Health Care Authority
Public Employees Benefits Board

Long-Term Disability (LTD) Claim Information Sheet

Only employer groups should use this form (e.g., counties, municipalities, political subdivisions).

1 Instructions for employer

When to file the *LTD Claim Information Sheet*

- As soon as you know the employee's last day physically on the job because of a disability or illness;
- When the employee's hours have been reduced or modified because of a disability or illness; or
- At the employee's or the Health Care Authority's (HCA's) request.

Do not wait to file the claim until the waiting period expires or the employee's sick leave is exhausted.
Terminated employees may still qualify for an LTD claim as long as they became disabled while actively employed.

Documents you need to send to HCA

- This completed *LTD Claim Information Sheet*.
- All original PEBB LTD enrollment forms completed by the employee. If no originals are available, you may include copies. If no forms are available, provide proof of premium payments for LTD coverage back to the coverage effective date.
- Employee's current position description.
- A detailed attendance record from the employee's last day physically on the job or the start of partial disability. For a definition of partial disability, refer to the *Long Term Disability Plan* booklet. If the employee received shared leave hours, include a record of the number of shared leave hours, usage, and dollar value.
- Employment application or résumé and documents listing income from other sources (Social Security, worker's compensation, retirement plan, Paid Family and Medical Leave, etc.).

Send this completed information sheet and supporting documentation to:

Mail
Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

Secure message
Send us a secure message through HCA Support at **support.hca.wa.gov**. You will need to set up a SecureAccess Washington (SAW) account to use this option.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call 1-800-200-1004 (TRS: 711).

2 Employee information (complete all fields)

Social Security number

Date of birth

Last name

First name

Middle initial

Street address

Address line 2

City

State

ZIP/Postal code

Mailing address (if different than above)

Address line 2

City

State

ZIP/Postal code

Phone number

3 Employee's position information

Employer/agency code

Employer name

Hire date at this employer

Last day physically on the job

Original hire date (unbroken service date)

Hours worked per week

Original insurance eligibility date (first date of eligibility with state service)

Balance hours of sick leave (in hours)

Regular days off

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Monthly salary as of last day physically on the job

$

Salary prior to last increase

$ per

Date of last salary change (prior to last day physically on the job)

Current job title

4 Claim information

Employee-paid LTD Yes No

If yes, effective date

Waiting period

through

Is employee subject to Social Security taxes?

Yes No

Is this an on-the-job injury?

Yes No

Is employee receiving assault pay?

Yes No

Has employee filed a worker's compensation claim?

Yes No

Labor & Industries (L&I) claim number

Has employee returned to work? Yes No

If yes, check one

Part-time Full-time Light duty

Regular duty Other

Return to work date

Has employee terminated employment?

Yes No

Date of termination

Reason

Is employment scheduled for termination?

Yes No

Date of termination

Name of person completing this form

Phone number

Date