2712-2 Dispute Between Department and a Voluntary Plan or Different Voluntary Plans Where Claim Filed Against a Voluntary Plan

(a)

If an individual files a claim for disability benefits against a voluntary plan and the voluntary plan insurer or self-insurer determines that the claimant is eligible for disability benefits, but that such benefits are payable from the Disability Fund or another voluntary plan, the voluntary plan insurer or self-insurer with whom the claim was filed shall immediately forward a copy of the claim and any medical and other records relating thereto to the department or other voluntary plan insurer or self-insurer, as the case may be, with a request that benefits be paid from the Disability Fund or the other voluntary plan. If any payment has been made from the voluntary plan against which the claim was filed, a statement of such payments and a request for reimbursement at the Disability Fund rate or other voluntary plan rate shall also be forwarded with the copy of the claim. If the department or other voluntary plan insurer or self-insurer concedes coverage and eligibility, prompt reimbursement shall be made to the voluntary plan with which the claim was filed at the Disability Fund rate and period or other voluntary plan rate and period, as the case may be, and the claimant shall be promptly paid the accumulated excess of benefits, if any, to which he or she is entitled. If the department or other voluntary plan insurer or self-insurer denies coverage, it shall

immediately so notify in writing the voluntary plan insurer or self-insurer with whom the claim was filed, and the claimant, giving its reason for the denial and, in such event, the voluntary plan insurer or self-insurer shall immediately pay benefits under the claim at not less than the Disability Fund rate.

(b)

If the department or the other voluntary plan insurer or self-insurer fails to give notice of acceptance or denial of coverage within twenty-five (25) days after a copy of the claim is mailed or delivered to it as provided in subdivision (a) of this section, such failure shall be deemed to be a denial of coverage and the voluntary plan insurer or self-insurer with whom the claim was filed shall immediately pay benefits under the claim at not less than the Disability Fund rate.

(c)

Subdivisions (a) and (b) of this section shall also apply to claims for Family Temporary Disability Insurance benefits.

(d)

Disclosure authorizations for Family Temporary Disability Insurance claims. Voluntary plans shall obtain a care recipient's, as defined in code section 3302, subdivision (a), authorization to disclose his or her medical information before forwarding any medical records to the department. The authorization shall accompany any care recipient's medical records to the department. The authorization must: (1) be in writing (2) be in 14-point typeface or larger (3) be clearly separate from any other language present on the same page (4) state the name of the claimant and identify him or her as the care provider (5) state the name of the physician or practitioner who is authorized to disclose the care recipient's medical information and identify that individual as the care recipient's treating physician or practitioner (6) state that the care recipient authorizes his

or her physician or practitioner to disclose his or her medical information to the care provider, the care provider's voluntary plan as the term is used in Chapter 6, Part 2, Division 1, of the code commencing with section 3251 et seq., and the Employment Development Department (7) state that the care recipient authorizes the disclosure solely to support the care provider's claim for Family Temporary Disability Insurance benefits (8) state that the physician or practitioner may disclose(A) the care recipient's diagnosis (B) the care recipient's International Classification of Diseases code or, where no diagnosis has yet been obtained, a detailed statement of symptoms (C) a statement setting forth the facts of the care recipient's serious health condition that warrants the participation of the care provider (D) the date on which the condition commenced (E) probable duration of the condition (F) estimated amount of time each day the physician or practitioner believes that the care provider is needed to care for the care recipient (9) state that the authorization is valid for 10 years from the date the voluntary plan receives it or the effective date of the claim, whichever is first (10) state that the care recipient may request a copy of the authorization from the voluntary plan by writing to it at a specified address (11) state that the care recipient may revoke the authorization by writing to the specified address (12) state that the medical information may be used by the voluntary plan or the Employment Development Department to determine the care provider's eligibility for Family Temporary Disability Insurance benefits (13) include a signature and date line for the care recipient (14) instruct authorized representatives, as defined in section 3302-1(a), to sign on behalf of the care recipient and indicate the source of authority to act for the care recipient.

(1)

be in writing

(2)

be in 14-point typeface or larger

(3)

be clearly separate from any other language present on the same page

(4)

state the name of the claimant and identify him or her as the care provider

(5)

state the name of the physician or practitioner who is authorized to disclose the care recipient's medical information and identify that individual as the care recipient's treating physician or practitioner

(6)

state that the care recipient authorizes his or her physician or practitioner to disclose his or her medical information to the care provider, the care provider's voluntary plan as the term is used in Chapter 6, Part 2, Division 1, of the code commencing with section 3251 et seq., and the Employment Development Department

(7)

state that the care recipient authorizes the disclosure solely to support the care provider's claim for Family Temporary Disability Insurance benefits

(8)

state that the physician or practitioner may disclose(A) the care recipient's diagnosis (B) the care recipient's International Classification of Diseases code or, where no diagnosis has yet been obtained, a detailed statement of symptoms (C) a statement setting forth the facts of the care recipient's serious health condition that warrants the participation of the care provider (D) the date on which the condition commenced (E) probable duration of the condition (F) estimated amount of time each day the physician or practitioner believes that the care provider is needed to care for the care

recipient

(A)

the care recipient's diagnosis

(B)

the care recipient's International Classification of Diseases code or, where no diagnosis has yet been obtained, a detailed statement of symptoms

(C)

a statement setting forth the facts of the care recipient's serious health condition that warrants the participation of the care provider

(D)

the date on which the condition commenced

(E)

probable duration of the condition

(F)

estimated amount of time each day the physician or practitioner believes that the care provider is needed to care for the care recipient

(9)

state that the authorization is valid for 10 years from the date the voluntary plan receives it or the effective date of the claim, whichever is first

(10)

state that the care recipient may request a copy of the authorization from the voluntary plan by writing to it at a specified address

(11)

state that the care recipient may revoke the authorization by writing to the specified address

(12)

state that the medical information may be used by the voluntary plan or the Employment Development Department to determine the care provider's eligibility for Family Temporary Disability Insurance benefits

(13)

include a signature and date line for the care recipient

(14)

instruct authorized representatives, as defined in section 3302-1(a), to sign on behalf of the care recipient and indicate the source of authority to act for the care recipient.