ADMINISTRATIVE PROCEDURES

Procedure Number: 23-8

Effective Date: 03/01/1999
Revision Date: 07/31/2013

C. Dahlberg
County Administrator

SUBJECT: **LONG TERM DISABILITY (LTD) PROGRAM**

DEPARTMENT RESPONSIBLE: **Human Resources Department**

I. STATEMENT

The purpose of this procedure is to assist departments in initiating Long Term Disability for an eligible employee who will be off work longer than six months due to an illness or injury.

II. ELIGIBILITY CRITERIA

A. Eligible Employees

1. Any employee who is a member of the Arizona State Retirement System (ASRS); and

2. The employee's illness or injury occurred while employed by Pima County; and

3. The employee is under the care of a licensed physician; and

4. The employee is unable to perform one or more of the job duties for which he/she was hired.

B. Ineligible Employees

1. Active plan members from the Public Safety Personnel Retirement System, the Elected Officials Retirement Plan, the University Optional Retirement Plan or the Correction Officers' Retirement Plan.

2. A participant who is already receiving retirement benefits from ASRS.

3. A participant who withdraws employee contributions with interest and ceases to be a member of the plan.

4. A participant who files an initial claim for disability benefits more than twelve months after the date of disability, unless they can show good cause for filing late.

III. PROCEDURES

A. Initial Contact Requirements

1. When the employee has been unable to work due to sickness or injury or has been working limited duty/hours and/or restrictions for "two consecutive months", it is the Department's responsibility to notify Human Resources Benefits Division to send out the Long Term Disability Plan Benefits information to the employee.

2. The employee may apply for Long Term Disability as soon as he/she is aware that his/her disability may result in him/her being off work longer than six months.

3. If the employee chooses to apply for Long Term Disability after reviewing the LTD Plan Benefit information, he/she must contact Human Resources to request the LTD claim packet. (Attachments B-1 through B-9)

4. The employee must satisfy the six-month waiting period as follows:
   a. Off work during a six-month waiting period; or
   b. Working in a less strenuous occupation (restructured/modified duties) as deemed by a licensed physician; or
   c. Working 20 hours or less per week. The employee may use annual or sick leave and, if eligible, receive donated time during the waiting period.
   d. Refer to Administrative Procedure 23-4 Leave of Absence – Insurance Procedures, for election and payment of health and life insurance.

B. Application for Long Term Disability – Department

1. "Long Term Disability Income Plan, Employer's Notice of Claim" form and Physical / Non Physical Aspects of Job (Attachment A) – the department Director or designee must complete this form and supply the requested information. A signature of the person completing the form is required.

2. "Job Description and Requirements" – In cases where the employee is/was working modified duties/hour and/or restrictions, a memo with a description of the modified duties/hours and/or restrictions the beginning and ending dates the modified duties are/were being performed must be submitted.

3. Submit any documentation in the employee's file from physicians excusing the employee from work, reducing hours or modifying duties in relation to the disability.

IV. RESPONSIBILITIES

A. Department shall:

1. Notify Human Resources to send out the Long Term Disability Plan Benefit information no later than two months of an employee being unable to work due to sickness or injury or has been working limited duty/hours

2. Complete the Long Term Disability Employee's Notice Claim forms within ten (10) working days.

3. Return the forms and requested information to the Long Term Disability representative in Human Resources Benefits.

B. Employee shall:

1. Contact Human Resources to request the Long Term Disability claim packet.

2. Submit all completed Employee Claim Forms (Attachments B1 through B8) to the Long Term Disability Representative in Human Resources Benefits.

3. Immediately resign from County employment upon receiving approval notification of his/her Long Term Disability coverage.

4. The Long Term Disability employee may be eligible for a Premium Benefits (subsidy) reimbursement from one ASRS. In this case, the LTD participant will need to notify Human Resources if health benefits are continued under Consolidated Omnibus Budget Reconciliation Act (COBRA).

C. Human Resources Benefits shall:

1. Inform the employee of the eligibility and waiting period requirements for Long Term Disability

2. Assist the employee in completing the necessary forms.

3. Obtain the official County Job Classification Specification to be submitted with Long Term Disability application.

4. Obtain copies of all Time and Attendance Forms (TAF's) from Central Payroll from the date of disability through the date of submission to the Long Term Disability Administrator.

