



HEALTH & WORK

Employer Disability Benefit Application Organizer

Assemble and verify an initial employer-sponsored short-term or long-term disability-income application after an accident prevents or limits work.

WHAT THIS WORKBOOK HELPS YOU DO

01

Complete your plan requirement map

02

Complete your contributor and submission control

03

Complete your work and earnings consistency audit

For people handling accident-related paperwork and preparing clear, evidence-backed questions.

Use it on screen or on paper. Save a personal copy before entering information. Blank response areas are fillable; printed copies work just as well. Keep completed copies private.

Scope. Educational organization tools, not legal, medical, tax or financial advice. No claim result, coverage decision or payment is promised. Verify policy language, current local rules and all deadlines with the appropriate professional or official source.



START HERE

Start with a clear working file

Work on one claim, account or issue at a time. Keep originals unchanged and label working copies with a short evidence ID. Complete the guidance in order, then use the worksheets to turn questions into an organized next step.

A practical order

- 01 Read the four guidance pages before filling the worksheets. Mark facts you can support and questions that still need an answer.

GUIDANCE / PAGES 03-06

- 02 Use the fictional examples to check your method. Their facts and dollar amounts do not describe your claim or predict an outcome.

EXAMPLES / PAGE 07

- 03 Complete the four working sheets, then use the readiness check and next-step page. Duplicate a worksheet when you need another record.

WORKSHEETS / PAGES 08-11

Protect your information

Store completed copies somewhere private. Use a claim or account suffix when a full identifier is unnecessary. Share only relevant copies through a verified recipient and appropriate channel. A saved PDF can contain personal information even when it is not open on screen.

Before a deadline. Do not wait to finish this workbook when a notice, release, court paper or policy deadline needs attention. Verify the actual requirement and seek qualified help promptly.



GUIDANCE 1

01

Identify the benefit and plan administrator

Start with the plan document and the person responsible for administering it. Short-term and long-term disability benefits replace income under their own terms; they do not automatically determine job-protected leave or accident compensation. Many private-employer plans are governed by the Employee Retirement Income Security Act, or ERISA, but not every workplace arrangement is. Government and most church plans can follow other rules, and some employer payments may be outside the same framework. Record the actual plan type and ask the administrator when unclear rather than assuming the insurer's brand establishes the rules.

Extract the application requirements

Obtain the summary plan description, often called the SPD, and the actual claim instructions. Identify the plan's definition of disability, eligibility requirements, waiting or elimination period, filing requirements and proof requested. Copy page references and dates into the policy worksheet. Do not use a definition from another employer or a friend's policy. If a term is ambiguous, write the question and the administrator's answer. This workbook helps you organize the plan's requirements; it cannot determine whether your condition satisfies them or whether an exclusion applies.

RELATED WORKING SHEETS

- Plan requirement map
- Contributor and submission control

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 2

02

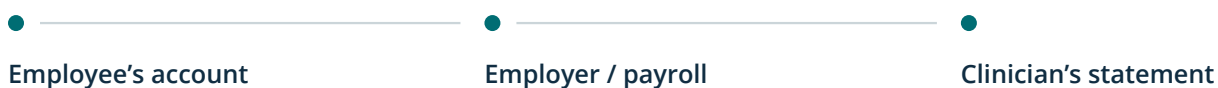
Coordinate three contributors

Most application packets require information from different sources. Separate the employee's account, employer/payroll information and clinician's statement so each person knows what to complete. Provide accurate job duties and contact information, and keep dates consistent with the underlying records. Do not complete clinical opinions or employer certifications yourself. Record when each form was sent, the due date and evidence it was received. If the insurer receives components separately, use the same claim reference where instructed and confirm that the pieces were associated with the correct file.

Build a task-specific work history

Describe the job as actually performed, including schedule, relevant physical or cognitive tasks and any change in duties. Distinguish your own description from a clinician's restrictions and the employer's official job description. Record the last day worked, partial work, attempted return and other dates using source records rather than memory alone. A label such as unable to work may be too broad to explain the facts; the application should be truthful and responsive to its questions. Never exaggerate limitations or conceal work that occurred during the claimed period.

Give each application component its own owner and verify that the administrator received it.



Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 3

03

Reconcile earnings and other benefits

Use payroll records and the plan's stated earnings definition to identify the figures requested. Overtime, bonuses, commissions and other benefits may be treated differently by different plans. List other payments or applications that the form asks about, but do not assume every amount is an offset or that none must be reported. Keep leave pay, disability income and accident damages separate in the source index. If the plan requires reporting other benefits or settlements, ask a qualified adviser about the implications rather than deciding the legal treatment from a generic worksheet.

Submit and verify completeness

Run the packet checklist before submission: correct person, plan, dates, signatures, required attachments and verified destination. Keep a copy and delivery confirmation. Then ask whether the file is complete for review or whether another contributor's statement is missing. A submission receipt does not necessarily mean every required component arrived. If more information is requested, record the exact item and stated response date, then coordinate the appropriate source. Do not invent an answer to close a blank; explain uncertainty and ask how to supply a correction.

