Disability Claim Form

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

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 actual 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.

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EMPLOYER SHEET

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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

Submission Date 12/21/2018

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EMPLOYEE TO COMPLETE

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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 Full Time: _____ Part Time: _____	19a. Expected Return Date Full Time: _____ 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. When were you first treated for your illness or injury? Date: _____
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.

I acknowledge having reviewed all of the CLAIMANTS' RESPONSIBILITIES as set forth in the Disability Policy document. By my signature below, I represent that I understand all of the stated Claimants' Responsibilities and that I will adhere to all of those responsibilities during the claim process.

Employee Signature: _____ Date: _____

Submission Date 12/21/2018

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 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.

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PHYSICIAN FORM

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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 unemployment? ☐ Yes ☐ No ☐ Unknown	e) Names and addresses of other treating physicians	

Diagnosis

a) Date of last exam	b) Diagnosis (including any complications) & ICD9 Code	c) Subjective Symptoms
d) Objective findings (including current x-rays, EKG's, lab data, and any clinical findings)	e) If pregnant, expected delivery date	f) 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: _____

Cardiac (if applicable)
a) Functional Capacity (American Heart Assn.)
☐ Class 1 (no limitation)
☐ 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? _____	

Name (attending physician) Please Print Degree Phone Number

Street Address City State Zip Fax Number

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