Concordia-Health
Official Legal Address
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REQUEST FOR AUTHORIZATION TO EXERCISE OR CONTINUE AN ACTIVITY DURING A PERIOD OF DISABILITY WHILE MAINTAINING RECOGNITION OF WORK INCAPACITY

Important – Please read this information before completing the form.

What is the purpose of this form?

You must complete this form if you wish to:

- return to part of the work you performed before your disability began;
- resume a different work activity as an employee;
- start or resume a self-employed activity compatible with your medical condition;
- engage in any paid or unpaid activity compatible with your medical condition;
- renew your current authorization to work part-time during disability.

Where should you submit this form?

This form includes two sections (an administrative section and a medical section).

Please complete both sections and submit the form to the **Concordia Health Medical Advisor** through your designated submission channel.

When should you submit this form?

You must submit this form no later than the first business day before your partial return to work.

For renewal of an existing authorization, the form must be received before the authorization expires.

Important

A late submission of a request to resume or renew part-time work may result in a **10% reduction of disability benefits** or **denial of benefits**, in accordance with the rules governing the coordination of disability benefits with income from authorized work activity.

Please note

This form serves as a request for authorization (or renewal of authorization) to engage in or continue an activity during a period of disability.

Before starting any part-time activity, you are strongly encouraged to obtain written approval from the **Concordia Health Medical Advisor**, even if the activity was previously authorized.

Exception

If you continue an activity that began before your disability and that remains compatible with your medical condition, you may continue it under your existing agreement. However, you must notify **Concordia Health** within one month of the start of your disability period.

Documents to attach

If your employment agreement has been modified or replaced, please attach a copy of the updated agreement.

If the updated version is not yet available, please submit it as soon as possible.

If applicable, you are encouraged to provide any supporting documentation from occupational health or workplace medical services.

If you encounter any difficulties completing this form, please contact **Concordia Health Member Services**.

Section 1: Declaration and Request for Part-Time Work During Disability

I, the undersigned,

First Name: _____

Last Name: _____

Member ID Number: *(or attach identification label if applicable)*

Mobile or Phone Number: _____

Email Address: _____

☐ I declare that I have resumed, or will resume, the following activity effective ____ /____ /_____:

☐ I declare my intention to renew my current authorization effective ____ /____ /_____ for the following activity:

Based on the request above, I hereby request approval from the **Concordia Health Medical Advisor** to perform this activity or to renew my current authorization.

In both cases, **Section 2 must be completed in full.**

I certify under penalty of program rules that all information provided in this form is true, complete, and accurate. I understand that any false, misleading, or incomplete information may result in denial, suspension, or adjustment of program benefits.

Important

During the first year of disability, you must continue to submit updated medical documentation within **7 calendar days** of any extension of your disability period, even if you are authorized to perform part-time work by the **Concordia Health Medical Advisor**.

Date: ____ /____ /_____

Signature: _____

Section 2: Request for Authorization or Renewal of Part-Time Work During Disability (with Continued Eligibility Recognition)

I, the undersigned,

First Name: _____
Last Name: _____

hereby request authorization or renewal from the **Concordia Health Medical Advisor** to begin or continue the following activity effective ____ /____ /_____:

Activity description:

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1. Please indicate the type of work activity.

☐ **Employee**

- ☐ With the same employer
- ☐ With a different employer

☐ **Self-employed**

- ☐ Existing self-employed activity prior to disability
- ☐ New self-employed activity

☐ **Independent contractor**

☐ **Childcare provider (licensed or recognized service provider)**

☐ **Volunteer**

☐ **Other activity**

- ☐ Paid activity
- ☐ Unpaid activity

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2. Activity continuity status

☐ This activity is a continuation of a contract or work arrangement that existed before my disability began.

☐ This is a new activity that did not exist prior to my disability.

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3. Work details

Please describe the tasks and responsibilities you will perform as clearly and specifically as possible:

4. Work Schedule Details

☐ I work a variable schedule (no fixed working hours).

Number of hours per week under the approved medical part-time arrangement:

☐ I work a fixed schedule. My weekly work schedule is provided below.

If your schedule is the same each week, please complete **Week 1 only**.

Number of hours per week under the approved medical part-time arrangement:

Full-time equivalent information

What is the total number of hours considered full-time within your organization?

(Your employer can provide this information if needed.)

Weekly Schedule

Day	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Week 1	From: ____ To: ____ |	From: ____ To: ____	From: ____ To: ____ |	From: ____ To: ____	From: ____ To: ____ |	From: ____ To: ____	From: ____ To: ____
	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____
Week 2	From: ____ To: ____ |	From: ____ To: ____	From: ____ To: ____ |	From: ____ To: ____	From: ____ To: ____ |	From: ____ To: ____	From: ____ To: ____

	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____
Week 3	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____
	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____
Week 4	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____
	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____	From: ____ To: ____

Additional Information

Please provide any additional details regarding your work schedule:

5: Employer and Supporting Information

Employer or Organization Information

(complete only if you are not self-employed)

Employer / Organization Name:

Address:

Phone Number:

Employer Identification Number (EIN)

Important:
If an Employer Identification Number (EIN) is not provided when applicable, this request may not be processed.

Additional Information (if available)

Primary Care Provider

Name: _____
Address: _____

Phone Number: _____

Occupational Health Provider (if applicable)

Name: _____
Address: _____

Phone Number: _____

Declaration

I certify that the information provided in this application is true, complete, and accurate.

Date: ____ /____ /_____

Signature: _____

Data Protection Notice

Concordia Health processes your personal data in accordance with applicable data protection and privacy laws.

You have the right to:

- access your personal data
- request correction or completion of your data
- object to certain types of data processing
- request restriction of processing
- request deletion of your data, where applicable

For additional information about how your data is processed, please refer to our **Data Protection Policy**, available at the following address:

https://www.concordia-health.org/terms-of-use