EXXONMOBIL INDIVIDUAL DISABILITY REPORT (IDR) FORM AND INSTRUCTIONS TO HEALTH CARE PROVIDER

Employees are encouraged to seek medical attention from their Health Care Provider whenever they have an injury or illness that results in a disability absence. The IDR Form is used to provide information to the company to support and assist employees in returning to work or ensuring they receive the appropriate disability benefits.

INSTRUCTIONS:

1. The IDR form may be used to obtain certification from a recognized Health Care Provider regarding (1) an employee's eligibility for extended Short-Term Disability benefits, and (2) an employee's mental or physical ability to safely perform his/her job following a period of disability.

   - The form may be required if an employee has been or will be admitted to a hospital, had a day surgery procedure or overnight stay for observation, or if the employee has been evaluated in an emergency room, has been absent due to illness or injury greater than days defined per local protocols and/or been given limitations by their healthcare provider.

   - It may be necessary for an IDR form to be completed more than once for the same period of disability. If the employee's disability is prolonged, he/she may be required to submit updated IDR forms, or equivalent medical documentation, upon request from Medicine and Occupational Health (MOH).

   - The information on the IDR form may be required in order to be eligible for disability benefits and for release to return to work following the disability.

   - Contact your local HR or MOH for applicable guideline or practice for your work site or situation.

2. Included with the IDR form are Instructions to the Health Care Provider, which should be given by the employee to his/her Health Care Provider along with the IDR form.

3. When using the IDR form, the first page (Instructions to Health Care Provider) will need to be individualized by inserting the date, employee's name, and contact information. In addition, the employee will need to complete the top section (section 1) of the IDR form which authorizes the release of their medical information and remember to sign the form.

   - If you have any questions about the process, contact your local MOH or local HR.

   - If there is a charge for completing the form, it is the employee's responsibility to pay the charge; it is not reimbursed by the company, the health plan or the disability plan.

4. Note: If there is a problem or delay in getting the form completed in an individual employee's disability or return to work situation, the employee should immediately call their local MOH contact to discuss other ways for MOH to obtain the required information.

INSTRUCTIONS ON HEALTH CARE PROVIDER FORM – Certain information is **required** to be completed before distribution to the health care provider. Please complete the required fields that are in **bold**.

INSTRUCTIONS ON IDR FORM – Certain information is required to be completed before distribution of this form to the health care provider. The top section of the form must be completed and the release of information should be signed before giving the form to the Health Care Provider. The Health Care Provider may also require that the employee complete a HIPAA release in the provider's office.

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Instructions to Health Care Provider

Please complete the enclosed Individual Disability Report for the following employee:

Employee Name:	**Phone Number:**
Address:	**Email Address:**
City, State, Zip:	

Return the completed form to our medical clinician contact as noted in the top right corner of the IDR form or give it to the employee. The information you provide will be used to determine eligibility for company provided disability benefits and to determine the person's physical and mental ability to safely perform his or her job. If there is a charge for completing the form, it is the employee's responsibility to pay the charge; it is not reimbursed by the company, the health plan or the disability plan.

ExxonMobil frequently has alternative work available so please do not simply indicate that the employee is unable to work if there are reasonable restrictions available outside of total bed rest and/or hospitalization. If you provide physical or mental limitations, ExxonMobil will assess availability of work within the constraints of the information you have provided. If limitations are recommended, please provide the expected duration. When possible, avoid recommending solutions (i.e., "only office work," "no field work," "only work from home" or "no overtime") but provide a specific description of physical or mental limitations that may require accommodation. For example: If an employee is "unable to work in a noise-filled environment," state that, rather than "employee must work from home." Job duties both in and out of the office environment may vary in physical/mental requirements.

When returning this form, please **do not include genetic information** since the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 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 member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and 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 receiving assistive reproductive services. If you submit medical records with your response, please provide page numbers where genetic information was removed so ExxonMobil does not assume records provided are incomplete.

Please complete and return this form to your Local ExxonMobil Medicine & Occupational Health as soon as possible (and within 15 calendar days from the date of receipt).

