THE SCHOOL DISTRICT OF PHILADELPHIA

WAGE CONTINUATION SUPPLEMENTAL FORM

SHORT TERM DISABILITY

Wage Continuation Policy Information:

Since you did not apply for this coverage during your initial period of eligibility, you are required to complete this form and it is subject for approval. The cost of this indemnity program is dependent upon your amount of accumulated sick leave, number of years of service, and salary. For a review of the pricing of this program, please visit our website at www.PhilaSD.org/offices/Benefits.

- **Approval of this application may take from 4-6 weeks from the date it is received.**
- **Approval of the application will be demonstrated through deductions in your paycheck. You will receive denial letter if you are found ineligible.**
- **This insurance becomes effective as soon as the form has been approved. You must be actively at work on the date of approval. If you are not at work on that date, coverage will be postponed until you return to work.**

Please complete this form and return it by fax to (215) 400-4631 (please call (215) 400-4630 to confirm receipt of fax)
or by mail to:
School District of Philadelphia
Office of Employee Benefits
440 N. Broad Street, Suite G-10
Philadelphia, PA 19130
Attention: Wage Continuation

Employee Information				
Employee ID 00000-	Last four digits of SSN	First Name	Last Name	M.I
Union	Daytime Phone Number	Date of Hire	School or Division	

Primary Care Physician's Contact Information		
Name	Address	Phone Number

- *Have you received payment from Wage Continuation benefits in the past 5 years?* ☐ Yes ☐ No

I hereby declare that the statements contained herein are true and complete.

I authorize any physician, other healthcare professional, hospital, pharmacy, pharmacy benefit manager or any other healthcare organization to give to The School District of Philadelphia ("the District) information concerning my medical history, prescription history, services or treatment. I understand that the District will comply with the federal Health Insurance Portability and Accountability Act (HIPPA) Privacy Rules and that disclosure of information will be done under the rules of HIPPA. I understand a copy of this authorization will be provided upon request, and that a photocopy of this authorization shall be as valid as the original.

Employee Signature: ______________________________ Date: ____________________

OFFICIAL USE ONLY:		**Approved / Denied**
EOB REC'D	EHS REC'D	Effective Date: __________
STAMP:	STAMP:	EHS Initials: __________

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