COUNTY of VENTURA
County Executive Office
Human Resources/Benefits

Ventura County Wage Supplement Plan (WSP)
Claim Statement

EMPLOYEE INSTRUCTIONS - *PLEASE READ CAREFULLY*

Your Wage Supplement Plan Claim Statement consists of three parts – PART 1: EMPLOYEE STATEMENT, PART II: DEPARTMENT STATEMENT, and PART III: ATTENDING PHYSICIAN STATEMENT. Every space should be filled in to avoid delay in processing of your claim. If for some reason a question does not apply, or information is not available, "N/A" should be written in the space, so we know you did not overlook the question. As the claimant, you complete all of Part 1, and section A of Part III (Attending Physician Statement). If you have seen more than one physician for this disability, a Physician Statement should be completed by each one. (Make copies or obtain additional forms from your department's Personnel Representative.)

PART I: EMPLOYEE STATEMENT ***(To be completed by COVERED EMPLOYEE)***

Fill out this Statement completely, making sure that you answer every question. Please print or type. If an incomplete form is received, it will be returned to you for completion prior to processing.

1. Name _____ 2. Employee No. _____ 3. Birth Date ____/____/____
4. Address _____ 5. Phone Number _____
   STREET OR P.O. BOX CITY STATE ZIP
6. Dept. _____ 7. Dept. No. _____ 8. Last Day Worked ___/___/___ 9. Date Returned ___/___/___
10. Type of Disability (*Check One*) ☐ Illness ☐ Injury ☐ Maternity
11. If illness/injury, it occurred on ___/___/___ at ___ : ___ am/pm ☐ At home ☐ At work
    Disability ended on/is expected to end on ___/___/___. ☐ Other (*specify*)_____
12. Describe symptoms of illness or how accident occurred. _____
    _____
13. Was your accident or illness caused by your work? ☐ Yes ☐ No
14. Have you filed for Workers' Compensation? ☐ Yes ☐ No If not, do you intend to file? ☐ Yes ☐ No
15. Date first treated for illness or injury ___/___/___
16. Date hospitalized (*if applicable*) ___/___/___ Name of Hospital _____
17. Have you been disabled from a similar accident or illness in the last five years? ☐ Yes ☐ No
    If yes, when? ___/___/___ Did you receive Workers' Compensation? ☐ Yes ☐ No

ACKNOWLEDGEMENT:
I certify that the above answers are true and complete to the best of my knowledge and belief.

_____ _____
DATE ***CLAIMANT (EMPLOYEE) SIGNATURE***

Please be aware that an unsigned, undated or incomplete Statement will be returned prior to processing.

After completing this EMPLOYEE STATEMENT, submit it to your department's Personnel Representative for completion of Part II, DEPARTMENT STATEMENT.

DEPARTMENT STATEMENT

PART II: DEPARTMENT STATEMENT (*To be completed by the PERSONNEL REPRESENTATIVE)*

1. Employee Name _____ 2. Employee No. _____

3. Department _____ 4. Date Employed ____/____/____

5. Currently enrolled in Wage Supplement Plan ☐ Yes ☐ No
   Benefit Amount *(check one)* ☐ $45.00 per week (low option) ☐ $80.00 per week (high option)

6. Job status at start of disability ☐ Regular full-time, ____ Scheduled hours per week
   ☐ Regular part-time, ____ Scheduled hours per week

7. If not at work when disability began, check one:
   ☐ On Sick Leave ☐ On Vacation ☐ On Annual Leave ☐ On Leave of Absence ☐ Laid Off

8. Last day physically at work before disability commenced ____/____/____

9. Last day of compensation to date ____/____/____

10. On ____/____/____, the employee (check one) ☐ Returned to Work ☐ Expects to return to work

11. Was this disability caused by work? ☐ Yes ☐ No

12. Has employee filed for Workers' Compensation or 4850 benefits? ☐ Yes ☐ No
    If YES, what was the weekly award? $ _____ /week

13. Has employee received Workers' Compensation benefits for a similar disability in the last 5 years?
    ☐ Yes ☐ No

14. Current Job Classification _____

15. Describe physical requirements of the job _____

_____

_____

EMPLOYING DEPARTMENT DEPARTMENT REPRESENTATIVE COMPLETING FORM

_____ *DEPARTMENT NAME*

_____ *REPRESENTATIVE'S SIGNATURE*

_____ *TITLE*

_____ *REPRESENTATIVE'S NAME*

_____ *DATE SIGNED*

_____ *TELEPHONE NUMBER*

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ATTENDING PHYSICIAN STATEMENT

Patient Name _____

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PART III: ATTENDING PHYSICIAN'S STATEMENT

INSTRUCTIONS

1. Section A of Part III must be completed by you, the claimant (employee). If you have seen more than one physician for this disability, a statement should be completed by each one. (You may make copies or obtain additional forms from your department's Personnel Representative.)
2. Section B of Part III must be completed by the attending physician.

a. All illnesses, surgical or obstetrical procedures, and/or complications should be explained and described.

b. Maternity claims should be submitted *after* the delivery unless medical complications exist that restrict or limit the claimant's ability to perform the job duties prior to delivery.

c. Every space should be completed to avoid any delay in processing of the claim. If for some reason a question does not apply, or information is not available, "N/A" should be written in the space, so we know you did not overlook the question.

A. TO BE COMPLETED BY **PATIENT**

Name _____ Birth date ___/___/___ Employee No. _____

Department _____ Enrolled in Wage Supplement Plan ☐ *High Option* ☐ *Low Option*

B. TO BE COMPLETED BY **ATTENDING PHYSICIAN**

1. Describe illness/injury *(include complications if any)*: _____

   _____

   _____

2. If pregnancy, expected date of confinement or date of delivery ____/____/____

   Describe restrictions and activity limitations to performing job duties before and/or after delivery, if applicable.

   _____

3. Was this sickness or injury caused by patient's employment? ☐ Yes ☐ No

   Is your office completing a Worker's Compensation claim form for this disability? ☐ Yes ☐ No

4. Nature of surgical or obstetrical procedure, if any *(describe fully)*: _____

   _____

   _____

5. Date surgical or obstetrical procedure performed ____/____/____
   (Month, Day, Year)

NOTE: PLEASE COMPLETE BOTH PAGES (signature required on 2nd page)

6. Give all dates of treatments: FIRST CONSULTATION ____/____/____
   (Month, Day, Year)

   OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY:

   ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

7. If hospital confined, date admitted ____/____/____ Date Released ____/____/____

   Name and Address of Hospital _____

8. The patient has been continuously and totally disabled (unable to work) from ____/____/____
   (Month, Day, Year)

   and ending ____/____/____
   (Month, Day, Year)

   If still disabled, when should patient be able to return to work? ____/____/____
   (Month, Day, Year)

9. Describe restrictions and activity limitations to performing job duties
   _____

   _____

   _____

   _____

PLEASE PRINT:

PHYSICIAN'S NAME_____ MEDICAL SPECIALTY _____

ADDRESS (Street or P.O. Box) _____

CITY AND STATE_____ ZIP _____

TELEPHONE NUMBER (_____) _____

PHYSICIAN'S SIGNATURE _____ DATE _____
ORIGINAL SIGNATURE (stamps not accepted)

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Upon completion, please return to County of Ventura Human Resources, Benefits Division:

COUNTY OF VENTURA
HUMAN RESOURCES, BENEFITS DIVISION OR LOA.Benefits@ventura.org
800 S. VICTORIA AVE., Loc# 1970
VENTURA, CA 93009