EMPLOYEE INDIVIDUAL DISABILITY REPORT

Send Completed Form to: ExxonMobil Medical & Occupational Health.
Call your local MOH contact for instructions on how to return the form

SECTION 1: TO BE COMPLETED BY EMPLOYEE	PRIVATE
NAME (PLEASE PRINT - FIRST, MIDDLE, LAST)	SOCIAL SECURITY NUMBER / PERSONNEL NUMBER
ADDRESS (STREET NAME, CITY, STATE, ZIP)	SUPERVISOR NAME / PHONE NUMBER

EMPLOYEE RELEASE OF INFORMATION

My signature authorizes my medical provider to release any and all medical information related to my current medical condition for a period of one year to the ExxonMobil Disability Plan and to ExxonMobil Medicine and Occupational Health (MOH) to be used in evaluating my ability to work, including work limitations where appropriate. I understand that any work limitations established will be communicated to my management for them to be able to determine whether or not I can return to work with those limitations with or without accommodations. I also authorize the use of this information to determine my eligibility for benefits under the ExxonMobil Disability Plan. I understand that I can prospectively revoke this release by providing written notice to MOH.

EMPLOYEE'S SIGNATURE	**E-MAIL ADDRESS:** **DATE:**	**WORK PHONE:** **HOME/CELL PHONE:**

SECTION 2: TO BE COMPLETED BY MEDICAL PROVIDER

CURRENT DATE OF VISIT:	**DATE OF EMPLOYEE'S NEXT APPOINTMENT**:	**IF PREGNANCY-RELATED, DATE OF EXPECTED CONFINEMENT / DELIVERY (SELECT ONE):**

HISTORY OF ILLNESS / INJURY:

DIAGNOSIS:	**PROSTHETIC / IMPLANT (LIST):**

HOSPITALIZED? YES / NO	**DISCHARGE DATE:**	**SURGERY DATE:**

TREATMENT PLAN:

PROVIDER'S SIGNATURE:	**DATE:**	**OFFICE PHONE: ( )** **OFFICE FAX: ( )**

PRINT PROVIDER'S NAME AND ADDRESS:

THE EMPLOYEE MAY RETURN TO WORK (SELECT ONE):

- ☐ WITHOUT LIMITS TO FULL DUTY ON______________________________(INSERT DATE OF RETURN TO WORK).
- ☐ WITH RECOMMENDED LIMITS LISTED BELOW BEGINNING ON_____________________AND ENDING ON_____________________.
- ☐ WITH RECOMMENDED LIMITS LISTED BELOW BEGINNING ON_____________________WHICH ARE EXPECTED TO LAST AT LEAST SIX MONTHS FROM TODAY.

THE EMPLOYEE IS NOT MEDICALLY FIT TO RETURN TO WORK WITH OR WITHOUT RECOMMENDED LIMITS (SELECT ONE):

- ☐ THIS STATUS WILL BE RE-EVALUATED AT THE NEXT SCHEDULED APPOINTMENT (DATE SHOWN ABOVE).
- ☐ THIS STATUS IS EXPECTED TO CONTINUE AND TO LAST AT LEAST SIX MONTHS FROM TODAY.

CHECK ALL WORK ACTIVITIES THAT ARE RECOMMENDED TO BE LIMITED:

- ☐ CLIMB STRUCTURES / LADDERS
- ☐ CLIMB STAIRS
- ☐ WORK ALONE
- ☐ WORK ABOVE GROUND LEVEL WITH FALL PROTECTION
- ☐ WORK AROUND MOVING MACHINERY
- ☐ OVERHEAD WORK
- ☐ KNEEL / CRAWL
- ☐ BEND / STOOP / SQUAT
- ☐ LIFT / PUSH / PULL / CARRY OVER_______POUNDS
- ☐ EXPOSURE TO TEMPERATURE EXTREMES
- ☐ SHIFT WORK
- ☐ OVERTIME
- ☐ DRIVE AUTOMOBILE / TRUCK / HEAVY EQUIPMENT
- ☐ PROLONGED WALKING / STANDING
  SPECIFY MAXIMUM AMOUNT OF TIME AND / OR DISTANCE _________________
- ☐ LIMITED WORK HOURS (SPECIFY):______HOURS PER DAY /______DAYS PER WEEK
- ☐ OTHER / COMMENTS (AVOID SOLUTIONS SUCH AS "ONLY OFFICE WORK", "WORK FROM HOME", "NO FIELD WORK" OR "NO OVERTIME")
  ____
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NOTE: **Do not** include genetic information in accordance with the Genetic Information Nondiscrimination Act of 2008 (GINA).