WHEN FAXING INSERT THIS END

Mail To: CompuSys/Erisa Group, Inc.
13706 Research Blvd. Suite 308
Austin, TX 78750

Disability Claim Form

Claim & Tax Questions: Toll Free 1-800-933-7472 **Fax to: (512) 597- 4692**

EMPLOYEE TO COMPLETE (PLEASE PRINT) If claim form is not completed in full, processing of benefits will be delayed until all information has been received. Write "NA" in non-applicable sections

2. Home Phone #	3. Employees DOB	4. Employees SS#
( ) -	/ /	- -

1a. Employee's Name:

_____

6.
a. Height_____ b. Weight_____
c. Gender: ☐ Male ☐ Female
d. Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

5. Employee's Address:
Street/Box/Apt._____

City, State, Zip_____

The above statements are true and complete to the best of my knowledge and belief. **Your signature is required for benefit consideration**.

7a. Occupation

7b. List the duties of your occupation at the time of your disability

8. Date of accident or date you first noticed symptoms:	9. You have been unable to work because of this disability since what date?	10. Have you returned to work? ☐ Yes ☐ No If yes, when? Full Time: _____ Part Time: _____	11.If you have not yet returned to work, when do you expect to return? Full Time: _____ Part Time: _____

12. Describe in Detail how, when, and where the illness/accident occurred, or describe the nature of your disability and its first symptoms.

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

15. If injury was due to an auto accident, have you applied for no-fault benefits? ☐ Yes ☐ No If yes, please list the name, address, phone number of carrier:

16. When were you first treated for your illness or injury?

Hospital Name:_____ Street_____ City_____State_____Zip_____
Doctor Name:_____ Street_____ City_____State_____Zip_____

____/____/____

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

18. 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.

Signature: X_____ Date:_____/_____/_____

Personal Email address: _____ (for confidential communications)

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Disability Claim
Employee's Authorization

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 CompuSys/Erisa Group, 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 CompuSys/Erisa Group, Inc. to assist with this purpose. This authorization is valid during the pendency of my claim. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

X_____

Signature

_____/_____/_____
Date

Address_____

_____

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