STATE OF NEW MEXICO

GENERAL SERVICES DEPARTMENT
RISK MANAGEMENT DIVISION

DISABILITY POLICY

July 2019

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Benefits at a Glance

The State of New Mexico (SoNM) Disability Program is a self-insured supplemental income program providing financial assistance to those that lose income due to a sickness or non-work-related injury and are unable to work for a period of time. The Disability Program is administered by Erisa Administrative Services, Inc., the SoNM's Third Party Administrator, and administered according to the Official Disability Guidelines (current edition) published by the Work Loss Data Institute. The Disability Program is a part of the SoNM Group Benefits Plan and subject to Plan eligibility.

The Disability Program is comprised of two benefits: Short-Term Disability and Long-Term Disability. This policy is designed to give the policyholder information regarding their Disability coverage.

Benefit claim forms* must be completed and submitted to the Disability Program Administrator (information below). Processing may be delayed if all required forms are not included. All Disability questions should be directed to Erisa (please see below website for claim details).

Erisa Administrative Services, Inc.
1200 San Pedro Dr. NE
Albuquerque, NM 87110
Fax: (505) 244-6009
Ph. (855) 618-1800
Disability Information:
https://www.mybenefitsnm.com/Documents/Disability-Policy-January-2019.pdf

*Claim forms can be found at the end of this document as well as online at the link above.

Disability premiums are paid 100% by the employee. If the employee should require disability benefit payments, no taxes will be withheld from these benefit payments due to the employee paying the full premium costs. A W-2 will be issued for the year in which benefit payments were received. Please update home mailing address as needed with Human Resources Department to ensure W-2 is received.

The SoNM reserves the right to review and alter the Disability Program at any time.

Eligibility for Benefits

- To be eligible *to make an initial claim*, the employee must:
  1. Be enrolled in the SoNM's Group Disability Benefits Program, **and**
  2. Have paid disability premiums for at least 12 *consecutive* months, **and**
  3. Have suffered a disabling, ***non-work-related*** illness or injury which prevents employee from working.
- Employee must submit documentation from a medical provider that establishes employee is not able to perform work in any capacity.
- There is a twenty-eight (28) calendar day **ELIMINATION PERIOD**. If all criteria are met at the end of the 28-day Elimination Period, the employee may qualify for disability benefits.
- An employee does not need to exhaust annual, sick, or donated leave time in order to be eligible to make an initial claim for disability benefits.
- Claimants on Long-Term Disability may separate from employment and still maintain eligibility.
- Dependents and independent contractors are not covered under this program.

Short-Term Disability Benefits

- Eligible employees must have paid disability premiums for at least 12 *consecutive* months prior to claiming disability.
- There is a twenty-eight (28) calendar day **ELIMINATION PERIOD**. This **ELIMINATION PERIOD** starts on the first day on which an employee is unable to work due to a disability. They must use their accrued time until they are able to qualify for Short-Term Disability benefits.
- Claimant **must continue to pay required premium contributions** while on Short-Term Disability in order to maintain eligibility. Claimants should work with their HR representative to determine how many hours of accrued leave, if any, need to be submitted each pay period while on Disability in order to ensure benefit premiums are covered. Otherwise, if claimant is not on Family Medical Leave (FML), then they will be responsible for paying 100% of their benefits out-of-pocket while on Disability. Failure to pay premiums will result in loss of eligibility of <u>all</u> benefits.
- Disability is considered a qualifying event (i.e., Family Medical Leave, Leave Without Pay, change in job status, etc.), which allows the claimant to make changes to their health plan coverage. The effective date would be the first day the employee is out of work. Note: Disability coverage cannot be dropped while receiving disability benefit payments from the program.
- **When on Short-Term Disability, claimant must continue to pay Disability premiums regularly and on time in order to avoid losing access to the program.** Only when Short-Term Disability converts to Long-Term Disability can the claimant stop paying their Disability premiums.
- Employee must submit medical provider documentation establishing that the employee is not able to perform work in any capacity while on disability benefits.
- A **CLAIMANT** is *not* eligible for disability benefits in the event of a work-related injury or illness. Participation in the Disability Program due to a work-related injury is considered fraud, as a claimant cannot benefit from both the Disability and WC programs for the same injury. In the event this does occur, the claimant will lose Disability coverage and all possibility of future participation. The claimant will also be required to reimburse the SoNM any funds they have received for this claim. If a Workers' Compensation claim is submitted, then the employee files a Disability claim, the SoNM reserves the right to conduct a full investigation.
- Claim must be filed within forty-five (45) days of the first day they are unable to work.
- Following the **ELIMINATION PERIOD**, Short-Term Disability benefit payments are payable weekly and are calculated at 60% of gross weekly earnings, less any **DEDUCTIBLE SOURCES OF INCOME**, to a maximum benefit of $500 per week.
- 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.
- Following the **ELIMINATION PERIOD**, Short-Term Disability benefits may be paid for a maximum period of twenty-six (26) weeks, based on proper medical documentation.
- Maternity benefits in the instance of a normal* delivery allow for 6 weeks of disability beginning on the date of delivery (this *includes* the four (4) week **ELIMINATION PERIOD**, resulting in two (2) weeks of paid benefits).

