

## Frequently Asked Questions - Ameren Long Term Disability Benefits

### **Q: What is Long Term Disability (LTD)?**

**A:** Ameren's Long Term Disability benefit provides wage replacement that is up to 60% percent of your base wage earnings in effect on your last day worked, before an injury or an illness has affected your ability to do the Essential Functions of your job and you have become Totally Disabled.

### **Q: Does Ameren have a Short Term Disability benefit?**

**A:** At this time, Ameren does not offer a Short Term Disability benefit. Eligible coworkers will use their sick time or vacation time, if allowed, to provide themselves an income while out on a Leave of Absence.

### **Q: When do I apply for Long Term Disability?**

**A:** Generally, you will apply for Long Term Disability after you have been out on sick leave after 90 days. If you are a MO Union, in which you have to exhaust all of your sick leave, you will want to apply no later than 90 days prior to the exhaustion date.

### **Q: How do I apply for Long Term Disability?**

**A:** In order to start the Long Term Disability process, a complete application must be received in its entirety by the Plan. You can request an application or one can be downloaded via [myameren.com](http://myameren.com).

The application must include:

1. Application form for Long Term Disability Benefits.
2. Copies of medical records from the last 3 years relating to your disability including:
  - a. A brief diagnosis, treatment and prognosis
  - b. Copies of diagnostic test results
  - c. Copies of x-ray results
  - d. Any other medical information that may be relevant in this case
3. HIPAA Authorization form (Medical Release).
4. Copy of your Acknowledgment of Application from the SSA. If you have already received a decision from the SSA regarding your entitlement to Social Security Disability benefits, please submit a copy of your Notice of Decision in lieu of submitting copies of medical records.

### **Q: Where do I send my completed application?**

**A:** A completed application can be mailed to/fax:  
Ameren Services  
Employee Benefits - Mail Code 533  
PO Box 66149  
Saint Louis, MO 63166-9989  
Confidential Fax Number: 314.612.2892

### **Q: What happens after I submit a complete application?**

**A:** Once a complete application has been received, the Plan will contact you to set an appointment with a doctor, who will perform an Independent Medical Evaluation. The Plan will take all information provided under advisement and will approve or deny your claim for disability. Please note that the Plan has 30 days from receipt of the complete application, to make a determination, but this could be extended by two additional 30-day extensions due to extenuating circumstances. The Plan will notify

you in writing if additional time is needed. Ameren understands that coworkers may be out of pay or closely approaching, so we do try to efficiently manage your case in a timely manner.

**Q: When will I receive my first benefits payment?**

**A:** If your LTD claim is approved and depending on if you are an Illinois, Missouri represented coworker or a Management worker, Ameren's LTD plans include an Elimination Period that lasts from 180 days/6 months (MO Unions must exhaust all sick leave) from Last Day Worked, before you are eligible to begin receiving LTD benefits. LTD benefits are paid on a monthly basis. If your approval occurs after your LTD effective date, you may receive a retro payment included in the first month's benefit payment.

**Q: How do I pay for my Health and Welfare benefits?**

**A:** Premiums for your benefits will be deducted from your monthly LTD benefit payment. If you have missed deductions, due to being in an unpaid Leave of Absence, missed deductions will be caught up through a future LTD Payroll(s), bringing you current. This process will prevent your benefits from being terminated. In the interim, you may receive a Direct Bill from the Benefits Center, requesting that you make payment directly to them.

**Q: If I receive a Social Security Disability Award, what should I do?**

**A:** If at any time you receive a Social Security benefit, you must notify the Plan and provide a complete copy of the award letter. Your LTD policy provides for what is known as an "offset" for any benefit you receive from SSDI and will reduce the benefit paid by the LTD policy. If you are approved for SSDI and receive a retroactive payment check, you are required to pay the amount back received by the LTD Plan during the time, which SSDA pays you.

**Q: How long can I stay on Long Term Disability?**

**A:** There are typically two periods of Total Disability: "Own Occupation" and "Any Occupation". During the *Own Occupation* period, benefits are payable if the employee is unable to perform his or her regular job or a similar job. This period can last up to 2-3 years, depending on your Union or if you are a Management coworker. After that, benefits are payable only if the employee is unable to perform *Any Occupation*, meaning you cannot perform any type of work, whether for Ameren or outside of the company. You may stay on the Plan until the maximum benefit period, described in the appropriate SPD.

