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**

**EMPLOYER TO COMPLETE** (PLEASE PRINT) **If claim form is not completed in full, processing of benefits will be delayed until all information has been received.**

| 1.Agency Name and Address: | 2. Employees Home Phone: ( ) - | 3. Employees DOB / / | 4. Employees SS# - - |
|---|---|---|---|

| 5. Employees Name and Address | 6. Employee's work schedule<br>☐ Full Time ☐ Exempt Regularly scheduled<br>☐ Part Time ☐ Non-exempt hours per week__________ |
|---|---|

| 7. Date of Hire | 8. Effective Date of Insurance | 9. Occupation at time last worked | Check off regular work schedule<br>☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT |
|---|---|---|---|

| 10. Confirm that Employee has paid twelve months of disability premiums, and attach payroll deduction print screen(s). | 11. Wages prior to date last worked:<br><br>Hourly wage $____________________ | 12. Date of Last Salary Increase<br><br>13. Date of Anticipated Return to Work? |
|---|---|---|

| 13a. Date last worked_______________ 13b. Number of hours worked that day___________<br><br>13c. Date paid through______________for ☐ Annual Leave ☐ Vacation Pay ☐ Accrued Sick Leave | 14. Has employee returned to work? If yes, date<br><br>Full Time__________ Part Time__________ |
|---|---|

**15. 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.**

16. Sick Pay Calculation for Timesheet Entry: Date Last Worked ____________ + 28 Day Elimination Period = _______________ Date to start reducing employees sick/annual/comp leave on timesheet if eligible for Disability Payments.

******An Employee Can NOT receive more than 40% of their normal weekly wage in order to qualify for Disability*****

17. **Have you notified the employee of FMLA eligibility?** ☐ **YES** ☐ **NO** **Have you completed FMLA forms?** ☐ **YES** ☐ **NO**
****Please forward a copy with this form**

I certify by signing this form that I will inform CompuSys/Erisa Group, Inc. 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 CompuSys/Erisa Group, Inc. any updated medical forms if I receive them.

**Signature** (**the above statements are true and complete to the best of my knowledge**) FAX NUMBER ( ) -

**X**_______________________________________________ Date Signed ___/_____/____

**Person completing this form please print or type name and title** **Telephone Number** ( ) -

_______________________________________________________

**Email address:** ________________________________________