- Maternity benefits available in the instance of a Cesarean* delivery allow for eight (8) weeks disability from the date of delivery (this *includes* the four (4) week **ELIMINATION PERIOD**, resulting in four (4) weeks of paid benefits).
- **CLAIMANTS** cannot perform work in any capacity (this would include non-State related work), while receiving Short-or Long-Term Disability benefits.
- **CLAIMANTS** returning to work need to make sure they have received a work release (fitness for duty report) from their physician and are ready to resume their regular work schedule. If a claimant returns to work and receives regular pay from the State and then finds that they were not prepared to return to work, a new Disability claim will need to be filed and the 28-day waiting period begins again. The extension of disability benefit payments is based on medical necessity.
- The **CLAIMANT** must provide medical updates every four to six (4-6) weeks or as necessary based on condition. This information is provided on the determination letter.
- Coverage ends when the disability condition is no longer the same condition under which the claim was originally filed and/or not a direct result of the original disabling condition. A change in medical condition will require a new claim and will be subject to approval or denial based on the policy guidelines and new **ELIMINATION PERIOD**.

*Above scenarios are without complications.

Coordination of Short-Term Disability Benefit Payments and Other Paid Leave Formula if employee makes $20.83 hourly or less:

Hourly Wage × 40 = Weekly Wage
Ex. 15.00 hr. × 40= $600
Weekly Wage × 60% = Disability Benefit Amount (maximum $500)
Ex. $600 × 60%= $360
Weekly Wage – Benefit Amount = Amount that can be paid by other sources (annual, donated, sick, etc.)
Ex: $600 – $360= $240
Amount that can be paid ÷ hourly wage = number of hours that can be paid from other sources of payment
Ex: $240 ÷ $15 hr. = 16 hours

Coordination of Short-Term Disability Benefit Payments and Other Paid Leave Formula if employee makes $20.84 hourly or more:

Hourly Wage × 40 = Weekly Wage
Ex: $22 hr. × 40 = $880
Weekly Wage × 60% = Disability Benefit Amount (maximum $500)
Ex: $880 × 60% = $528, so the program will pay to the maximum of $500
Weekly Wage – Benefit Amount = Amount that can be paid by other sources (annual, donated, sick, etc.)
Ex: $880 – $500 = $380
Amount that can be paid ÷ hourly wage = number of hours that can be paid from other sources of payment
Ex: $380 ÷ $22 hr. = 17.27 hours

Long-Term Disability Benefits

- Long-Term Disability begins after Short-Term Disability has ended as long as the employee still meets all eligibility requirements.
- Long-Term Disability benefits are payable for a maximum of 18 months.
- No work-related injuries or illnesses are covered by either Short-Term or Long-Term Disability.
- The **CLAIMANT** must provide medical updates every four to six (4-6) **weeks** or as necessary based on condition. This information will be provided in the determination letter.
- Long-Term Disability benefit payments are payable monthly and are calculated at 40% of regular monthly earnings, less any **DEDUCTIBLE SOURCES OF INCOME** (see Glossary), to a maximum benefit of $2,000 per month.
- **CLAIMANT** must show proof that they have applied for Social Security Disability Insurance (SSDI) and Retirement Disability **within 45 days** of being approved for Long-Term Disability in order to continue eligibility for this benefit.
- **CLAIMANT** is responsible for providing reimbursement to the SoNM Disability Program if the claimant is approved by Social Security and if the Social Security benefit is reimbursed retroactive to the initial proven date of Disability. Failure to reimburse the State Disability Program will result in the State of New Mexico taking action against the claimant to collect the over payment.
- It is the claimant's responsibility to appeal any denial made by SSDI. Claimant must provide copies of the appeals to Erisa for verification purposes. Failure to do so will result in a loss of eligibility to participate in the Disability Program.
- **CLAIMANTS** cannot perform work in any capacity (this would include non-State related work), while receiving Short- or Long-Term Disability benefits.