**Q: After being on Long Term Disability, what do I do if I want to Return-to-Work?**

**A:** If you are interested in returning to work at Ameren, please contact your HR Client Consultant/ and or business unit. Additionally, please notify the Long Term Disability Plan of your intent. Once in receipt of sufficient documentation from your treating physician(s), your eligibility for LTD benefits will end and can return no sooner than the first of the month following your return-to-work date provided.

*If you have any questions about the LTD process or status about your case, please contact the Plan at 877.769.2637, Option #5, Monday through Friday, 9:00 a.m. to 3:00 p.m. For additional details about the Long Term Disability Plan, please login to your [myAmeren.com](http://myAmeren.com) account>Healthcare Elections>Helpful Benefits Information to access your LTD Summary Plan Description.*

RE: Application for Long Term Disability Benefits

Dear Co-Worker.:

Enclosed is an Application for the Long Term Disability ("LTD") benefits potentially available to you under your Ameren LTD Plan (the "Plan"). Please review this letter and return your completed application to begin the LTD process.

The Plan may provide monetary benefits to you if it is determined that you are eligible for the benefits described in the Plan. The Plan may combine with Workers' Compensation benefits, Social Security benefits, and other sources of monetary benefits to replace up to 60% of your normal monthly earnings. The enclosed Summary Plan Description ("SPD") more fully summarizes the benefits provided by the Plan. Please review the SPD carefully before completing your Application.

Because the Plan must take into consideration the amount of your Social Security Disability benefits (if any) when determining your LTD benefits provided by the Plan, you must also apply for Social Security Disability benefits from the Social Security Administration ("SSA"). You can contact the SSA at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at 1.800.772.1213. The SSA will provide you with an Acknowledgement of Application ("Acknowledgement") once it receives your completed application. You are required to send us a copy of the Acknowledgement with your LTD Application.

### **Summary of Claims and Appeals Procedure for the LTD Plan**

As a participant in the Plan, you are entitled to certain rights and protections as stated in the regulations issued by the Department of Labor, which are effective for all Employee Retirement Income Security Act of 1974 (ERISA) governed disability claims as follows:

- The Plan will generally make a determination of your application for disability benefits within 45 days of receipt of your Application and all required supporting documentation. The Plan is permitted two 30-day extensions to obtain more information or due to matters beyond the control of the Plan.

**To apply for Long Term Disability Benefits, please submit the following in its entirety:**

1. Application for Long Term Disability Benefits.
2. Copies of medical records from the last 3 years relating to your disability including:
  - A brief diagnosis, treatment and prognosis
  - Copies of diagnostic test results
  - Copies of x-ray results
  - Any other medical information that may be relevant in this case
3. HIPAA Authorization form (Medical Release).
4. A copy of your Acknowledgment of Application from the SSA. If you have already received a decision from the SSA regarding your entitlement to Social Security Disability benefits, please submit a copy of your Notice of Decision in lieu of submitting copies of medical records.

**Please mail your completed application and supporting documentation to:**

Ameren Services  
Employee Benefits – Mail Code 533  
PO Box 66149  
Saint Louis, MO 63166-9989

If you have any questions about the LTD Application process, please call Employee Benefits at 877.7myAmeren (877.769.2637), option #5.

Employee Benefits

Enclosures



# APPLICATION FOR LONG TERM DISABILITY

Employee's Statement

## GENERAL INFORMATION

Please print clearly.

Name of Employee (first, middle initial, last) \_\_\_\_\_

Employee ID \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Personal Email Address \_\_\_\_\_

Spouse's name \_\_\_\_\_

Return to:

Ameren Services

P.O. Box 66149, MC533

St. Louis, MO 63166-6149

## INFORMATION ABOUT CONDITION CAUSING YOUR DISABILITY

Please give details about why you are applying for LTD.

Illness/Injury \_\_\_\_\_ Date First Noticed: \_\_\_\_\_

Is condition work related? Yes  No

Describe in detail how, when and where the accident occurred or describe the nature of your illness/condition and its first symptoms: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## TREATING PHYSICIAN(S) FOR YOUR DISABILITY

If you need more space, check here  and attach a separate page.