RELATED WORKING SHEETS

- Plan requirement map
- Contributor and submission control

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 4

04

Track decisions and information requests

Keep the plan's acknowledgement, extensions and requests in date order. Department of Labor guidance describes timing rules for ERISA disability claims, including a general initial decision period of up to 45 days and permitted extensions under specified conditions. Actual timing can depend on the process and information requested. Record notices instead of declaring that any delay proves a violation. If a claim is denied, preserve the denial and appeal instructions promptly and seek appropriate assistance; this workbook does not replace a plan-specific appeal strategy.

Verify approval and ongoing obligations

Read an approval for the covered dates, benefit calculation, waiting period, payment frequency and continuing proof requirements. Compare the first payment with the written determination and ask about unexplained differences. Keep any return-to-work or earnings-reporting obligations visible. A short-term approval does not automatically establish long-term eligibility, and an income-benefit approval is not a medical clearance or leave designation. Close the initial application stage when the decision and payment status are documented, while leaving any required future report or transition clearly assigned.

RELATED WORKING SHEETS

- Plan requirement map
- Contributor and submission control

Sources for this page: [1], [2], [3]. See the linked source guide.



FICTIONAL EXAMPLES

Work through the examples

These invented cases demonstrate the method. They are not case results, estimates of what you will receive or statements of universal rights.

01 Fictional: missing employer component

The employee and clinician forms show delivered, but the plan reports no payroll statement. The packet tracker marks the application received but incomplete. The employee asks payroll to send the required component with the claim reference and verifies receipt, rather than resubmitting medical records that were already received.

02 Fictional: plan-specific earnings

A worker's payroll includes a salary and commissions. The workbook lists both with source records and flags the plan's earnings definition for confirmation. It does not assume all commissions count or calculate a universal replacement percentage.



WORKSHEET 1

01

Plan requirement map

Use the actual plan's language and page references; do not import another plan's terms.

Plan/administrator

Plan type/ERISA status source

SPD version

Disability definition/page

Eligibility provision

Waiting period

Filing deadline/source

Required forms

Other-benefit reporting provision

Question/answer

Related guidance: [Identify the benefit and plan administrator](#)



WORKSHEET 2

02

Contributor and submission control

Confirm receipt of each component separately.

Form/component

Employee/employer/clinician owner

Requested date

Sent date

Due date/source

Signature required

Received by administrator

Claim reference

Missing item

Follow-up owner

Related guidance: [Coordinate three contributors](#)



WORKSHEET 3

03

Work and earnings consistency audit

Preserve differences for clarification; do not edit medical or payroll source records.

Last full workday

Partial-work dates

Job duties source

Clinician restriction dates

Payroll period

Requested earnings definition

Amount/source

Other payment reported

Date inconsistency

Correction explanation

Related guidance: [Coordinate three contributors](#)



WORKSHEET 4

04

Decision and first-payment verification

An approval letter, payment receipt and future reporting obligation are distinct items.

Decision date

Covered period

Waiting period applied

Approved benefit calculation

First payment expected/received

Difference/question

Continuing proof due

Return/earnings reporting

Transition needed

Next action

Related guidance: [Track decisions and information requests](#)



READINESS REVIEW

Check the file before using it

REVIEW EACH ITEM BEFORE MOVING ON

- ☐ Each working figure or statement is linked to an identifiable document.
- ☐ Missing information is marked as unverified rather than estimated as fact.
- ☐ The exact question and the person or organization able to answer it are identified.
- ☐ The current document version and any conflicting version are preserved.
- ☐ Independent deadlines and the source of each deadline have been checked.
- ☐ The final written response has been compared with the original question.

What still needs attention

Open fact or decision, who can resolve it, and the source needed

Completion standard. The working file is complete when the important facts are supported, the next action is assigned and any unresolved issues remain clearly visible. A completed checklist does not establish coverage, entitlement or legal compliance.



ACTION PLAN

Write down the next step

Choose the smallest useful next step. Make the request specific enough that the recipient can locate the record and explain or address the exact issue. Keep proof of what you sent and what came back.

The exact issue or request

Evidence IDs and document versions that support the request

Verified recipient and channel

Date sent and follow-up date

What response will resolve the issue, and what still needs professional review

Separate decisions. A courtesy follow-up date is not a legal deadline. A document request does not automatically pause another requirement. Do not sign, settle, move property or disclose sensitive records merely because a box on this page is complete.



REFERENCE GUIDE

Sources and scope

The linked official sources support the educational background. The forms and examples are original organization tools. Sources were checked on October 1, 2026; policies, procedures and law may change. Recheck the current source before relying on a rule.

[1] U.S. Department of Labor

The Department of Labor explains reviewing the SPD, following plan claim procedures, ERISA disability-claim timing and decision notices. Its guidance does not establish that a particular injury qualifies under an individual plan.

<https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-disability-benefits.pdf>

[2] U.S. Department of Labor

The Department of Labor describes the summary plan description and participant access to important plan information.

<https://www.dol.gov/general/topic/health-plans/planinformation>

[3] U.S. Department of Labor

The Department of Labor explains the scope of ERISA health/disability claims procedures, exclusions for some plans and the importance of claim-specific notices, response periods and appeal instructions.

<https://www.dol.gov/node/63367>

Keep the scope clear

Plan-specific initial application only; no guaranteed benefits or universal replacement percentage

ERISA does not govern every employer program, government plan or church plan

State statutory disability, workers' compensation and Social Security have separate rules

No medical eligibility opinion, pre-existing-condition ruling or benefit-offset calculation