DPS SUPPLEMENTAL BENEFITS PROGRAM (DPSSBP)

Voluntary Payroll Protection Plan Claim Form

1617 S. Acoma Street

Denver, Co 80223-3624

(303) 377-0222

1. EMPLOYEE COMPLETES SECTION A, PROVIDING ORIGINAL SIGNATURE WHERE INDICATED.
2. PHYSICIAN COMPLETES SECTION B, PROVIDING ORIGINAL SIGNATURE WHERE INDICATED.
3. **CLAIMS WITHOUT ORIGINAL MEMBER AND/OR PHYSICIAN SIGNATURE WILL NOT BE PROCESSED. NO COPIES WILL BE ACCEPTED.**
4. RETURN **ORIGINAL** FORM COMPLETED AND SIGNED TO ADDRESS ABOVE. DO NOT SEND CLAIM FORM TO PAYROLL DEPARTMENT.
5. IF YOU ARE ON A DPS APPROVED HEALTH LEAVE, PLEASE PROVIDE A COPY OF YOUR HEALTH LEAVE NOTIFICATION WITH YOUR CLAIM.
6. PLEASE ALLOW FOUR TO SIX WEEKS FOR CLAIM PROCESSING.
7. MEMBERS WORKING UP TO 220 DAYS PER YEAR WILL BE PAID FOR EACH PERSONAL SICK DAY (ABSENCE CODE 3050) AFTER USING TEN PAID SICK DAYS.
8. MEMBERS WORKING 230+ DAYS PER YEAR WILL BE PAID FOR EACH PERSONAL SICK DAY (ABSENCE CODE 3050) AFTER USING TWELVE PAID SICK DAYS.
9. ALL CLAIMS FOR A GIVEN CLAIM YEAR MUST BE RECEIVED BY THE DPSSBP OFFICE **NO LATER THAN SEPT 1ST OF THE FOLLOWING YEAR**.

SECTION A - TO BE COMPLETED BY EMPLOYEE

LAST NAME | FIRST NAME | M.I. | HOME PHONE | WORK PHONE

HOME ADDRESS | CITY | ZIP

WORKSITE | POSITION | DPS ID No.

My signature below indicates my understanding and agreement with the following statement:

As a result of the illness/injury attested to by my physician in Section B, I have been absent from my job on the dates listed below. I understand that I will receive benefits only for those dates which have been recorded with the payroll department as personal sick days and/or are covered by an approved leave of absence for the illness/injury described by my physician in Section B. I affirm that the dates listed are a direct result of the illness/injury described by my physician in Section B (Diagnosis) and occurred while in his/her care. Further, the dates I have listed below are not covered by Workers' Compensation, and I am not now nor will I be pursuing Workers' Compensation coverage for this illness/injury. **I understand that if my absences have been approved by Health Services, I must include a copy of my Health Leave Notification when filing this claim. If no leave has been approved, documentation of my absence dates signed by my supervisor must be included when filing this claim.**

ABSENCE DATES ATTRIBUTABLE TO ILLNESS/INJURY:

DATE **EMPLOYEE SIGNATURE**

SECTION B - TO BE COMPLETED BY PHYSICIAN

DIAGNOSIS (DESCRIBE ILLNESS/INJURY):

IS ILLNESS/INJURY WORK-RELATED?: IF YES, PLEASE EXPLAIN:

PLEASE **INDICATE** THE DATE YOU BELIEVE THIS EMPLOYEE WILL BE ABLE TO RETURN TO WORK:

PHYSICIAN NAME | TYPE OF PRACTICE | PHONE

ADDRESS | CITY | STATE | ZIP

YOUR SIGNATURE BELOW CONFIRMS THE INFORMATION PROVIDED IN SECTION B. FURTHERMORE, YOU ARE CONFIRMING THAT THE CLAIMANT WAS UNDER YOUR CARE FOR THE ILLNESS/INJURY DESCRIBED ON THE DATES LISTED BY THE CLAIMANT IN SECTION A:

DATE **PHYSICIAN SIGNATURE**

DO NOT WRITE IN THIS AREA - DPSSBP OFFICE USE ONLY

PLAN TYPE: PLAN YEAR: NO. DAYS ABSENT: NO. DAYS PAID: PAID THROUGH:

DATE PAID: CK. NO.: AMOUNT: YTD TOTAL:

DURING THIS PLAN YEAR, THIS EMPLOYEE IS ELIGIBLE FOR BENEFITS EQUAL TO BUT NOT MORE THAN $