# ACKNOWLEDGEMENTS

# Claimant Responsibilities

**Disability premiums are paid 100% by the employee on a post-tax basis.** Employee must continue to pay disability premiums while on Short-Term Disability. If the employee should utilize the Disability benefit, payments received will not be subject to taxes as the employee pays the Disability premiums with after-tax dollars. The SoNM will issue a W-2 for the calendar year in which the disability benefit was utilized.

I, _____, acknowledge that in order to receive disability benefits I must adhere to the following (please initial **each item**):

_____ I understand it is my responsibility to ensure that my mailing address is up to date with my employer and Benefits Plan Administrator.

_____ I understand that I must file my disability claim within forty-five (45) days from the last date of work.

_____ I understand that it is not mandatory, although highly encouraged, to complete and submit Family Medical Leave paperwork at the same time I submit my disability paperwork.

_____ I understand while on Short-Term Disability I must provide the Benefits Plan Administrator with a Physician Update Form, and any other information as requested on the Disability Approval Letter; usual reporting time is every four to six (4-6) weeks or as necessary based on condition.

_____ I understand that while on Long-Term Disability I must provide a Physician Update Form, and any other information as requested by the plan on the Short-Term to Long-Term Disability Transition Letter. Reporting time is every four to six (4-6) or as necessary based on condition.

_____ I understand I must inform the Disability Program Administrator when receiving any **DEDUCTIBLE SOURCES OF INCOME** (See *Glossary* for definition)

_____ I understand I must ensure I am not receiving more than 100% of my gross salary while receiving disability benefit payments.

_____ I understand I must inform the Disability Program Administrator immediately of the return to work date.

_____ I understand that a change in medical condition will require a new claim and will be subject to approval or denial based on the policy guidelines and a new **ELIMINATION PERIOD** will be required.

_____ I understand I must immediately inform the plan when there is a separation of employment.

_____ I understand I must appeal any denials or termination of benefits by the Plan within 30 days. No late requests will be granted.

_____ I understand if separation of employment occurs, I must continue to make bi-weekly premium payments directly to the Benefits Plan Administrator. Failure to do so can result in a loss of access to the disability benefits.

_____ I understand I must apply for Social Security Disability Income (SSDI) and Retirement Disability no later than forty-five (45) days from the date my Short-Term Disability coverts to Long-Term Disability.

____ I understand I must appeal any denials from SSDI within two (2) weeks of receiving the denial. I must also supply proof of all appeals to the Benefits Plan Administrator.

____ I understand it is my responsibility to pay back to the State any over-payments received (e.g. from the first retro-payment received from SSDI benefit monies, or monies received from my employer due to returning to work, etc.)

____ **I understand that I must work closely with my HR/SPO Representative/Supervisor during this process. It is suggested that claimants utilize a personal email address for all Disability communications.**

During my absence, I would like (please choose one):

____ the HR Representative/Supervisor to enter enough time to cover my benefit premium payments on my behalf.

____ to have no time entered on my behalf.

I, THE UNDERSIGNED, CERTIFY THAT I FULLY UNDERSTAND AND AGREE TO COMPLY WITH ALL NECESSARY REQUIREMENTS IN ORDER TO PARTICIPATE IN THE DISABILITY PROGRAM.

Name (Print): _____

Signature: _____

Date: _____ Phone: _____

Agency Name: _____

Agency Rep: _____

Agency Rep Phone #: _____

# Agency Representative Responsibilities

It is of the utmost importance that the Agency Representative complies with the following in order to ensure the timeliness of approval and accuracy of benefit payments to the Claimant requesting Disability (please initial each item):

____ Upon request, supply employee with the Family Medical Leave (FML) paperwork and the Disability Policy/Claim Packet.

____ Work closely with the employee and supervisor to ensure the FML and Disability paperwork is completed accurately.

____ Fax completed Disability forms and copies of employee's SHARE pay advice reflecting the required twelve (12) consecutive months of disability premium payments to the Disability Program Administrator.

