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.
**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.

<table>
<thead>
<tr>
<th>1. Agency Name and Address:</th>
<th>2. Employees Name:</th>
<th>3. Employees DOB</th>
<th>4. Employees SS#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home Phone: (  ) -</td>
<td>/ /</td>
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</table>

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

   Full Time ________ Part Time ___________

14. Has employee returned to work? If yes, date

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 ( ) -

Date Signed / / 

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

Email address: __________________________
### Disability Claim Form

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

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

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**EMPLEESS TO COMPLETE (PLEASE PRINT)**  
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</table>

6.  
- a. Height________   
- b. Weight________

5. Employee’s Address:  
Street/Box/Apt.________________________________________________________

City, State, Zip___________________________________________

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?  
- Yes  
- No

10. Have you returned to work?  
- Yes  
- No

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

If 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.

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.

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

### Name of Patient
- **Date of Birth**
- **Social Security Number**

<table>
<thead>
<tr>
<th>a) When did symptoms first appear or illness/accident happen?</th>
<th>b) Date you advised your patient to stop working.</th>
<th>c) Has patient ever had same or similar condition?</th>
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<td>If yes, state when and describe.</td>
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<tr>
<th>d) Is condition due to injury or sickness arising out of patient’s employment?</th>
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<tbody>
<tr>
<td>□ Yes   □ No   □ Unknown</td>
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</table>

<table>
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<tr>
<th>a) Date of last examination</th>
<th>b) Diagnosis (including any complications) &amp; ICD9 Code</th>
<th>c) Subjective Symptoms</th>
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<tr>
<th>d) Objective findings (including current x-rays, EKG’s, laboratory data and any clinical findings)</th>
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<table>
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<tr>
<th>a) Date of first visit for this illness or injury.</th>
<th>b) Date of last visit</th>
<th>c) Date of next visit</th>
<th>d) frequency of visits</th>
</tr>
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</table>

### Nature of Treatment (including surgery and medications prescribed, if any)
- **a) Has patient**
- **□ Recovered**
- **□ Improved**
- **□ Unchanged**
- **□ Regressed**

### Progress
- **a) Has patient been hospital confined?**
- **□ Yes**
- **□ No**

### Treated/ Diagnosed
- **a) Date of first visit for this illness or injury.**
- **b) Date of last visit**
- **c) Date of next visit**
- **d) Frequency of visits**

### Cardiac (if applicable)
- **a) Functional Capacity**
  - □ Class 1 (no limitation)
  - □ Class 3 (marked limitation)
  - □ Class 2 (slight limitation)
  - □ Class 4 (complete limitation)
- **b) Therapeutic Class (Activity)**
  - □ A. (no restrict.)
  - □ B. (slight restrict.)
  - □ C. (moderate 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:**

### Mental Impairment (if applicable)
- **a) 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:

### Tax ID Number
- **SIGNATURE:**
- **Date:** / /