PINELLAS COUNTY SCHOOLS

**WAIVER OF HEALTH INSURANCE PREMIUM APPLICATION / EMPLOYEE INFORMATION SHEET**

DATE SENT _____

DATE DUE _____

Employee Name_____

Date of Birth _____ / _____ / _____

Home Address _____

Home Phone # _____

Physicians who were consulted because of this disability:

Dr. _____ Telephone _____ From _____ / _____ / _____

Address _____ To _____ / _____ / _____

Dr. _____ Telephone _____ From _____ / _____ / _____

Address _____ To _____ / _____ / _____

Hospitals where the patient was treated for this disability:

_____ Address _____ From _____ / _____ / _____

_____ To _____ / _____ / _____

_____ Address _____ From _____ / _____ / _____

_____ To _____ / _____ / _____

I declare that to the best of my knowledge and belief all of the above answers are complete and true. If they are found to be untrue, my waiver will be cancelled and all premiums waived will become due and payable to the School Board of Pinellas County.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, or other organization or institution, which has any records or knowledge of my mental or physical health to provide such information upon request of the School Board of Pinellas County, Florida.

Employee's Signature _____ Date _____

Please complete the Employee Information Sheet, and send it with the remaining pages to your physician. If your claim is due to a work-related illness or injury, this form must be completed by your workers' compensation treating physician. Upon completion, it must be returned to the Risk Management Department for review and processing. Note, it is your responsibility to notify your physician that these forms must be totally completed and returned to Risk management within the 30 day time frame or your waiver will be denied.

If you have any questions concerning the Waiver of Premium or the requirements for eligibility, please call Risk Management at 588-6197.

**Attending Physician's Statement:** Premium Waiver Application
(all sections must be completed or marked N/A)

**1. History:**

A. When did the symptoms first appear or the accident happen? _____/_____/_____

B. Has the employee ever had the same/similar condition? Yes ☐ No ☐
If yes, state when and describe:

_____

C. Is this illness/injury work related? Yes ☐ No ☐
Describe how it is work related.

_____

**2.. Diagnosis:**

A. Subjective symptoms_____

B. Objective symptoms _____

C. Current Diagnosis (including any complications)

_____

**3. Treatment:**

A. Date of first visit: _____/_____/_____

B. Date of last visit: _____/_____/_____

C. Frequency of visits: Weekly Monthly Other

D. Nature of Treatment (include type and date of surgery, medications prescribed, frequency type of treatments, if any.)

E. Date of next visit: _____/_____/_____

**4. Progress:**

A. Is Patient: Recovered?☐ Improved? ☐ Unchanged? ☐ Retrogressed ☐

B. Is Patient: Ambulatory:☐ House confined?☐

Remarks _____

**5. Maternity: ( If applicable)**

A. What is expected/was delivery date: _____/_____/_____

B. Please describe any complications that would extend disability longer than for a normal pregnancy

_____

**6. Cardiac: (If applicable)**

A. Functional Capacity (American Heart Association)

☐ Class 1 (no limitation)

☐ Class 2 (slight limitation)

☐ Class 3 (moderate limitation)

☐ Class 4 (marked limitation)

☐ Class 5 (severe limitation)

B. Blood Pressure at last visit

_____ Systolic _____ Diastolic

C. If employee can return in a modified working capacity, what restrictions or modifications are necessary?

_____

_____

D. Is the patient now totally disabled and cannot perform any type of work? No ☐ Yes ☐

**If yes**, when did the employee become totally disabled _____/ _____/ _____

**If no,** when were the dates, if any of total disability?

Begin Date _____/ _____/ _____ End Date _____/ _____/ _____

**7. Physical Impairment: (If applicable)**

A. ☐ Class 1 - No limitation of functional activity

☐ Class 2 - Slight limitation of functional capacity; capable of light work.

☐ Class 3 - Medium manual activity

☐ Class 4 - Moderate limitation of functional capacity; capable of sedentary activity.

☐ Class 5 - Severe limitation of functional capacity; incapable of even minimal sedentary activity (May not perform ANY type of work at all)

B. If employee can return in a modified working capacity, what restrictions or modifications are necessary?

_____

_____

C. Is the patient *now* totally disabled and cannot perform any type of work? No ☐ Yes ☐

**If yes**, when did the employee become totally disabled _____/ _____/ _____
**If no,** when were the dates, **if any** of total disability?

Begin Date _____/ _____/ _____ End Date _____/ _____/ _____

**8. Mental/Nervous Impairment: (If applicable)**

A. ☐ Class 1 - No limitation; patient is able to function under stress and engage in interpersonal relations.

☐ Class 2 - Slight limitation; patient is able to function in most stress situations and engage in most interpersonal relations.

☐ Class 3 - Moderate limitation; patient is able to engage in only limited stress situations and engage in only limited interpersonal relations.

☐ Class 4 - Marked limitation; patient is unable to engage in stress situations or engage in interpersonal relations.

☐ Class 5 - Severe limitation; patient has significant loss of psychological, physiological, personal and social adjustment.

B If employee can return in a modified working capacity, what restrictions or modifications are necessary?

_____

_____

C. Is the patient *now* totally disabled and cannot perform any type of work? No ☐ Yes ☐

**If yes**, when did the employee become totally disabled _____/ _____/ _____
**If no,** when were the dates, *if any* of total disability?

Begin Date _____/ _____/ _____ End Date _____/ _____/ _____

Remarks _____

**9. Prognosis:**

A. Do you expect a fundamental or marked change in the future?

_____ Yes _____ No

**1. If yes,** when do you estimate patient will be able to resume work?

_____/ _____/ _____ One Month? _____ 1-3 Months? _____ 4-6 Months _____Unknown _____ *See question below.

**2.** If unknown at this time, please when the patient will be re-evaluated.

_____

**10. Additional Remarks**_____

"Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such act."

_____ _____ _____

Name of Attending Physician | Specialty | Telephone Number

_____

Address | City State | Zip Code

_____ _____

Signature of Attending Physician | Date

_____

Florida License Number

Please mail this form directly to: Pinellas County School Board
Attn: Risk Management & Insurance
301 4th Street S.W.
Largo, FL 33770