5. Compile forms, verify information, and send the application to the ASRS Long Term Disability Administrator.

6. Notify the department when a decision has been reached regarding the application.

7. Notify the employee and advise of the COBRA process for health insurance continuation.

8. Notify the appropriate State retirement system, if the LTD member elects COBRA and makes the first payment, to determine eligibility for Premium Benefit (subsidy) reimbursement.

9. After the County has received the subsidy payment from the retirement system, the County will reimburse the LTD member the subsidy amount provided the LTD member has made the COBRA premium payment in full.

Attachment A
Page 1

ARIZONA STATE RETIREMENT SYSTEM
LONG-TERM DISABILITY INCOME PLAN
EMPLOYER'S NOTICE OF CLAIM

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Employer's Notice of Claim
Be sure to answer all questions
Please type or print
Fax completed forms to: (818) 591 7664

MAILING ADDRESS
SEDGWICK
P.O. Box 9830
Calabasas, CA 91372 - 0830

TO BE COMPLETED BY THE EMPLOYER New claim: ☐ Yes ☐ No

1. Full name of employee (Please print)
2. Date employed
3. Effective date of protection under ASRS plan
4. Social Security number
5. Employer's normal work schedule in a fiscal year
   A. Period(s) covered by contract
   B. ___ Days per week ___ Hours per day
   If you are a school district, has claimant signed a contract for the next school year? ☐ Yes ☐ No
   Number of Pay periods per year ___
6. Amount of salary as of date disability began for purpose of ASRS:
   $ _____ Gross Monthly Salary
   (If school district give 1/12th of the annualized compensation)
7. Date last worked (no. of hours that date)
   ___ hrs
8. Reason for not working after this date
9. Date disability began
10. Did this disability occur as a result of the claimant's employment? ☐ Yes ☐ No ☐ Currently disputed
    If "Yes," or under dispute, please provide us with the policy number, name, address and phone number of Workers Compensation administrator
11. Have you and the claimant discussed reasonable accommodations which would allow a return to work? ☐ Yes ☐ No
    If "Yes" please explain
12. Has employee resigned or been terminated? ☐ Yes ☐ No If "Yes" please give exact date.
13. Has employee returned to work? ☐ Yes ☐ No Current work schedule
    ☐ Regular duties ☐ With restrictions If "Yes" on what date? Days per week Hours per day
14. Has the employee ever made a prior claim for benefits?
    ☐ Yes ☐ No (If "Yes" please provide date returned to work.)
15. Sick leave end date
16. Vacation pay end date
17. Is the employee receiving donated leave? ☐ Yes ☐ No
    If "Yes" please indicate how much they are receiving per pay period: _____ and the end date
18. Is the employee receiving Short - Term Disability or Mid Term Disability? ☐ Yes ☐ No
    If "Yes," are the premiums paid by the ☐ Employee or ☐ Employer? If by the employer, please complete Question 19
19. To the best of your knowledge, is the employee receiving, or is he entitled to receive, benefits from any other source such as a salary continuance plan, other group insurance, Workers' Compensation, Social Security, Veterans Administration, retirement or pension plan, etc? ☐ Yes ☐ No If "Yes," please furnish the following information:

Name and Address Of Source	Group or Individual Basis	Policy or Claim Number, If Any	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits Paid

20. Remarks

Client - Plan No 401 / 401000
ASRS Employer No 210200 (Six Digit Code)
Telephone No (520) 724-2798
Fax No (520) 724-8150
E-mail Address pam.shimek@pima.gov

Employer Name Pima County Government
Contact Title
Signature
Date
Pima County LTD Administrator: **PAMELA SHIMEK**

SEDGWICK ER FORM FEBRUARY 2013

Attachment A
Page 2

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Employer Claim Statement – Part 2
Physical / Non Physical Aspects of Job

Please complete this section of the claim statement to provide us with information concerning the physical / non physical demands of the claimant's job.

