STATE OF NEW MEXICO

GENERAL SERVICES DEPARTMENT
RISK MANAGEMENT DIVISION

DISABILITY POLICY

REVISED July 1, 2014

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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 CompuSys/Erisa Group, 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 CompuSys/Erisa. See below website for claim details.

CompuSys/Erisa Group, Inc.
13706 Research Blvd. Suite 308
Austin, TX 78750
Fax: (512) 597- 4692
Ph. 1-800-933-7472

***Claim forms are at the back of the Disability Policy found on www.mybenefitsnm.com (Forms, Guidelines, and Policies section) at the following link:**

https://www.mybenefitsnm.com/Documents/Disability_Policy_July_2013_Final_1.PDF

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.

Eligibility for Benefits

- To be eligible *to make an initial claim*, the employee must:

    1. Be enrolled in the State's Group 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) 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 be enrolled in medical coverage through the State's Group Benefits Plan to participate in the Disability Program.

- 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 day (28 calendar days) **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 health benefits and/or disability benefit premium contributions must continue to be paid, through your Agency's HR office, while on Short Term Disability to maintain coverage.

- 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.

- Claim must be filed within ninety (90) 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 regular 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 regular salary with sick, annual, and disability benefits combined.

- Following the **ELIMINATION PERIOD**, Short Term Disability benefits may be paid for a maximum period of twenty-four (24) weeks, based on proper medical documentation.

- Maternity benefits in the instance of a vaginal 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 claims).

- 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 claims). **

  Above scenarios are without complications

- Extension of disability payments is based on medical necessity.

- The **CLAIMANT** must provide medical updates at least every four to six (4-6) weeks.

- 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**.

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.

- 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.

- An individual cannot receive more than 100% of their regular salary with sick, annual, and disability benefits combined.

- 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.

- A **CLAIMANT** must apply for Social Security Disability Insurance (SSDI) and Retirement Disability to continue eligibility for Long Term Disability benefits.

- It is the claimant's responsibility to appeal any denials made by SSDI and provide appeals to CompuSys/Erisa Group, Inc. for verification purposes.

- The **CLAIMANT** must provide medical updates at least every 90 days.

CLAIMANTS' 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.

- Claim must be filed within 90 days of the day the **CLAIMANT** stops working.

- If on short-term disability, the **CLAIMANT** must provide a medical/physician update and other information as requested by the plan at least every 4-6 weeks. Long-term disability **CLAIMANTS** must provide medical updates and other information as requested by the plan at least every 90 days.

- **CLAIMANT** must apply for Social Security Disability Income (SSDI) and Retirement Disability when converted to Long Term Disability.

- **CLAIMANT** must appeal any denials from Social Security Disability Income.

- **CLAIMANT** must inform the plan (CompuSys/Erisa) when receiving any **DEDUCTIBLE SOURCES OF INCOME.**

- **CLAIMANT** is responsible for paying back any overpayments made by the disability program when approved for SSID. Payment must be received when the claimant receives the first retro-payment from SSDI.

- **CLAIMANT** must inform the plan (CompuSys/Erisa) immediately when able to return to work.

- 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**.

- **CLAIMANT** must inform the plan when there is a separation of employment.

- **CLAIMANT** must appeal any denials or termination of benefits by the plan within 30 days.

- **CLAIMANT** is responsible to immediately pay back to the State any over-payments received.

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 CompuSys/Erisa Group, Inc. immediately upon receipt. The final grades must also be submitted to CompuSys/Erisa Group, Inc.

- If a State employee or a Local Public Body 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 <u>only</u>**, monthly disability *premiums* to:

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

    Premium payments must be clearly marked with "Disability Monthly Premium."

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** 2013 (Eighteenth Edition) published by Work Loss Data Institute.

- **CLAIMANTS** cannot perform work in any capacity while receiving Short or Long Term Disability.

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 becomes eligible for Social Security Disability, or retirement (this also includes voluntarily withdrawing your retirement funds). If this occurs, notify CompuSys/Erisa Group, Inc. immediately.

- Coverage ends on the date a claimant is denied Social Security Disability Income Benefits 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 on the date of claimant's death.
    - 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.

- 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 **ELIMINATION PERIOD**, the maximum duration of payment for Short Term Disability benefits is twenty-four (24) weeks.

    - Following the **ELIMINATION PERIOD**, the maximum duration of payment for Long Term Disability benefits is two (2) years.

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 assign a medical case manager and request independent medical examinations at the cost of the plan.

- 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.

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 CompuSys/Erisa Group, 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 CompuSys/Erisa Group, 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 NE Albuquerque, NM 87110
Employer Identification Number:	85-6003005
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
Plan Year:	July 1, 2013 through December 31, 2014
Agent for Legal Services and Address:	Director, RMD State of New Mexico General Services Dept. Employee Benefits Bureau, Joseph M. Montoya Building Suite 2081, 1100 St. Francis Drive Santa Fe, NM 87502-0110 (505) 827-0442

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:

- 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

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 to 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 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 benefit payment begins.

EMPLOYER means the 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.

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

1. Employee's Name:	2. Home Phone #	3. Employees DOB	4. Employees SS#
_____	( ) -	/ /	- -

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

City, State, Zip_____

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

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

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:

14. Have you filed a Worker's Compensation claim? ☐ Yes ☐ No
Do you intend to file a Work Comp claim? ☐ Yes ☐ No

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.

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:** / /