STATE OF NEW MEXICO

GENERAL SERVICES DEPARTMENT
RISK MANAGEMENT DIVISION

DISABILITY POLICY

January 2019

Table of Contents

Disability Claim Forms located at end of this document.

Benefits at a Glance

The State of New Mexico Disability Program is a self-insured supplemental income plan to provide 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 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 sent to Erisa Administrative Services, Inc., the State's Benefits Third Party Administrator for disability. Processing may be delayed if all required forms are not included. All Disability questions should also be directed to Erisa. 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

*Claim forms are at the back of this document and available online at http://mybenefitsnm.com/Disability.htm.

Disability premiums are paid 100% by the employee. With the employee paying the full premium costs, no taxes are withheld if the employee should require disability payments. A W-2 will be issued for the year in which benefits were received. Please make sure your mailing address is up to date with your Human Resource Department to ensure that you receive your W-2 for tax filing purposes.

The state reserves the right to review and alter the program at any time.

Eligibility for Benefits

- To be eligible *to make an initial claim*, the employee must:
    1. Be enrolled in the State's Group Disability Benefits Plan, **and**
    2. Have paid disability premiums for at least 12 *consecutive* months, **and**
    3. Suffer a disabling, *non-work-related* illness or injury which prevents employee from working.

- Employee must submit medical provider documentation which establishes employee is not able to perform work in any capacity.
- There is a twenty-eight (28) calendar day **ELIMINATION PERIOD**. At the end of the 28 day Elimination Period, the employee may qualify for disability benefits if all plan criteria are met.
- 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 maintain eligibility.
- Dependents and independent contractors are not covered under this plan.

Short-Term Disability Benefits

- An eligible employee 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**. The **ELIMINATION PERIOD** is the length of time between when an employee is unable to work due to a disability to when they might qualify for Short-Term Disability benefits.
- Required premium contributions must continue to be paid while on Short-Term Disability to maintain eligibility. Claimants should work with HR to determine how many hours of accrued leave, if any, need to be submitted on their timesheet each pay period while on Disability to cover their benefits. Otherwise, the claimant will be responsible for paying their benefits out of pocket while on Disability. Failure to pay premiums will result in loss of eligibility.
- Disability is considered a qualifying event which allows the claimant to make changes to their health plan coverage. The effective date is the first day the employee is out of work. Note: Disability coverage cannot be dropped while receiving benefits from the program. Premiums must still to be paid regularly and on time in order not to risk losing access to the program.
- Employee must submit medical provider documentation which establishes 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 work-related injury or illness will result in loss of coverage with Disability and any future participation. The claimant will be required to reimburse the plan any funds paid out for these reasons.
- Claim must be filed within forty-five (45) days from the first day out of work.
- Following the **ELIMINATION PERIOD**, Short-Term Disability benefits 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 benefits 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 your employer during the time you are 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).

  *Above scenarios are without complications
- 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). **

  **Above scenarios are without complications

- Claimants returning to work need to make sure that they have received a work release from their physician and are ready to resume their regular work schedule. If a return to work claimant receives regular pay from the State and 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. Extension of disability 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**.

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

Hourly Wage X 40 = Weekly Wage
Ex. 15.00 hr. X 40= $600
Weekly Wage X 60% = Disability Benefit Amount (maximum $500)
Ex. $600 X 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 Benefits and Other Paid Leave Formula if employee makes $20.84 hourly or more:

Hourly Wage X 40= Weekly Wage
Ex: $22 hr. X 40 = $880
Weekly Wage X 60% = Disability Benefit Amount (maximum $500)
Ex: $880 X 60% = $528, so we 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 two (2) years.
- No work-related injuries or illnesses are covered by either Short-Term or Long-Term Disability.
- The **CLAIMANT** must provide medical updates every 4 to 6 weeks or as necessary based on condition. This information will be provided in the determination letter.
- Long-Term disability 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 $2000 per month. Claimant must receive monthly payments via direct deposit.
- **CLAIMANT** must apply 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.
- The claimant is responsible for providing reimbursement to the State Disability Plan 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 any means necessary 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 Administrative Services, Inc., for verification purposes. Failure to do so will result in a loss of eligibility to participate in the program.