____ Contact the Disability Program Administrator within the next two (2) weeks to request a status on an employee's pending approval or denial of Disability benefits.

____ Discuss with employee the options of how leave will be entered onto their timesheet each pay period. NOTE: It is the responsibility of the HR Representative and/or Supervisor to ensure the employee does not receive more than 100% of their gross salary (disability benefits plus hourly wages) while the employee is receiving disability benefits.

____ An individual cannot receive more than 100% of their gross salary with sick, annual, leave, and disability benefit payments combined while receiving disability benefits. When reporting sick leave or personal leave while out of work, a maximum of 40% of gross salary may be submitted through the employer during the time the employee is participating in Disability.

____ Ensure the employee understands that approval for Disability is considered a Change in Job Status, which is considered a Qualifying Event (QE); therefore, the employee has the opportunity to make changes to his/her current benefit elections. NOTE: If the employee chooses to change benefit elections when on Disability, returning to work is also considered a Change in Job Status and is considered a QE. The employee has the option to change benefit elections at this time. The request to change benefit elections must be done within 31 days of the QE.

____ Confirm the employee returns to work on the expected day. If the employee does not report as expected, contact the Disability Program Administrator.

____ Ensure SHARE (Job Data and/or Time and Labor) is updated accordingly.

I HEREBY AGREE TO COMPLY WITH THE REQUIREMENTS STATED ABOVE.

Name (Print): _____

Signature: _____

Title: _____ Agency: _____

Date: _____ Phone: _____

# Supervisor Responsibilities

In order to ensure the timeliness of approval and accuracy of benefit payments to the Claimant requesting Disability, it is of the utmost importance that the Supervisor complies with the following (please initial each item):

____ Keep in contact with Agency HR/SPO representative to ensure that the proper Disability/FML paperwork was submitted.

____ Work with Agency HR/SPO representative to make sure hours required to pay for benefit premiums are entered correctly per pay period.

____ Coordinate with employee to ensure that they are ready to return to work at full capacity upon agreed return to work date.

____ Inform Agency HR/SPO representative when the employee has returned to work. Ensure the employee has notified the Benefits Plan Administrator of his/her return to work and confirm discontinuation of disability benefit payments.

____ Discuss with employee the options of how leave will be entered onto their timesheet each pay period. NOTE: It is the responsibility of the HR Representative and/or Supervisor to ensure the employee does not receive more than 100% of their gross salary (disability benefits plus hourly wages) while the employee is receiving disability benefits.

____ An individual cannot receive more than 100% of their gross salary with sick, annual leave, and disability benefit payments combined while receiving disability benefits. When reporting sick leave or personal leave while out of work, a maximum of 40% of gross salary may be submitted through the employer during the time the employee is participating in Disability.

I HEREBY AGREE TO COMPLY WITH THE REQUIREMENTS STATED ABOVE.

Name (Print): _____

Signature: _____

Title: _____ Agency: _____

Date: _____ Phone: _____

# DISABILITY CLAIM FORMS

## Disability Packet

1. Instruction Cover Form
2. Employer Sheet
3. Employee Sheet
4. Signature Page
5. Physician Form
6. Change of Address Notification

# Disability Claim Form

Email: sonm@easitpa.com
Phone: (855) 618-1800 (press 1)
Fax: (505) 705-3311

Erisa Administrative Services, Inc.
1200 San Pedro Dr. NE
Albuquerque, NM 87110-6726

## Instructions for Filing a Claim

### SUBMITTING AN APPLICATION

All sections of this application must be completed and sent to Erisa Administrative Services, Inc. If the claim form is not completed in full, processing of benefits will be delayed until all required information has been received. However, if any questions are not applicable to your situation, please write "N/A" (Not Applicable) in those spaces.

