# COVID-19 Work Arrangement Request

3-20

verizon

**PART 1**

**Employee action needed, if Work Arrangement Request is for your own underlying medical condition**

**Sign this Medical Authorization and attach to the Workplace Arrangement Request form on COVID-19 Resource Page. You can also include any related medical records.**

**Additionally, in order to medically substantiate the request, you may be required to submit medical documents related to your request.**

Verizon Workplace Accommodations Team
One Verizon Way
Basking Ridge, NJ 07920

## Authorization to Disclose Information About Me

**For purposes of administering my request for a work arrangement, I permit and authorize:** any physician, other medical/treating practitioner, hospital, clinic or other medical-related facility/service (and any medical consultants or examiners that may be retained in connection with my request for workplace arrangements) to disclose to the Verizon Workplace Accommodations Team ("WPAT"), in its capacity as evaluator of my request for workplace arrangements, any and all information concerning my Workplace Arrangement request and medical care that is related to this request.

I understand that Sedgwick Claims Management Services ("Sedgwick") and Anthem Inc. ("Anthem Inc.") perform advisory services to WPAT to enable WPAT to determine if my request for workplace arrangement is medically substantiated. For purposes of clarity, Anthem is providing services only to WPAT and is not acting on behalf of the Verizon health plans. As such, the Anthem representatives will not have access to any of my medical information under the Verizon health plans in connection with the provision of their services to the WPAT, and Anthem in its capacity as the administrator of the Verizon health plans shall not disclose or otherwise share in any manner any of my medical information Anthem holds on behalf of the Verizon health plan with the Anthem representatives providing advisory services to the WPAT. **For purposes of performing such advisory services,** I authorize any physician, other medical/treating practitioner, hospital, clinic or other medical-related facility/service (and any medical consultants or examiners that may be retained in connection with my request for workplace arrangements) to disclose to Sedgwick or Anthem (solely in its capacity as advisor to WPAT), upon request, any and all information concerning my Workplace Arrangement request and medical care that is related to this request.

WPAT and/or Sedgwick and Anthem (solely in its capacity as advisor to WPAT), in their respective capacities and for the purposes set forth above, are authorized to use any information relevant to my request for workplace arrangements that may be contained in any file maintained by Sedgwick or Anthem (solely in its capacity as advisor to WPAT) related to a claim made by me for Worker's Compensation benefits or for any group disability income benefits under a Verizon plan.

This form specifically grants my permission to disclose medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological conditions; and alcohol or drug abuse (including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws) with the specific exception of psychotherapy notes.

**Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses might be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to re-disclosure by the recipient and may no longer be covered by those rules.**

*I understand that I may revoke this authorization at any time by writing to both the Verizon Workplace Accommodations Team, One Verizon Way, Basking Ridge, NJ 07920 and Sedgwick, P.O. Box 14192, Lexington, KY, 40512-4192 (Fax: 1-859-264-4384), except to the extent that action has been taken in reliance on it by either party before such party's receipt of my revocation. If I do not, this authorization will be valid for 18 months from the date I sign this form or the duration of my request for workplace arrangements, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.*

_____ _____

**Printed Name of Employee** **Employee ID or Enterprise:**

_____ _____

**Signature of Employee:** **Date:**

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitles covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and the genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member received assistive reproductive services.*