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

1. Employer: Fully complete section "For Employer To Complete." Page 1, answering all questions**. REMEMBER TO FORWARD VIA FAX, COPIES OF EMPLOYEES PAY STUBS SHOWING DISABILITY PREMIUM PAYMENTS, WAGES PAID, AND LEAVE BALANCES AFTER THE 30 DAY ELIMINATION PERIOD IS OVER PER QUESTION 16 ON EMPLOYER APPLICATION.**

2. Employee: Fully complete and sign the "Authorization," page This will allow the State of New Mexico Risk Management Division to secure additional information (if necessary) to make a decision on your claim. Fully complete section "For Employee To Complete," page 3 answering all questions.

3. Have the attending physician complete the section "Attending Physician". Before giving the form to the physician, complete the top line with your name, date of birth and social security number.

4. When all sections of this form have been completed, send it to the State of New Mexico Risk Management Division office by mail, e-mail or by fax. If you FAX the claim, do not mail the original to the State of New Mexico Risk Management Division. The e-mail address is Jennifer.beebe@state.nm.us The FAX number is 505-827-2843.

Employer/Employee Notice

Please inform The State of New Mexico Risk Management Department of any scheduled or actual return to work date as soon as possible by calling our office at (505) 827-0414, faxing notification to 505-827-2843, or email Jennifer at Jennifer.beebe@state.nm.us.

If The State of New Mexico Risk Management Department extends benefits beyond the actual return to work date, the amount overpaid must be returned to the State of New Mexico Risk Management Division. **You MUST forward copies of employees pay stub showing annual leave, sick leave or compensatory leave taken. Please make appropriate changes to employees 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. The State of New Mexico Risk Management Department 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.

Mail To: State of New Mexico
RMD – Disability Division
1100 St. Francis Dr., Room 2073
PO Drawer 26110
Santa Fe, NM 87502-0110

Disability Claim Form

Claim Questions: 505-827-0414; Toll Free 1-877-301-8043; Tax Questions: 505-827-0414; FAX TO: 505-827-2843

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

10a. How was employee paid? (Please check one)
☐ Hourly ☐ Salaried
10b. Year to Date Earnings (For FICA Deductions)_______________
10c. Tax Exemptions (W4 Form)______

11. Wages prior to date last worked: (refer to earnings definition in your contract)
Hourly wage $____________________
Salary $__________________________

12. Date of Last Salary Increase

13. Employees work schedule time last worked
Days per week_______Hours per week_______

13a. Date last worked_______________
13b. Number of hours worked that day_______________
13c. Date paid through______________For ☐ Annual Leave ☐ Donated Leave ☐ Accrued Sick Leave

14. Has employee returned to work? If yes, date
Full Time___________ Part Time__________

15a. Are you as the employer able to accommodate the employee's restrictions and limitations, if appropriate, for an early return to work? (i.e. job modification, part time, ect.) Please elaborate.

15b. Please submit a copy of employee's job description if expected to be out of work for more than 6 weeks.

16. Sick Pay Calculation For Timesheet Entry: Date Last Worked ___________ + 30 Day Elimination Period = _______________
Date to start reducing employees sick/annual/comp leave on timesheet if eligible for Disability Payments.
First 6 Weeks After Elimination Period: $125 /(Divided By) Employees Hourly Wage = ______hours to be reduced on Timesheet
Weeks 7-21 After Elimination Period: $175 (Divided By) Employees Hourly Wage = _______hours to be reduced on Timesheet

17. Is employee eligible for:	YES	NO	If yes, amount?	Weekly	Monthly	Provider/Carrier name:	Date Began	Date Through
Annual Leave	☐	☐	$______________	☐	☐		___/___/___	___/___/___
Other Disability	☐	☐	$______________	☐	☐	________________________	___/___/___	___/___/___
Disability Pension	☐	☐	$______________	☐	☐	________________________	___/___/___	___/___/___
Retirement Pension	☐	☐	$______________	☐	☐	________________________	___/___/___	___/___/___
Auto No Fault	☐	☐	$______________	☐	☐	________________________	___/___/___	___/___/___
Social Security	☐	☐	$______________	☐	☐	________________________	___/___/___	___/___/___
Other Benefits	☐	☐	$______________	☐	☐	________________________	___/___/___	___/___/___