Employer Submission Checklist:

- ☐ Completed Employer Sheet
- ☐ Copy of Disability Premium Payments
- ☐ Copy of Wages Paid
- ☐ Copy of Leave Balances
  - Calculated to after 28-day Elimination Period per question 25 on Employer Sheet
- ☐ Attachment pages as needed

Employee Submission Checklist:

- ☐ Completed Employee Sheet
- ☐ Signed Signature Page
- ☐ Completed Physician Form
- ☐ Attachment pages as needed

### RETURNING TO WORK

Please inform Erisa Administrative Services, Inc. of any scheduled or actual return to work date as soon as possible by submitting the Return to Work Notice located at www.mybenefitsnm.com/Disability.htm by email to sonm@easitpa.com or by fax to (505) 705-3311.

If Erisa extends benefits beyond the return to work date, the amount overpaid must be returned to the State of New Mexico. Employer MUST forward copies of employee's pay stub showing annual leave, sick leave, or compensatory leave taken. Please make appropriate changes to employee's time sheets for employees who become eligible for payment AFTER the elimination period.

### FRAUD NOTICE

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim and/or application containing any false, incomplete, or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this claim form may also constitute a crime under federal laws. Erisa Administrative Services, Inc. and the State of New Mexico will pursue any appropriate legal remedies in the event of insurance fraud, including prosecution under federal mail fraud, federal wore fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

# Disability Claim Form

**EMPLOYER SHEET**

Email: sonm@easitpa.com
Phone: (855) 618-1800 (press 1)
Fax: (505) 705-3311

Erisa Administrative Services, Inc.
1200 San Pedro Dr. NE
Albuquerque, NM 87110-6726

**If claim form is not completed in full, processing of benefits will be delayed until all information has been received.**

| 1. Employee Name | 2. SSN | 3. ID | 4. DOB |
|---|---|---|---|
| | | | |

| 5. Address | 6. City | 7. State | 8. Zip |
|---|---|---|---|
| | | | |

| 9. Home Phone | 10. Cell Phone | 11. Email |
|---|---|---|
| | | |

| 12. Agency | 13. Occupation | 14. Hire Date | 15. Effective Date of Insurance | 16. Hourly Wage |
|---|---|---|---|---|
| | | | | |

| 17. HR Name | 18. HR Phone | 19. HR Email |
|---|---|---|
| | | |

| 20. Supervisor Name | 21. Supervisor Email |
|---|---|
| | |

22. Work Schedule
☐ Full Time ☐ Exempt Regularly scheduled
☐ Part Time ☐ Non-exempt hours per week_____
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

23. Last Date of Salary Increase

24. Expected Return to Work ☐ Full ☐ Part

| 25a. Last Day Worked | 25b. Hours worked that day | 25c. Date Paid Through For: ☐ Annual Leave ☐ Vacation Pay ☐ Accrued Sick Leave |
|---|---|---|
| | | |

26. Are you as the employer able to accommodate the employee's restrictions and limitations for an early return to work? (i.e. job modification, part time, etc.) Please elaborate. (Attach additional sheets as needed.)

27. Have you notified the employee of FMLA Eligibility? ☐ Yes ☐ No
Have you completed FMLA forms? ☐ Yes ☐ No (Please attach a copy with this form)

28. Sick Pay Calculation for Timesheet Entry:
Date Last Worked _____ + 28 day Elimination Period = _____
Date to start reducing employee's sick/annual/comp leave on timesheet if eligible for Disability
*An Employee can NOT receive more than 40% of their normal weekly wage in order to qualify for Disability*

29. Confirm that employee has paid 12 consecutive months of disability premiums and attach payroll deduction print screen(s).

I certify by signing this form that I will inform Erisa of any change to this form or the employee's work status. I certify that the information above is true and correct to the best of my knowledge. I will send Erisa any updated medical forms if I receive them.

