Concordia Plan Services
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CONCORDIA PLAN SERVICES

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Worker Status Verification for Workers on Disability

It is the responsibility of the Employer to notify Concordia Plan Services (CPS) when a disabled worker ***returns to partial or full-time*** employment after receiving disability benefits under the Concordia Disability and Survivor Plan (the Plan). Verification of a worker's status must be submitted to CPS as often as needed to ensure all worker information remains current. Your cooperation in providing the requested information is essential to:

- maintaining the worker's Concordia Plan eligibility
- calculating the worker's disability income benefits accurately
- preparing accurate employer invoices

Note: If a disabled worker's change in status is a result of their disability claim being closed, this form must be received by CPS no later than 30 days after the date of notification from third party administrator; otherwise the Concordia Plan benefits will be terminated retroactive to the end of the month in which we receive notification of the closure.

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Employer Information

Employer Name _____ Concordia Plan Services Employer Account Number (if known) _____

Address _____

City _____ State _____ Zip Code _____ Employer Phone Number _____

Employer Email Address _____ Employer Fax Phone Number _____

B Worker Information

Worker Name _____ Worker ID _____

Please check all applicable boxes:

☐ **Worker remains on disability* and is working part time.** Worker remains on disabled status and, if applicable, contributions for the Concordia Plans may be waived unless otherwise required by the Plan.
Partial return to work date: _____.

☐ **Worker recovered from disability* and has or will take additional personal/vacation time prior to returning to work.** Worker has or will return to work:

- ☐ **At pre-disability hours, duties and salary**. Place worker on active status following date of recovery and bill employer for Concordia Plans.
  (Expected) return to work date: _____.
- ☐ **With a change in the worker's duties, hours or salary** that affects their participation in the Concordia Plans. Employer will complete and attach a *Worker Change Report-Duties/Hours/Employment Classification* form (available at ***ConcordiaPlans.org/Forms)***.
  (Expected) return to work date: _____.

☐ **Worker recovered from disability* and has returned to work:**

- ☐ **At pre-disability hours, duties and salary.** Place worker on active status following date of recovery and bill employer for Concordia Plans.
  Return to work date: _____.
- ☐ **With a change in the worker's duties, hours or salary** that affects their participation in the Concordia Plans. Employer will complete and attach a *Worker Change Report-Duties/Hours/Employment Classification* form (available at ***ConcordiaPlans.org/Forms)***.
  Return to work date: _____.

☐ **Worker recovered from disability* and is on a Family Medical Leave (FMLA).** Place worker on active status following date of recovery and bill employer for Concordia Plans. Expected return to work date: _____.

☐ **Worker is not returning to work following the recovery from disability*.** Participation in the Concordia Retirement Plan and Concordia Disability and Survivor Plan will terminate and if applicable, the Concordia Health Plan will continue as indicated below:

- ☐ **Yes.** Following date of recovery, continue coverage and bill employer through the date of _____.
- ☐ **No.** Coverage under the Concordia Health Plan **will not be** continued following date of recovery.

* Date of recovery from disabled status is determined by a third party administrator in accordance with Plan provisions.

C Employee Representative Signature

As the employer representative, I acknowledge that the information entered on this form for this worker is complete and accurate to the best of my knowledge.

X _____
Signature of Authorized Employer Representative _____ Date _____

Printed Name of Authorized Employer Representative _____ Title or Office Held _____

Email Address _____ Daytime Phone Number _____

In the event of a conflict between the information on this form and the terms of the Plan, the Plan document will govern.