- Grandfathered Participants Only: Benefits for those approved prior to July 1, 2006, will be reduced by **DEDUCTIBLE SOURCES OF INCOME** (such as social security or retirement) and benefits will end upon the claimant's 65th birthday.
    - Long-Term disability participants with approval prior to July 1, 2006, are eligible for a *one-time* life benefit payout of $1,000.00, to an eligible survivor. Survivor must provide, in writing, a request for the life benefit and furnish a copy of the claimant's death certificate.

Other Benefit Features

- At the discretion of the Director of the State of New Mexico Risk Management Division, disability payments may continue for eligible Long-Term Disability if the claimant elects to enroll into 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 Administrative Services, Inc., immediately upon receipt. The final grades must also be submitted to Erisa Administrative Services, Inc.
- If a State employee or a Local Public Body Employee, or Local Public Body Agency separates from the State Group Benefits Plan, any Short or Long-Term disability claimant currently receiving benefits will continue to receive benefits until the claim is closed according to the terms and conditions of the Plan. In this situation, to continue receiving Short-Term Disability payments, claimants must send, by cashier's check or money order only, monthly disability *premiums* payable to:

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

The payment must be made payable to Risk Management Division, and you must indicate on the payment that the check is for disability premiums.

Limitations and Exclusions

- Work-related injuries and/or illnesses are *not* covered under this Plan.
- 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 while receiving Short or Long-Term Disability benefits.
- The State has the right to review and amend coverage and policy without prior notice.

Plan Rights

- The plan has the right to approve or deny the claim based on submitted information and plan eligibility requirements.
- The plan has the right to terminate benefits at any time due to failure to comply with the plan requirements and guidelines.
- The plan has the right to recover any overpaid monies as the result of incorrect benefit payments, fraud, or **DEDUCTIBLE SOURCES OF INCOME**.
- The plan has the right to request employees' financial, employment, and medical information at any time while enrolled and receiving benefit payments.
- The plan 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 State's Group Benefit Plan is cancelled, coverage ends on the cancellation date.
- Coverage ends on the date a claimant is approved for Social Security Disability, or retirement (this also includes voluntarily withdrawing your retirement funds). If this occurs, notify the plan administrator (Erisa Administrative Services, Inc.) immediately.
- 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 make required premium payments.
- Coverage for both Short and Long-Term Disability ends on the date the claimant no longer meets the terms of the plan.
- 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 State of New Mexico.
- Coverage ends when the Claimant is approved for SSDI benefits. NOTE: The claimant is responsible for reimbursing the State for all disability benefits paid to the Claimant while the SSDI application was under review and approved. These payments must be received within 30 days of receipt of the SSDI payment. If this does not happen the State will take legal action to recover such monies.
- 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 payment:
- Following the completion of the 28-day **ELIMINATION PERIOD**, the maximum duration of payment for Short-Term Disability benefits is twenty-six (26) weeks.
- Following the completion of Short-Term Disability, the maximum duration of 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 and the appeal process. The appeal process is as follows:

- First Level- The claimant should write a letter to the plan administrator, Erisa Administrative Services, Inc., explaining why the claim should not have been denied and/or benefits should not have terminated. Please include any and all supporting documentation to support the need to review the original denial.
    - First Level will be reviewed by Erisa Administrative Services, Inc.

- 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.
    - Second Level will be reviewed by the State's Group Benefits Plan Bureau Chief.

- Third Level- If the denial was upheld after the first and second level, all documentation including the original first level and second level appeals and responses should be sent, with a written notice, requesting a third and **FINAL** level appeal.
    - Third Level will be reviewed by the State Risk Management Division Director.

- No 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.

Plan Information

Plan Name:	State of New Mexico Self-Insured Disability Plan, a component of the State's Group Benefits Plan
Plan Sponsor/Administrator:	Erisa Administrative Services, Inc. 1200 San Pedro Drive NE Albuquerque, NM 87110
Employer Identification Number:	36-4463161
Type of Plan:	Short-Term and Long-Term Disability
Type of Administrator:	The Plan is provided by the State of New Mexico with the benefits 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, State of New Mexico General Services Dept. - Risk Management Division Employee Benefits Bureau, 1100 St. Francis Drive Santa Fe, NM 87502-0110 (505) 827-2036

Glossary

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

DEDUCTIBLE SOURCES OF INCOME means 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 payments received under claimant's current employer's retirement plan (Retirement Disability payments)
- Social Security Disability payments

DISABILITY PLAN ADMINISTRATOR means: Erisa Administrative Services, Inc. (EASI)

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

MEDICAL PROVIDER means:

- A person performing tasks that are within the limits of his or her medical license; and
- A person who is licensed to practice medicine and prescribe and administer drugs or perform surgery; or
- A person with a doctoral degree in Psychology (Ph.D. or Psy.D.) 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.
- The State of New Mexico will not recognize the claimant, or claimant's spouse, children, parents or siblings as a doctor for a claim that is sent to us.