Name of physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of next visit \_\_\_\_\_

Name of physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of next visit \_\_\_\_\_

Name of physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of next visit \_\_\_\_\_

## OTHER INCOME SOURCES

*Check all that apply and provide award/email notice or application associate with any source of income.*

X	Source of Income	Amount of Each Payment	Weekly or Monthly
	Social Security		
	Worker Compensation		
	Retirement/Pension		
	Other Employment		
	Unemployment		
	Other:		

## SIGNATURE

This form and related attachments constitute my application for disability benefits under the Ameren Long Term Disability Plan. I understand that my cooperation in obtaining and providing information is necessary in order for the Plan Administrator to determine my initial and ongoing eligibility for benefits as provided in the plan document. I agree to participate and cooperate fully in this process. In addition, I authorize my email address for communication regarding my application and any future notices from Ameren.

I further understand that if I am entitled to a benefit from the Long Term Disability Plan, the beginning of or future adjustments in my Workers' Compensation payments (if applicable) or Social Security Disability payments (if applicable), may affect the benefits to which I am entitled. If such payments or adjustments to payments result in an overpayment of benefits to me from the Long Term Disability Plan, I agree to repay to the Plan the full amount of any overpayments. If I fail to repay the overpayment to the Long Term Disability Plan, I understand all of my future Long Term Disability benefits will cease until the overpayment is recovered.

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Employee Signature (or Signature of Employee's Legal Representative)

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Date

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF  
HEALTH RELATED INFORMATION

I HEREBY AUTHORIZE any physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information (collectively Medical Information) concerning me, except as described below, to the administrator of the Ameren Long Term Disability Plan (the "Plan") for the purpose of determining eligibility for Long Term Disability ("LTD") benefits under the Plan.

I understand that such Medical Information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my Medical Information do not apply to this Authorization, and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose all of my Medical Information without restriction consistent with this Authorization. I understand that my healthcare provider may not condition my treatment on whether I sign this Authorization.

I understand the Plan will use the Medical Information it obtains pursuant to this Authorization to make a determination as to whether I am eligible to receive an LTD benefit provided by the Plan. As a result, I understand that if I do not sign this Authorization or otherwise authorize my healthcare provider to provide the Plan my Medical Information, then my application for LTD benefits may be denied.

I understand the Plan will not disclose the Medical Information it obtains about me except as defined by this Authorization, as may be required or permitted by law, or as I may further authorize. I understand that if the Medical Information is re-disclosed as permitted by this Authorization, then it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it or the duration of my claim for benefits, whichever period is shorter; (b) I may revoke this authorization at any time by writing to the Plan at P.O. Box 66149 MC533, St. Louis, MO 63166 or by informing my healthcare provider or health plan, except to the extent that action has been taken in reliance on it; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Employee/Representative

\_\_\_\_\_  
Date

***Note: If you are signing as the employee's representative, you must attach a copy of the legal document(s) authorizing you to act on behalf of the employee.***

**AUTHORIZATION FOR RELEASE AND DISCLOSURE OF  
PSYCHOTHERAPY RELATED INFORMATION**

I HEREBY AUTHORIZE any: physician, healthcare provider, health plan, medical professional, hospital, clinic, or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to disclose any psychotherapy notes relating to me to the administrator of the Ameren Long Term Disability Plan (the "Plan") for the purpose of determining eligibility for Long Term Disability ("LTD") benefits under the Plan.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose all of my psychotherapy notes relating to me without restriction consistent with this Authorization. I understand that my healthcare provider may not condition my treatment on whether I sign this Authorization.

I understand the Plan will use the Medical Information it obtains pursuant to this Authorization to make a determination as to whether I am eligible to receive an LTD benefit provided by the Plan. As a result, I understand that if I do not sign this Authorization or otherwise authorize my healthcare provider to provide the Plan my Medical Information, then my application for LTD benefits may be denied.

I understand the Plan will not disclose the Medical Information it obtains about me except as defined by this Authorization, as may be required or permitted by law, or as I may further authorize. I understand that if the Medical Information is re-disclosed as permitted by this Authorization, then it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it or the duration of my claim for benefits, whichever period is shorter; (b) I may revoke this authorization at any time by writing to the Plan at P.O. Box 66149 MC533, St. Louis, MO 63166 or by informing my healthcare provider or health plan, except to the extent that action has been taken in reliance on it; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Employee/Representative

\_\_\_\_\_  
Date

***Note: If you are signing as the employee's representative, you must attach a copy of the legal document(s) authorizing you to act on behalf of the employee.***