Instructions for Filing a Claim

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 "NA" (not applicable) in those spaces.

How To File A Claim	All sections of this form must be completed and sent to CompuSys/Erisa Group, Inc. by mail or by fax. The FAX number is **(512) 597- 4692.** **1.** Employer: Fully complete section "For Employer To Complete." Page 1, answering all questions. **REMEMBER TO FORWARD COPIES OF EMPLOYEE RECORDS SHOWING DISABILITY PREMIUM PAYMENTS, WAGES PAID, AND LEAVE BALANCES AFTER THE 28 DAY ELIMINATION PERIOD IS OVER PER QUESTION 16 ON EMPLOYER APPLICATION.** **2.** Employee: Fully complete and sign pages 2 and 4 of the Benefit Claim Forms. **3.** Employee: Obtain and submit completed Physician Form, page 5. (Before giving the form to the physician, complete the top line with your name, date of birth and social security number).
Employer/Employee Notice	Please inform CompuSys/Erisa Group, Inc. of any scheduled or actual return to work date, as soon as possible, by calling the office toll free at (800)-933-7472 or faxing notification to **(512) 597- 4692.** If CompuSys/Erisa Group, Inc. extends benefits beyond the actual return to work date, the amount overpaid must be returned to the State of New Mexico. **You MUST forward copies of employees 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 CompuSys/Erisa Group, 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 statues. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.**

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 ☐ Full Time ☐ Exempt Regularly scheduled ☐ 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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ 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: Hourly wage $_____	12. Date of Last Salary Increase 13. Date of Anticipated Return to Work?

13a. Date last worked_____ 13b. Number of hours worked that day_____ 13c. Date paid through_____ for ☐ Annual Leave ☐ Vacation Pay ☐ Accrued Sick Leave	14. Has employee returned to work? If yes, date 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: _____

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)

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.

Physician Form

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

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

Name of Patient	Date of Birth / /	Social Security Number - -

History

a) When did symptoms first appear or illness/accident happen? / /	b) Date you advised your patient to stop working. / /	c) Has patient ever had same or similar condition? If yes, state when and describe ☐ Yes ☐ No

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

Diagnosis

a) Date of last examination / /	b) Diagnosis (including any complications) & ICD9 Code	c) Subjective Symptoms

d) Objective findings (including current x-rays, EKG's, laboratory 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

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

Progress

a) Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	b) Is patient ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

c) If unchanged or regressed, please explain:

d) Has patient been hospital confined? ☐ Yes ☐ No confined from_____ to _____ When will patient recover? _____	If "Yes" give name and address of hospital

Cardiac (if applicable) a) Functional Capacity (American Heart Assn.) ☐ Class 1 (no limitation) ☐ Class 3 (marked limitation) ☐ Class 2 (slight limitation) ☐ Class 4 (complete limitation)	b) Therapeutic Class (Activity) ☐ A.(no restrict.) ☐ C.(moderate restrict.) ☐ B.(slight restrict.) ☐ D.(marked restrict.) ☐ E.(complete restrict.)	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 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 engage in only 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:

Progress

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 is able to accommodate patient's limitations and restrictions, is this patient able to return to work? ☐Yes ☐No ☐Part Time ☐Full Time	d) What date could employment begin? / /

e) Under what conditions can this patient 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**	**Telephone Number** ( ) --
Street Address **City or Town** **State or Province** **Zip Code**	**Fax Number** ( ) --

Tax I.D. Number **SIGNATURE:** **Date:** / /