Other Benefit Features

- At the discretion of the Director of the SoNM Risk Management Division, disability benefit payments may continue for eligible Long-Term Disability if the claimant elects to enroll in school and/or training that will provide them with the necessary skills to obtain gainful employment.
  1. The claimant must request this benefit in writing, with an explanation of the classes and/or training that the claimant will be enrolling in and what employable skills will be attained by taking these classes.
  2. The claimant must provide the admission letter to Erisa immediately upon receipt. The final grades must also be submitted to Erisa.
- If a State or Local Public Body employee or Local Public Body Agency separates from the SoNM Group Benefits Plan, any Short- or Long-Term Disability claimant currently receiving benefit payments will continue to receive these benefit payments until the claim is closed, according to the terms and conditions of the Plan. In this situation, in order to continue receiving Short-Term Disability benefit payments, claimants must pay the monthly disability *premium* by cashier's check or money order only, mailed to:

Risk Management Division
ATTN: Disability Program
Employee Benefits Bureau
P.O. Box 6850
Santa Fe, NM 87502

The premium payment **must be made payable to: Risk Management Division**, with "**Disability Premium**" indicated on the cashier's check or money order.

Limitations and Exclusions

- Work-related injuries and/or illnesses are *not* covered under this Program.
- All Disability durations are administered according to the **OFFICIAL DISABILITY GUIDELINES** (current edition) published by Work Loss Data Institute.
- **CLAIMANTS** cannot perform work in any capacity (this would include the non-State related work) while receiving Short- or Long-Term Disability benefits.
- The SoNM has the right to review and amend coverage and/or policy without prior notice.

Program Rights

- The program has the right to approve or deny the claim based on submitted information and program eligibility requirements.
- The program has the right to terminate benefits at any time due to failure to comply with the program requirements and guidelines.
- The program has the right to recover any and all overpaid monies as the result of incorrect benefit payments, fraud, or **DEDUCTIBLE SOURCES OF INCOME**.
- The program has the right to request employees' financial, employment, and medical information at any time while enrolled and receiving benefit payments.
- The program has the right to stop benefits if the disability condition is no longer the same condition as originally claimed and/or not a direct result of the original disabling condition.

When Coverage Ends

- If the SoNM Group Benefits Plan is cancelled, Disability coverage ends on that cancellation date.
- Coverage ends on the date a claimant is approved for Social Security Disability, or retirement (this also includes voluntarily withdrawing retirement funds). If this occurs**, immediate notification must be submitted to the Disability Program Administrator**.
- Coverage ends on the date a claimant is denied Social Security Disability Income Benefits (SSDI) during Long-Term Disability and refuses to appeal the denial.
- Eligibility for benefits terminates upon failure to pay required premium payments.
- Coverage for both Short- and Long-Term Disability ends on the date the claimant no longer meets the terms of the program.
- Coverage ends on the date claimant fails to submit proof of continuing disability.
- Coverage ends when claimant is able to work in any capacity.
- Coverage ends when the disability condition is no longer the same condition under which the claim was originally filed and/or not a direct result of the original disabling condition.

- Coverage ends on the date claimant refuses an independent medical examination at the request of the SoNM.
- Coverage ends when the Claimant is approved for SSDI benefits. NOTE: The claimant is responsible for reimbursing the SoNM for **all** disability benefit payments paid to the claimant while the SSDI application was under review and approved. These repayments must be paid by cashier's check or money order and **received by the SoNM within 30 days of receipt of the SSDI payment**. If this deadline is not met, the SoNM will take legal action to recover these paid disability benefit payments.
- Coverage ends on the date of claimant's death.
- Assuming all other elements of eligibility and continuing eligibility are met, coverage for both Short- and Long-Term Disability ends upon reaching the maximum duration of benefit payment.
- Following the completion of the 28-day **ELIMINATION PERIOD**, the maximum duration of benefit payment for Short-Term Disability benefits is twenty-six (26) weeks.
- Following the completion of Short-Term Disability, the maximum duration of benefit payment for Long-Term Disability benefits is two (2) years.

