Michigan Work Connections department may continue to be in contact with you while your LTD claim is in process. We ask that you continue to cooperate with Work Connections as we coordinate with their office to secure your medical information and documentation related to your LTD claim. We will advise you if any additional information is needed. Upon receipt of your full medical file and LTD application forms, York will review your claim within 5 business days for approval or denial of LTD benefits. You will be notified in writing once a claim determination has been made.

Please contact our Customer Service Department at (800)533-9366 Monday through Friday, 8:00 a.m. to 5:00 p.m., if you have any questions regarding this correspondence.

Sincerely,

Disability Claims Specialist
York Disability Team
# LONG-TERM DISABILITY (LTD) APPLICATION PROCESS CHECKLIST

<table>
<thead>
<tr>
<th>WHAT TO DO</th>
<th>WHEN TO DO IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.) Contact Work Connections at 734-615-0643 or toll-free at 1-877-869-5266, or visit their website at: workconnections.umich.edu.</td>
<td>As soon as possible after you can no longer work or when you expect to be absent from work for a period of ten (10) consecutive days or more.</td>
</tr>
<tr>
<td>2.) Fully cooperate with Work Connections and provide medical information and documentation. This may include, but is not limited to:</td>
<td>You will work with Work Connections to determine the appropriate time to apply for LTD benefits.</td>
</tr>
<tr>
<td>- A Health Care Provider Statement (HCPS),</td>
<td></td>
</tr>
<tr>
<td>- A Functional Abilities Form (FAF),</td>
<td></td>
</tr>
<tr>
<td>- Clinical Notes, Summaries, and Diagnostic Testing Results,</td>
<td></td>
</tr>
<tr>
<td>- A Functional Job Description, and/or</td>
<td></td>
</tr>
<tr>
<td>- Any other medical evidence, documentation, or forms.</td>
<td></td>
</tr>
<tr>
<td>To determine the nature and extent of your disability or impairment, you may be required to undergo examinations by other physicians/psychologists/psychiatrists and/or be interviewed by nurse case managers and/or vocational rehabilitation specialists.</td>
<td></td>
</tr>
<tr>
<td>3.) Complete the LTD application forms before termination of coverage or employment, retirement, reduction in force (RIF) leave, educational leave, military leave, or Workers’ Compensation Redemption/Settlement.</td>
<td>Within 30 days from the date of the cover letter included with the forms mailed to you.</td>
</tr>
<tr>
<td>The UM Benefits Office and its Third-Party Claims Administrator, York, are the only offices authorized to distribute and process an application for LTD benefits. The LTD application packet includes:</td>
<td></td>
</tr>
<tr>
<td>- Employee Request for Participation and Personal Profile</td>
<td></td>
</tr>
<tr>
<td>- Medical Release Authorization</td>
<td></td>
</tr>
<tr>
<td>- Other Disability Income and Reimbursement Agreement</td>
<td></td>
</tr>
<tr>
<td>- Social Security Administration Consent for Release of Information</td>
<td></td>
</tr>
<tr>
<td>4.) Undergo examinations by other physicians/psychologists/psychiatrists and/or meet with nurse case managers and/or vocational rehabilitation specialists.</td>
<td>As requested by the York</td>
</tr>
<tr>
<td>5.) Contact the Social Security Administration (SSA) to apply for Social Security Disability Income (SSDI) benefits. You can contact SSA by phone at 1-800-772-1213 or visit their website at: ssa.gov</td>
<td>Immediately upon approval of LTD benefits, if not already done.</td>
</tr>
</tbody>
</table>

For further information about the university’s LTD Program, please visit the Benefits Office website at: http://benefits.umich.edu/plans/ltd. You may also contact a benefits representative at 734-615-2000 during normal business hours.
Employee Request for Participation and Personal Profile

The University of Michigan Long-Term Disability Plan

Please complete all pages of this application to submit your claim for Long-Term Disability (LTD) benefits. Forms may be returned to the Third-Party Claims Administrator, **York, PO Box 620, Howell, MI 48844-0620** within 15 calendar days from the date the forms were mailed to you. Omitted information will cause delays, and in no case will your application be accepted after your employment with the university has terminated or LTD coverage is no longer in force.

SECTION I

CONTACT INFORMATION

1. Faculty or Staff Member Information.

<table>
<thead>
<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>UMID</th>
<th>□ Single</th>
<th>□ Married</th>
<th>□ Divorced</th>
<th>□ Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City, State, Zip</td>
<td>Daytime Phone Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Date of Hire</td>
<td>Email Address</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Authorized Alternate Contact Information.

If you have a family member, friend, or other support person you would like to list as an authorized alternate contact for the University of Michigan and its Third-Party Claims Administrator, York, please provide his or her information below.