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

EMPLOYER means the State Agency/Local Public Body participating in the State's Group Benefits Plan.

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

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY PAYMENT means your payment after any **DEDUCTIBLE SOURCES OF INCOME** have been subtracted from your gross disability payment.

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

PAYABLE CLAIM means a claim for which the State of New Mexico is liable under the terms of the policy.

PLAN means the State of New Mexico Self-Insured Disability Program.

WE, US AND OUR means the State of New Mexico Self-Insured Disability Program.

WEEKLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

WEEKLY PAYMENTS means your payment after any DEDUCTIBLE SOURCES OF INCOME have been subtracted from your gross disability payment.

YOU means an employee who is eligible for 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. Premium payments must continue to be paid while on Short-Term Disability. Since the employee pays premiums with after-tax dollars, no taxes are withheld if the employee should require disability payments. A W-2 will be issued for that calendar year that you participated in the Disability Program.

I, _____, acknowledge that in order to receive disability benefits I must adhere to the following (check each box):

- ☐ I understand it is my responsibility to ensure that my mailing address is up to date with my employer and Disability Administrator.
- ☐ I understand that I must file my disability claim within forty-five (45) days from the last date of work.
- ☐ I understand that although it is not mandatory, however 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 Disability Plan Administrator with a Physician Update Form, and any other information as requested on the Disability Approval Letter; usual reporting time is every 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, usual reporting time is every 90 days or as necessary based on condition.
- ☐ I understand I must inform the Disability 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 benefits.
- ☐ I understand I must inform the plan 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 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 Disability 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 THE UNDERSIGNED CERTIFY THAT I UNDERSTAND AND WILL COMPLY WITH ALL REQUIREMENTS AS A PARTICIPANT IN THE DISABILITY PROGRAM.

Name (Print): _____

Signature: _____

Date: _____ Phone: _____

Agency Name: _____

Agency Rep: _____

Agency Representative Phone Number: _____

Agency Representative Responsibilities

In order to ensure the timeliness of approval and accuracy of payment to the Claimant requesting Disability, it is of the most upmost importance that the Agency Representative comply with the following:

- ✓ Distribute to the employee the Family Medical Leave Act (FMLA) paperwork and the Disability Policy/Claim Packet upon request.
- ✓ Work closely with the employee and supervisor to ensure the FML and Disability paperwork is completed accurately.
- ✓ Fax completed Disability forms to the Plan Administrator along with copies of the employee's pay advices, from SHARE, reflecting the required twelve (12) consecutive months of disability premium payments.
- ✓ Contact the Plan 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 option of having leave entered into timesheet each pay period. NOTE: The Agency Rep and/or Supervisor must 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.
- ✓ Ensure the employee understands that when approved for Disability this 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 choses 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 should be given 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 Plan 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 payment to the Claimant requesting Disability, it is of the most upmost importance that the Supervisor comply with the following:

- ✓ Keep in contact with Agency or SPO representative to ensure that the proper Disability/FMLA paperwork was submitted.
- ✓ Work with Agency or SPO representative to make sure hours required to pay for benefit premiums are entered correctly per pay period. Should the employee request to have time entered.
- ✓ Coordinate with employee to ensure that they are ready to return to work at full capacity upon returning to work.
- ✓ Inform Agency or SPO representative when the employee has returned to work and ensure that the employee has notified the plan administrator to ensure disability benefit payments stop.

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. Physician Update Form
7. 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 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.

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

Submission Date 01/28/2019

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. 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 01/28/2019

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.

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) 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: _____

Disability Claim Form PHYSICIAN UPDATE 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
5. Case Number		6. Current Disability Level: ☐ Short-Term ☐ Long-Term ☐ Maternity	

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) Names and addresses of other treating physicians			
f) 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 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: _____

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

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: _____

Submission Date 01/28/2019