Employer Signature: _____ Date: _____

*Do not write below this point - For official use only*

Initial Assessment: _____ PH and Master Approval: _____ Verification: _____
Date Received: _____ Additional Info Received: _____ Last Day +90: _____
Elimination Period End: _____ Paid Through: _____ Start Date: _____
Return to Work Date: _____ Disability Rate: _____ x 0.6 x _____ = _____
☐ Employer Page ☐ Employee Page ☐ Signature Page ☐ Physician Form ☐ Deductions
☐ STD ☐ LTD ☐ Maternity – Delivery Date _____ ☐ 2 weeks ☐ 4 weeks

# Disability Claim Form

**EMPLOYEE SHEET**

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Fax: (505) 705-3311

Erisa Administrative Services, Inc.
1200 San Pedro Dr. NE
Albuquerque, NM 87110-6726

## EMPLOYEE TO COMPLETE

**If claim form is not completed in full, processing of benefits will be delayed until all information has been received.**

| 1. Employee Name | 2. SSN | 3. ID | 4. DOB |
|---|---|---|---|
| | | | |

| 5. Address | 6. City | 7. State | 8. Zip |
|---|---|---|---|
| | | | |

| 9. Home Phone | 10. Cell Phone | 11. Email |
|---|---|---|
| | | |

| 12. Height | 13. Weight | 14. Gender | 15. Marital Status |
|---|---|---|---|
| | | ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Widowed ☐ Divorced |

| 15. Occupation | 16. List the duties of your occupation at the time of your disability |
|---|---|
| 17. Date of accident/first symptoms | |

| 18. Last date worked | 19. Have you returned to work? ☐ Yes ☐ No<br>Full Time: _____ Part Time: _____ | 19a. Expected Return Date<br>Full Time: _____<br>Part Time: _____ |
|---|---|---|

| 20. Supervisor Name | 21. Supervisor Email |
|---|---|
| | |

22. Describe in detail how, when, and where the illness/accident occurred, or describe the nature of your disability and its first symptoms. Attach additional sheets as needed.

23. Is your accident or illness related to your occupation? If yes, please explain. ☐ Yes ☐ No

24. Have you filed a Workers Compensation claim?
☐ Yes ☐ No
Do you intend to file a Work Comp claim?
☐ Yes ☐ No

25. If injury was due to an auto accident, have you applied for no-fault benefits? ☐ Yes ☐ No
Carrier Name: _____
Carrier Phone: _____

26. Date you were first treated for your illness or injury: _____
Hospital name: _____ Address: _____
Doctor Name: _____ Address: _____

27. Please list any sources of income that you are currently receiving and their amounts. Please attach copies for income verification.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and will be subject to civil fines and criminal penalties. I certify by signing this form that I will inform Erisa of any change(s) to this form or employee's work status and will provide them with any updated medical forms as soon as I receive them. I certify that the information above is true and correct to the best of my knowledge. I have reviewed and fully understand all CLAIMANT'S RESPONSIBILITIES set forth in this Disability Policy document and agree to adhere to all of those responsibilities.

Employee Signature: _____ Date: _____

# Disability Claim Form
## Employee Authorization

**Signature Page**

For Employee to Complete

**AUTHORIZATION FOR RELEASE OF INFORMATION**

PERSONS OR INSTITUTIONS: This authorizes you to give the State of New Mexico Group Benefits Plan and Erisa Administrative Services, Inc. Disability Claims Office, its affiliate departments and representatives, any information, data, or records you have regarding my medical history and treatment (including records pertaining to psychiatric, drug or alcohol use, and any medical condition I may have or have had), and any information, data, or records regarding my activities (including records relating to my Social Security, Workers' Compensation, credit, financial, earnings, and employment history) needed to evaluate my claim for benefits. I understand that any such information obtained may be provided to a person or agency requested by the State or Erisa to assist with this purpose. This authorization is valid during the pendency of my claim. I understand that I have the right to request a copy of this authorization. A photocopy of this authorization is as valid as the original.

_____ _____

Employee Name (Please print) Date

_____ _____

Employee Signature SSN/ID

A photo static copy of this authorization is considered as valid as the original and is effective for the duration of the claim.