<table>
<thead>
<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Relationship to You (i.e., spouse, partner, son, daughter, friend)</td>
<td></td>
</tr>
</tbody>
</table>

3. Spouse, Partner, and/or Dependent Information.

Please provide the following information for your spouse, partner, dependent children under age 19, and/or disabled dependent children who are any age.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>UMID (If applicable)</th>
<th>Relationship</th>
<th>Date of Birth MM/DD/YY</th>
<th>Gender M / F</th>
<th>Disabled?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION II
EDUCATION, TRAINING, AND EXPERIENCE

1. Please indicate your current and previous occupations:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. Are you involved in any kind of business for wage or profit (as sole owner, co-owner, consultant, manager, investor, etc.)?
   Yes □  No □  If Yes, please provide further details as to the extent of your involvement/participation in the business.
   ____________________________________________________________
   ____________________________________________________________

3. Please indicate your highest level of education:
   ____________________________________________________________
   Specific degree(s) and/or certificates held:
   ____________________________________________________________
   Any trade, vocational program, or other special training you have completed or expect to complete:
   ____________________________________________________________

4. Have you served in the military?  Yes □  No □
   If Yes, please indicate the dates you served:____________________
   Your branch and rank:_______________________________________
   The job/roles you held while serving:__________________________

5. Do you participate in any social or community activities? Yes □  No □
   Do you hold offices in any groups?  Yes □  No □
   If Yes, please list and describe each activity and/or office:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

6. What kind of hobbies, interests, or other activities do you have (fishing, bowling, sewing, swimming, traveling, movies, etc.)? Please list all hobbies and how often you participate in each.
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

7. Please indicate any other skills you have acquired as a result of your education, training, or work experience.
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

8. Do you possess a valid driver’s license?  Yes □  No □
   Do you drive a motor vehicle?  Yes □  No □
   If Yes, how often do you drive and what is the typical distance you travel?
   ____________________________________________________________
SECTION III
MEDICAL INFORMATION

1. Please describe the nature of your illness or injury: __________________________________________________________
   What date did you first treat for this illness or injury? __________________________________________________________
   If due to injury, what was the date of the accident? __________________________________________________________
   Where and how did the accident occur? __________________________________________________________
   Please list all physical and/or psychiatric/psychological symptoms, complaints, and limitations: ________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________

2. What was your most recent last day of work prior to your current illness or injury? ________________________________

3. Please list all physicians you have consulted because of your current illness or injury.

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Telephone</th>
<th>Hospital Affiliation</th>
<th>Treatment Dates/Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Please list all inpatient hospital stays related to your current illness or injury.

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Admission Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Do you need any special help to take care of your personal needs and grooming?   Yes ☐   No ☐
   If Yes, please indicate what kind of help you require (washing, bathing, dressing, and so on), why, and how often.
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________

6. Please provide a detailed description of your daily activities, including household chores such as laundry, vacuuming,
dusting, mopping, washing dishes, household repairs, lawn care, shoveling snow, shopping, etc.
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
7. In your opinion, how do your symptoms, complaints, and limitations prevent you from performing your usual job duties?
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

8. Have you discussed returning to work with your physician(s), your department or human resources, or other rehabilitation specialist(s)? Yes ☐ No ☐
   If Yes, please provide further details including the opinions of those with whom you have discussed returning to work.
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

9. On what date were you able to return to work, or on what date do you expect to return to your current occupation?
__________________________________________________________________________________________________

10. Do you expect to return to work in another occupation on a full-time or part-time basis? Yes ☐ No ☐ If Yes, please provide further details.
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

SECTION IV
Other Disability Income

1. Have you applied for, or are you entitled to, benefits from the following sources because of your current illness or injury?
   Social Security Disability Income (SSDI) Benefits ☐ ☐
   Workers’ Compensation ☐ ☐
   Veterans Affairs Disability Compensation ☐ ☐
   Travel Accident Benefits ☐ ☐
   Canada/Quebec Pension Plan Benefits ☐ ☐
   Any Other Federal, State, Provincial, or Public Program ☐ ☐

   NOTE: You are encouraged to apply for SSDI benefits as soon as possible because Social Security Administration (SSA) takes approximately four (4) months to make an initial determination. Applying for SSDI is a requirement under the University of Michigan LTD Plan.

2. If you answered Yes to any above, please return a copy of your application confirmation, award notice, or denial notice from each agency.
SECTION V
Statement of Disability Certification and Signatures

I believe that I am now totally disabled and unable to work. I believe that my disability has lasted, or is expected to last, for a continuous period of not less than twelve (12) months from my last day of work. I request that I be placed on the Long-Term Disability (LTD) Plan until recovery, retirement, in the event of death, or as otherwise defined under the provisions of the LTD Plan.