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**

Person completing this form please print or type name and title

Telephone Number ( ) -

Signature (the above statements are true and complete to the best of my knowledge)

X____

/ /
Date Signed

FAX NUMBER ( ) -

WHEN FAXING INSERT THIS END

Disability Claim Form

State of New Mexico
RMD – Disability Division
1100 St. Francis Dr., Room 2073
PO Drawer 26110
Santa Fe, NM 87502-0110

Claim Questions: 505-827-0414; Toll Free 1-877-301-8041; Tax Questions: 505-827-0414; FAX TO: 505-827-2843

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

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

5. Employees Address:
Street/Box/Apt.______________________
City, State, Zip______________________

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

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 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 filing 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. Have you ever had the same or a similar condition in the past? ☐ Yes ☐ No

Hospital Name:______________________ Street_____________________ City______________State_______Zip__________
Doctor Name:______________________ Street_____________________ City______________State_______Zip__________

If yes, give the name and address of hospital and doctor above.

18a.If you are married: Spouse's name___________________ Spouse's Date of Birth____/____/____ Spouse employed? ☐Yes ☐ No

18b.List your children who are under age 25:	Date of Birth	Married?	Attending High School?
______________________	____/____/____	☐ Yes ☐ No	☐ Yes ☐ No
______________________	____/____/____	☐ Yes ☐ No	☐ Yes ☐ No

19. If your request for benefits is approved, benefits will be subject to federal and state income tax withholdings.

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

Signature:X________________________________ **Date:**______/_______/_________

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 Risk Management Division Non-Occupational Disability Claims Unit, 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 of New Mexico 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

Address____

____

Optional Authorization (Authorization to provide information to your employer)

You are not required to sign this authorization in order to submit a claim for disability benefits to The State of New Mexico, RMD.

I (employee's name)________________________ authorize The State of New Mexico Risk Management Division to disclose or furnish to **my employer** any and all information in The State of New Mexico Risk Managements' possession including HIV, ARC, and AIDS test results, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records that may be requested with respect to any illness including mental illness, drug/alcohol abuse and injury. My employer will not disclose to any third party any information received from The State of New Mexico pursuant to this authorization without my express written consent.

A photostatic copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

X________________________ ________/________/________

Signature **Date**

Physician Form

The State of New Mexico RMD - Disability Benefit Services
1100 St. Francis Dr., Room 2073, PO Drawer 26110, Santa Fe, NM 87502-0110

Claim Questions: 505-827-0414 or Toll Free 1-877-301-8041 FAX TO: 505-827-2843

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

History

a) When did symptoms first appear or accident happen? / /	b) Date you advised your patient to stop working. / /	c) Has patient ever had same or similar condition? Yes No	If yes, state when and describe
d) Is condition due to injury or sickness arising out of patients employment? **Yes** **No** **Unknown**		e) Names and address of other treating physicians	

Diagnosis

a) Date of last examination / /	b)Diagnosis (including any complications) Inc. ICD9	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 & Method / /

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)

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

c) If unchanged or retrogressed, 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 restric.) ☐ C.(moderate restric.) ☐B.(slight restric.) ☐ D.(marked restric.) ☐ E.(complete restric.)	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:

Prognosis

a) Does patient currently have limitations/restrictions? Patients Occupation: ☐Yes ☐No Any Other Work ☐Yes ☐No	b) Describe specific limitations and restrictions
c) If employer is able to accommodate patients 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)		**Degree**		**Telephone Number** ( ) --
Street Address	**City or Town**	**State or Province**	**Zip Code**	**Fax Number** ( ) --

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