# Disability Claim Form

**PHYSICIAN FORM**

Email: sonm@easitpa.com
Phone: (855) 618-1800 (press 1) Fax: (505) 705-3311

Erisa Administrative Services, Inc.
1200 San Pedro Dr. NE, Albuquerque, NM 87110-6726

| 1. Name of Patient | 2. SSN | 3. Gender ☐ Male ☐ Female | 4. DOB |
|---|---|---|---|
| | | | |

**History**

| a) Date symptoms first appeared or illness/accident happened | b) Date you advised patient to stop working | c) Has patient ever had same or similar condition? ☐ Yes ☐ No *If yes, attach description and dates* |
|---|---|---|

| d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown | e) Names and addresses of other treating physicians |
|---|---|

**Diagnosis**

| a) Date of last exam | b) Primary Diagnosis (including any complications) | c) ICD9 Code |
|---|---|---|
| | | |

d) Subjective Symptoms

| e) Secondary Diagnosis (if applicable) | f) ICD9 Code | g) Subjective Symptoms |
|---|---|---|
| | | |

| h) Objective findings (including current x-rays, EKG's, lab data, and any clinical findings) | i) If pregnant, expected delivery date | j) If delivered, actual delivery date |
|---|---|---|
| | | |

**Treatment**

| a) Date of first visit for this illness or injury | b) Date of last visit | c) Date of next visit | d) Frequency of visits |
|---|---|---|---|
| | | | |

e) Nature of Treatment (including surgery and medications prescribed, if any)

f) Is patient: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

g) Has patient been hospital confined? ☐ Yes ☐ No If yes, when?_____ to _____

Hospital Name:_____ Expected Recovery Date: _____

Hospital Address: _____

_____

_____

Additional Remarks:

# Disability Claim Form

**PHYSICIAN FORM**

**Cardiac (if applicable)** ☐ Class 1 (no limitation)
a) Functional Capacity (American Heart Assn.) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

b) Therapeutic Class (Activity Restriction)
☐ A. (none) ☐ B. (slight)
☐ C. (moderate) ☐ D. (marked)
☐ E. (complete)

c) Blood pressure last visit
_____
Systolic/Diastolic

**Physical Impairment** (*As defined in federal dictionary of occupational titles) **REMARKS:**
☐ Class 1 – No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
☐ Class 2 – Medium manual activity * (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work * (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)

**Mental Impairment** (if applicable)
a) Please define "stress" as it applies to this claimant b) What stress and problems in interpersonal relations has claimant had on the job?
☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations)
Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

**REMARKS:**

a) Does patient currently have limitations/restrictions?
Patient's Occupation: ☐ Yes ☐ No
Any Other Work: ☐ Yes ☐ No

b) Describe specific limitations and restrictions:

c) If employer can accommodate limitations and restrictions, is this patient able to return to work?
☐ Yes ☐ No ☐ Part-Time ☐ Full-Time

d) Date employment could begin

e) Under what conditions could this employee return to work? Please elaborate.

Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship? _____

**NOTE:** If there are multiple unrelated diagnoses, please complete a second physician form with all relevant information.

**ADDITIONAL REMARKS:**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and will be subject to civil fines and criminal penalties.

As the authorized physician, I acknowledge that the information and statements provided in this form are true and correct to the best of my knowledge. I certify that I have fully reviewed said issue and treatment pertaining to this claim with the patient and they have communicated to me that they fully understand.

Name (attending physician) *Please Print* Degree Phone Number

Street Address City State Zip Fax Number

Tax ID #:_____ Physician Signature:_____ Date: _____

# Disability Claim Form

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Fax: (505) 705-3311

Erisa Administrative Services, Inc.
1200 San Pedro Dr. NE
Albuquerque, NM 87110-6726

## CHANGE OF ADDRESS FORM

| 1. Employee Name | 2. SSN | 3. ID | 4. DOB |
|---|---|---|---|
| | | | |

| 5. Home Phone | 6. Cell Phone | 7. Email |
|---|---|---|
| | | |

| 8. Case Number | 9. Current Disability Level: |
|---|---|
| | □ Short-Term □ Long-Term □ Maternity |

**Updated Address:**

| 10. Address | 11. City | 12. State | 13. Zip |
|---|---|---|---|
| | | | |

Employee Signature: _ Date: _