I agree to apply for Social Security Disability Income (SSDI) benefits for me and my dependents within thirty (30) days of submitting this LTD application. I understand if my SSDI application is denied, I must follow the reconsideration process and continue in that process through the highest level of appeals, including filing for a hearing with an SSA Law Judge. I agree to immediately inform the University of Michigan Benefits Office and/or its Third-Party Claims Administrator, York, of the award amount(s) and the effective date of benefits. I also understand that any LTD advances/overpayments made to me by the University of Michigan are due immediately upon receipt of other disability income as defined under the provisions of the LTD Plan.

I hereby certify that all information I have given in this application is true and I understand that any willful falsification of facts presented may result in my claim being denied and/or the pursuit of legal action by the University of Michigan.

Faculty/Staff Member Signature ___________________________ Date ___________________________
I, _____________________________, hereby authorize and direct any and all medical providers and facilities to release information contained in my patient records and to disclose any such information to authorized representatives of the University of Michigan, its Third-Party Claims Administrator, York, and its managed care company, Brown Rehabilitation Management, Inc.

This specifically includes, but is not limited to, all medical, psychiatric, dental, hospital, clinical, employment, insurance claims, vocational records, and other such information. This authorization allows the University of Michigan, York, and Brown Rehabilitation Management, Inc. to release and share the above-mentioned information and records with each other.

This release is valid during the pendency of my LTD claim and shall expire when my claim concludes. The purpose of this disclosure is to provide medical and related documentation in order for my claim(s) for LTD benefits to be adequately evaluated. This release may be revoked at any time. However, any information already obtained as a result of this release may be used for the purpose of evaluating my LTD benefit claim(s). I understand once the information has been disclosed, UMHS and/or my provider can no longer protect it from further disclosure. I understand that the records released for the above purpose will be handled in a confidential manner, and utilized only for the purpose of determining my LTD benefits.

This medical release can be faxed, or copied, and a fax or photocopy of this medical release is as valid and acceptable as the original medical release. I understand that failure to provide a signed copy of this medical release may prevent the University of Michigan’s Third-Party Claims Administrator, York, from processing my LTD claim.
Other Disability Income and
Reimbursement Agreement
The University of Michigan Long-Term Disability Plan

I, _____________________________, hereby acknowledge and understand that I must pursue the possibility of receiving Other Disability Income for me and my dependents. Other Disability Income includes, but may not be limited to, Social Security (Disability or Retirement) Benefits, Workers’ Compensation, Veterans Affairs (VA) Disability Compensation, Travel-Accident Benefits, and/or any other source from a public program. Therefore, I agree to:

1. Apply immediately for Other Disability Income benefits in which me or my dependents may be eligible due to my disability,

2. Inform the UM Benefits Office immediately upon approval or denial of Other Disability Income benefits for me and my dependents, and

3. Provide the UM Benefits Office with a copy of all pages of any award (or denial) letters for Other Disability Income benefits.

To the extent that my Other Disability Income exceeds the maximum benefit limits of the UM Long-Term Disability (LTD) Plan, I understand that my LTD income replacement benefits will be reduced accordingly. Because I may not be approved for Other Disability Income until after I am approved for LTD benefits, and because some time may be required to determine my eligibility for Other Disability Income, the UM Benefits Office reserves the right to offset only for known cash payments (thus providing me with greater income.) **In return, I agree to reimburse the university for such advances (overpayments) immediately out of any retroactive or current lump-sum payment from Other Disability Income sources.**

This agreement is valid throughout the pendency of my LTD claim and shall expire when my claim concludes. This agreement can be faxed, or copied, and a fax or photocopy of this agreement is as valid and acceptable as the original. I understand that failure to sign or abide by the terms set forth in this agreement gives the UM Benefits Office the right to reduce, withhold, or discontinue all benefits under the LTD Plan and the right to seek termination of my employment status.

Faculty/Staff Member Signature _____________________________ Date ________________
TO: Social Security Administration:

*Name: ____________________________  *Date of Birth: ____________________________  *Social Security Number: ______

I authorize the Social Security Administration to release information or records about me to:

*NAME: University of Michigan  *ADDRESS: 3003 S. State Street, Suite G405
Ann Arbor, MI 48109-1278

*I want this information released because:
Under the University of Michigan’s Long-Term Disability Plan, I am required to provide documentation regarding the status of my OASDI claim.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

☐ Social Security Number
☒ Current monthly Social Security benefit amount
☒ Current monthly Supplemental Security Income payment amount
☒ My benefit/payment amounts from _______________ to Present
☒ My Medicare entitlement from _______________ to Present
☐ Medical records from my claims folder(s) from _______________ to _______________
☒ Complete medical records from my claims folder(s)
☒ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) Notice of Award or Disapproved Claim for me, and/or my dependents, or any other SSA Favorable or Unfavorable Decision letters.

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: ____________________________________________  *Date: ____________________________

Relationship (if not the individual): ____________________________  *Daytime Phone: ____________________________