Short-Term Disability Plan
FOLLOW-UP FORM
FOR EMPLOYEE TO COMPLETE

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>Date of Birth:</th>
<th>“C” Number:</th>
</tr>
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<tbody>
<tr>
<td>Home Address:</td>
<td>City:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Department:</td>
<td>Work Phone:</td>
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NOTICE TO EMPLOYEE

- All claim forms MUST be submitted directly to HR-Benefits, not Human Resources. If HR-Benefits does not receive your claim form, your STD payment will not be processed.
- Follow-up claim forms MUST be submitted to HR-Benefits every four (4) weeks during disability and MUST be completed by your physician.

Employee Signature: ___________________________ Date: ___________________________

ATTENDING PHYSICIAN’S STATEMENT

<table>
<thead>
<tr>
<th>PROGRESS</th>
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<tbody>
<tr>
<td>(a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has:</td>
<td>Recovered</td>
<td>Improved</td>
<td>Stabilized</td>
<td>Retrogressed</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is:</td>
<td>Ambulatory</td>
<td>House confined</td>
<td>Bed confined</td>
<td>Hospital confined</td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td></td>
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| If hospital confined, name and address of hospital: ___________________________
| (d)      |   |   |   |   |   |
| Confined from ____________________ through ____________________

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<tr>
<th>PROGNOSIS</th>
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</table>
| What is the patient’s prognosis? ___________________________
| (b)       |   |   |   |   |   |
| When do you feel the patient’s maximum medical improvement will be reached? | 1 Month | 1 - 3 Months | 3 -6 Months |
| (c)       |   |   |   |   |   |
| Estimated date patient will return to work: Month _____ Day _____ 20_____

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<tr>
<th>REMARKS</th>
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</table>
| Print attending physician’s name: ___________________________
| Specialty: ___________________________ Phone: ___________________________
| Address: ___________________________
| Signature: ___________________________ Date: ___________________________

Submit completed form to HR-Benefits:
(Interoffice)  (Fax)  (Email)
HR-Benefits  305-284-4568  benefitsmessages@miami.edu
100 Gables One Tower
LC: 2902
Coral Gables Campus