Southeastern Pennsylvania Transportation Authority

BENEFITS DEPARTMENT

1234 Market Street, 6th Floor
Philadelphia, PA 19107

SICK BENEFITS APPLICATION

Part I: TO BE COMPLETED BY EMPLOYEE

Name:________________________________ **Account Number:**___________________

Address:______________________ **City:**__________ **State:**_______ **Zip:**________

Home Phone:________________ **Location** (Depot, Department, Shop, etc):__________________

Position:__________________________ **Date of Hire:** (month/day/year___________________

Nature of Problem: (Auto Accident, slips, falls, illness, etc.)_______________________________

HAVE YOU FILED A WORKER'S COMP CLAIM FOR THIS INJURY/SICKNESS YES _______ NO _______

ARE YOU CURRENTLY RECEIVING WORKERS COMP BENEFITS RELATING TO THIS INJURY/SICKNESS YES _______ NO _______

IF YES WHAT IS THE AMOUNT OF WORKERS COMP BENEFIT YOU ARE RECEIVING? $ ____________

FMLA ELIGIBILITY: By applying for Sick Benefits, you have notified us of a potential FMLA qualifying event.

You are possibly eligible for FMLA leave. The leave time will be counted against your 12-week entitlement and will run concurrently with your sick leave. This leave is being **PROVISIONALLY** designated pending receipt of certification from your health care provided and approval by WorkPartners

Please be advised approval for Sick Benefits does not guarantee approval for FMLA leave.

I understand that benefits shall commence the fourth day of illness, provided that the Authority receives this request within the first five (5) days of illness, and will be in accordance with SEPTA Sick Benefit Regulations. Sick benefits paid to me, as the result of a 3rd party suit will, in compliance with the Labor Agreement, be reimbursed to the Authority. I also understand this form is to be completed fully and accurately by my treating Health Care provider. I agree that SEPTA Medical Department, or its designated medical representative, may contact my treating health care provider to obtain clarification of the information provided on this form.

Employee's Signature:______________________________ Date:____________________

PART II: TO BE COMPLETED BY EMPLOYEE'S LOCATION FOR APPROVAL

Date application received:__________________ **Last date employee worked:**______________

First day off for current illness:_______________ **Return to work date if known:**_____________

Current days off:____________________

Date:_______________ **Director:**____________________________________

Upon receipt of this form please fax SEPTA Benefits (215) 580-7185 and WORKPARTNERS (844) 860-9306.

Please have your health care provider COMPLETE THE REVERSE SIDE OF THIS FORM. All questions must be answered or benefits may be delayed. If physically able, bring the completed application to the Benefits Department. If confined or otherwise incapacitated, forward the completed form to **SEPTA Benefits Department, 1234 Market Street, 6th Floor, Philadelphia, PA 19107**

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Part III: TO BE COMPLETED BY HEALTH CARE PROVIDER (please type or print)

The named employee is applying for monetary Sick Benefits due to his/her inability to perform his/her duties with SEPTA. Please complete the following questions in full so that we may authenticate our employee's eligibility to receive Sick Benefits. If you have any questions you may contact SEPTA Medical (phone numbers are listed below).

Diagnosis (Primary Cause of Illness):______________________________

____

State the approximate date the condition commenced, and the probable duration of the condition.

Date absence began: ______/______/______ **Duration:**______________________

Date employee can return to work - Full Time: ______/______/______ **Part Time:**______/______/______

Date of first visit for current illness:__________________ **Date of most recent treatment:**__________________

is he/she confined to: Home:_______ **Institution:**_______ **Name of Institution:**______________________

Treatment (including prescriptions, physical therapy, etc.)______________________________

____

____

Surgery:

Contemplated ________**Yes** _______ **No** **If Yes, Please Give Date(s)**______________________

Performed ________**Yes** _______ **No** **If Yes, Please Give Date(s)**______________________

Provider Name:
(Please print Legibly) ______________________ **License #**______________________

Address: ______________________ **Date:**______________________

Telephone: ______________________ **Signature:**______________________

PART IV: TO BE REVIEWED BY SEPTA'S ABSENCE MANAGER

Reviewed by Absence Mgr ______________________ **Recert Date:** ____________
(date)

Absence Manager ______________________ ____________
(signature)

Add'l Notes: ______________________ ____________

______________________ ____________

______________________ ____________

______________________ ____________

Return Form to:
SEPTA Benefits Department
1234 Market Street, 6th Floor
Philadelphia, PA 19107
FAX (215) 580-7185

Contact information:
SEPTA Sick Benefits Department (215) 580-7116
WorkPartners (FMLA): (844) 860-9305