Claimant's Occupation: _____

Signature / Title _____ Date _____

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. Hours	May Alternate Positions: At Will	15-30 Minutes	Hourly	Never
Sitting	____	☐	☐	☐	☐
Standing	____	☐	☐	☐	☐
Walking	____	☐	☐	☐	☐
Driving	____	☐	☐	☐	☐

2.

Claimant must		Never	Occasionally (½ - 2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ -8 hours)
A. Bend/Stoop		☐	☐	☐	☐
B. Climb		☐	☐	☐	☐
C. Reach above shoulder level		☐	☐	☐	☐
D. Kneel		☐	☐	☐	☐
E. Balance		☐	☐	☐	☐
F. Enter data/keystroke		☐	☐	☐	☐
G. Squat		☐	☐	☐	☐
H. Crawl		☐	☐	☐	☐
I. Crouch		☐	☐	☐	☐
J. Lift:	Usual ____ lbs.	☐	☐	☐	☐
	Max ____ lbs.	☐	☐	☐	☐
K. Carry	Usual ____ lbs.	☐	☐	☐	☐
	Max ____ lbs.	☐	☐	☐	☐
L. Push/Pull	Usual ____ lbs.	☐	☐	☐	☐
	Max ____ lbs.	☐	☐	☐	☐

3. On the job, claimant uses feet repetitive movements as in operating foot controls.
Right ☐ Yes ☐ No Left ☐ Yes ☐ No Both ☐ Yes ☐ No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	☐	☐	☐
B. Left	☐	☐	☐

5. Does job require:
A. Working at unguarded heights? ☐ Yes ☐ No
B. Exposure to marked changes in temperature and humidity or extremes thereof? ☐ Yes ☐ No
C. Exposure to dust, fumes, gases, chemicals? ☐ Yes ☐ No

Stress / Non Physical

1. Percentage of time claimant spends answering customer complaints. ____ %
2. Percentage of claimant's work primarily judged on production. ____ %
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks? ☐ Yes ☐ No ____ % of time
4. How many employees does this claimant supervise? _____
5. Is this claimant routinely subject to close supervision? ☐ Yes ☐ No
6. Percentage of time spent by the claimant working with his/her co-workers. ____ %
7. Percentage of claimant's time spent on: ____ % Prescheduled activities ____ % Random activities
8. Percentage of time claimant spends meeting deadlines set by others. ____ %
9. Percentage of responsibility the claimant has for the performance of his/her particular department. ____ %

Attachment B-1
Page 1

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Long Term Disability Employee Claim Statement

TO BE COMPLETED BY THE EMPLOYEE New claim ☐ Yes ☐ No

1. Full name of employee (Please print) ☐ Male ☐ Female
2. Date of Birth
3. Social Security number
4. Marital status ☐ Single ☐ Widowed ☐ Married ☐ Divorced
5. Employer
6. Date on which you were first unable to work
7. If still totally disabled, where do you expect to return to work?
8. Occupation
9. Have you engaged in any work, part time or otherwise, since your sickness or injury began? ☐ Yes ☐ No (If "Yes" please explain and give dates.)
10. Names and birth dates of spouse and of all dependent children under age 18
11. If you have recovered or returned to work, give date.
12. Are you receiving or have you applied for benefits from any of the following?

	Yes	No
1. Social Security Disability?	☐	☐
2. Social Security or Railroad Retirement?	☐	☐
3. Sick pay/Vacation pay from your employer?	☐	☐
4. Arizona State Retirement System?	☐	☐
5. Veterans Administration?	☐	☐
6. Workers' Compensation?	☐	☐
7. Short Term Disability?	☐	☐
8. Unemployment Benefits?	☐	☐
9. Other?	☐	☐

For each question answered "Yes" please furnish the following information:

Name and Address of Source	Group or Individual Basis	Policy or Claim Number if any	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits

For Social Security, Workers' Compensation, State Disability and other similar benefits, please furnish a copy of the benefit award (or denial letter, if applicable.)