Appeal Process

If at any time a claim is denied and/or benefits are terminated, the plan will notify claimant regarding the status of benefits as well as the appeal process. The appeal process is as follows:

- First Level – The claimant should write a letter to the Disability Program Administrator explaining why the claim should not have been denied and/or why benefits should not have terminated. Please include any and all supporting documentation in support of the need to review the original denial.
    - First Level will be reviewed by Erisa.
- Second Level – If the denial was upheld after the first level appeal, the claimant should send all documentation, including the original first level appeal and response, with a written notice requesting a second level appeal to Erisa.
    - Second Level will be reviewed by the SoNM Employee Benefit Bureau Chief.
- Third Level – If the denial was upheld after the first and second level, all documentation including the original first and second level appeals and responses should be sent to Erisa, with a written notice, requesting a third and **FINAL** level appeal.
    - Third Level will be reviewed by the SoNM Risk Management Division Director.

No benefit payments will be made during the course of an appeal. In the event the claimant prevails in an appeal, an appropriate lump sum payment will be issued within thirty (30) days of the date appeal is granted.

Program Information

Program Name:	State of New Mexico Self-Insured Disability Program, a component of the SoNM Group Benefits Plan
Disability Program Administrator:	Erisa Administrative Services, Inc. 1200 San Pedro Dr. NE Albuquerque, NM 87110 Telephone: (855) 618-1800
Employer Identification Number:	36-4463161
Type of Program:	The Disability Program (short-term and long-term) is offered by the State of New Mexico. Disability benefits are provided in accordance with the provisions of the State of New Mexico Self-Insured Program.
Share of Contributions:	Employee contributes the full cost of premium for the Disability Program.
Agent for Legal Services and Address:	Director: Risk Management Division General Services Department, State of NM 1100 St. Francis Drive Santa Fe, NM 87502-0110 Telephone: (505) 827-2036

Glossary

BENEFIT PAYMENT – the total benefit payment amount for which an employee is insured under this program after any **DEDUCTIBLE SOURCES OF INCOME** have been subtracted from gross disability payment, subject to the maximum benefit. Payable **weekly** under Short-Term Disability and **monthly** under Long-Term Disability.

CLAIMANT – an employee who is eligible for the State of New Mexico Self-Insured Disability Program

DEDUCTIBLE SOURCES OF INCOME – income from deductible sources that claimant receives or is entitled to receive while **DISABLED**. This income will be subtracted from the gross disability payment. Deductible Sources of Income include but are not limited to:

- State compulsory benefit act or law
- Other group insurance plan
- Under the mandatory portion of any "no fault" motor vehicle plan
- Under salary continuation or accumulated sick leave plan
- From a third party (after subtracting attorney's fees) by judgment, settlement, or otherwise

DISABILITY PROGRAM ADMINISTRATOR – Erisa Administrative Services, Inc. (EASI)

DISABLED – the inability to perform any work due to a sickness or non-work-related injury

ELIMINATION PERIOD – the period between the first day an employee is unable to work due to a disability and the day eligibility for disability benefits begins

EMPLOYER – the SoNM Agency/Local Public Body participating in the SoNM Group Benefits Plan

INJURY – a bodily injury that is the direct result of a non-work-related accident

OCCUPATIONAL SICKNESS OR INJURY – a sickness or injury that was caused or aggravated by any employment for pay or profit

MAXIMUM BENEFIT – the maximum amount receivable while on disability. This amount is either 60% of gross income while on Short-Term Disability less Deductible Sources of Income, 40% of gross income while on Long-Term Disability less Deductible Sources of Income, or $500, whichever is least.

MEDICAL PROVIDER –

- A person performing tasks that are within the limits of his/her medical license; and
- A person who is licensed in the United States to practice medicine, prescribe and administer drugs, or perform surgery (The SoNM will not recognize the claimant, or claimant's spouse, children, parents, or siblings as a doctor for a claim); and
- A person with a doctoral degree in Psychology earned within the United States whose primary practice is treating patients; or
- A person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction of the United States.

PAYABLE CLAIM – a claim for which the SoNM is liable under the terms of this policy

PLAN – the State of New Mexico (SoNM) Group Benefits Plan

PREMIUM PAYMENT – the amount payable to the State of New Mexico Group Benefits Plan for ongoing benefits, including Disability benefits and any continuing medical, dental, and/or vision benefits

PROGRAM – the State of New Mexico Self-Insured Disability Program

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

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

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 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. 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 unemployment? ☐ 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 ☐ Class 2 (slight limitation) (American Heart Assn.) ☐ 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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Phone: (855) 618-1800 (press 1)
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: _