



## CATHOLIC DIOCESE OF CLEVELAND STD DISABILITY BENEFITS CLAIM FORM

1404 EAST NINTH STREET, EIGHTH FLOOR • CLEVELAND, OH 44114-1722  
216-696-6525 EXT. 5040 • FAX 216-621-9622 • hbo@dioceseofcleveland.org

**PLEASE RETURN TO THE DIOCESE BENEFITS OFFICE UPON COMPLETION**

### TO BE COMPLETED BY EMPLOYER

Employee Name \_\_\_\_\_ Last 4 Digits Of SS# \_\_\_\_\_  
Title \_\_\_\_\_ | Hourly \_\_\_\_\_ Salary Current Rate Of Pay \_\_\_\_\_ Effective Date \_\_\_\_\_  
Reg. Work Year Annual Salary/52 = \$ \_\_\_\_\_ Hire Date: \_\_\_\_\_  
Accrual Balances: Sick \_\_\_\_\_ Vacation \_\_\_\_\_ Other \_\_\_\_\_  
Academic/Contract Start Date: \_\_\_\_\_ Year End/Last Work Day: \_\_\_\_\_ (last academic day for teachers)  
Date Last Worked \_\_\_\_\_ Expected Date Return To Work \_\_\_\_\_ Injured On Job? ☐ Yes (explain) ☐ No  
Explanation: \_\_\_\_\_  
\_\_\_\_\_  
Will sick and other PTO balances be paid? ☐ Yes ☐ No Date through which sick pay will be paid by employer \_\_\_\_\_  
If your church or institution has 50 or more employees, was the employee provided FMLA paperwork? ☐ Yes ☐ No  
Is FMLA paper work returned ☐ Yes ☐ No ☐ N/A  
Name of Employer (Church or Institution) \_\_\_\_\_  
Address \_\_\_\_\_  
Date \_\_\_\_\_ Authorized Name (Print) \_\_\_\_\_  
Authorized Signature \_\_\_\_\_ Phone \_\_\_\_\_

**THE FORM MUST BE SUBMITTED WITH TWO (2) MOST RECENT PAY STUBS  
AND A SCREEN SHOT OF PTO BALANCES IF NOT INCLUDED ON THE PAY STUB**

### TO BE COMPLETED BY EMPLOYEE

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_ ☐ Male ☐ Female  
Beginning of \_\_\_\_\_ Maternity \_\_\_\_\_ Disability \_\_\_\_\_ If disabled due to accident, how, when, where did it occur (explain) \_\_\_\_\_  
\_\_\_\_\_  
Do you expect payment from other sources because of this accident (insurance, legal action, etc.)? ☐ Yes ☐ No  
I certify that the information provided is complete and accurate. I authorize any physician, healthcare provider, hospital, or other institution that has provided care to me to release any and all relevant information to The Catholic Diocese Group Life and Benefits Office or its authorized representative. A photocopy or electronic copy of this authorization shall be considered as valid as the original. I understand that FICA tax will be withheld from any benefits paid and that disability benefits are subject to Federal Income Tax.  
DATE \_\_\_\_\_ EMPLOYEE SIGNATURE \_\_\_\_\_

### ATTENDING PHYSICIAN'S STATEMENT

Diagnosis \_\_\_\_\_  
\_\_\_\_\_  
Hospitalized? Yes ☐ No ☐ If yes: From \_\_\_\_\_ To \_\_\_\_\_  
Pregnancy? Yes ☐ No ☐ If yes: Due Date \_\_\_\_\_  
Date patient first consulted you for the disability condition (omit for pregnancy) \_\_\_\_\_  
Patient disabled and unable to work? From \_\_\_\_\_ to \_\_\_\_\_  
Date patient has or should be able to return to work \_\_\_\_\_  
Physician's name (print) \_\_\_\_\_  
Physician's (signature) \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_

## CATHOLIC DIOCESE OF CLEVELAND STD DISABILITY/MATERNITY BENEFITS CLAIM FORM

1404 EAST NINTH STREET, EIGHTH FLOOR • CLEVELAND, OH 44114-1722  
216-696-6525 EXT. 5040 • FAX 216-621-9622 • hbo@dioceseofcleveland.org

### INSTRUCTIONS FOR COMPLETING THE DISABILITY/MATERNITY WEEKLY CLAIM FORM

#### 1. PARISH / EMPLOYER SECTION

Complete the 'TO BE COMPLETED BY EMPLOYER' portion of the form:

- Fill in all requested information about the employee (name, last 4 of SSN, title, pay rate, effective date, work year salary calculation, accrual balances, last day worked, expected return date, etc.).
- Indicate if the injury occurred on the job and whether PTO balances will be paid.
- Confirm if FMLA paperwork has been provided and whether it was returned.
- Provide authorized name, signature, date, phone number, and parish/institution address.

**ATTACH:**

- Two most recent pay stubs
- Screenshot of PTO balances (if not shown on pay stub)
- FMLA forms (if applicable)

#### 2. EMPLOYEE SECTION

Complete the 'TO BE COMPLETED BY EMPLOYEE' portion of the form:

- Fill in personal information (name, address, phone, date of birth, gender).
- Indicate whether the leave is for maternity or disability and provide accident details if applicable.
- Answer whether you expect payment from other sources.
- Read and sign the authorization statement.
- Date and sign where indicated.

#### 3. PHYSICIAN SECTION

Complete the 'ATTENDING PHYSICIAN'S STATEMENT' portion of the form:

- Provide diagnosis.
- State if hospitalized (include dates).
- If pregnancy, list due date.
- For disability, give date first consulted, period unable to work, and projected return-to-work date.
- Print name, sign, date, and provide contact information (phone, address, fax/email).

#### 4. SUBMISSION

Claim Forms should be submitted as soon as possible for an upcoming maternity and within twenty-one (21) days of an illness or injury.

Once all three sections are complete and required attachments are included, submit the form and documents to:

**Catholic Diocese of Cleveland – Benefits Office**

**1404 East Ninth Street, 8th Floor**

**Cleveland, OH 44114-1722**

**Fax: 216-621-9622**

**Email: hbo@dioceseofcleveland.org**