Training, Education & Experience - For possible Rehabilitation services

14. What is your level of education?
    A. Have you received a high school diploma or the equivalent of a high school diploma? ☐ Yes ☐ No
    If "No" please advise us of the last grade completed _____ grade
    B. Have you attended college? ☐ Yes ☐ No If yes, please check one: ☐ Some college ☐ College graduate ☐ Post graduate
    Please specify: Major field of study _____ Degree earned _____
    Date last attended _____
    C. Have you attended any trade schools or received any other special training? ☐ Yes ☐ No
    Please specify: Type of training _____
    Date last attended _____
15. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.
16. Please list names, addresses and inclusive dates of employers you have worked for the past three years.

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17 What was your occupation when disability commenced and what were the usual duties of your occupation?

18 Which of the above jobs does you unable to perform?

19 Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor? ☐ Yes ☐ No

20 Have you asked your employer to provide any accommodations, which would allow you to return to work? ☐ Yes ☐ No If "Yes," what accommodations did you request and what was your employer's response?

21 What accommodations do you feel could be made by your employer to allow you to return to work?

22 Have you considered retraining? ☐ Yes ☐ No If "Yes" what vocational area(s) would interest you?

Authorization to Release Information

I certify all of the information on the Employee's Statement (#'s 1-22) is to the best of my knowledge true, correct and complete. I hereby authorize the use or disclosure of my personal health information upon request by Sedgwick from the following authorized persons or organizations: United Health Care, Aetna, Cigna, Blue Cross Blue Shield, AmeriBen, and Assurant Employee Benefits. I hereby further authorize the above persons or organizations, any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, Claims Administrator, and my employer(s) to disclose or furnish to Sedgwick, my employer, or any of their authorized representatives, all facts concerning my medical condition and disability (including physical, mental health, alcohol, substance abuse and HIV related information), wages or earnings and other benefit/pension information, that are within their knowledge and to allow inspection of and provide copies of any medical records (including diagnosis, prognosis, prescriptions or medication, psychiatric, drug or alcohol abuse treatment). I understand that this information will be used to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer, which requires evaluation for physician or mental condition, including, but not limited to, a leave from work for medical reasons. I further authorize disclosure of my personal health information to others by Sedgwick, my employer, or any of their authorized representatives. In order to determine my eligibility for, process, evaluate and administer all claims for benefits or compensation for which I may be entitled. I acknowledge my right to make a copy of this authorization. I understand this authorization is valid for the duration of my claim for disability benefits or twenty-four months, whichever is earlier. A photocopy of this authorization is as valid as the original. I may revoke this authorization at any time before its expiration date by notifying Sedgwick in writing, but the revocation will not have any affect on any actions the party took before it received the revocation. I understand that my personal health information may be released to others in accordance with the terms of this release.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Signature _____ Date Signed _____ ( ) _____ Phone Number

Address _____ City or town, State _____ Zip code _____

Name of Person Representative who has Authority to Sign on Behalf of the Employee _____ Signature of Personal Representative who has Authority to Sign on Behalf of the Employee _____

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Long Term Disability Employee Claim Statement

TO BE COMPLETED BY THE EMPLOYEE

1. Nature of sickness or injury (if due to accident, explain when, where and how it happened)

2. Date of first medical treatment for the condition

If pregnancy, provide expected or actual delivery date

3. Have you been confined to a hospital for this disability? ☐ Yes ☐ No (If "Yes" please complete.)

Name of Hospital	City	From:	Through

4. Name and addresses of all physicians who have been consulted because of this condition

Name	Address, Phone & Fax	Dates of Consultation or Treatment

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AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

YOUR CLAIM FOR DISABILITY BENEFITS CANNOT BE PROCESSED WITHOUT THIS FORM

Employee Name:		**Date of Birth:**
Employer Name: Arizona State Retirement System		
Plan Number: 401000	**Plan Name:** Arizona State Retirement System - LTD	
Last Date Worked:	**First Date Unable to Work:**	**Date:**

COMPLETE THE STEPS BELOW AND RETURN THIS FORM TO SEDGWICK IMMEDIATELY:

STEP 1: Please complete the information above and then sign and date in the spaces provided below.

STEP 2: You should also provide a copy of this form to your doctor's office as they may require a copy of this form in order to provide SEDGWICK information regarding your disability. Failure to complete this completed form can impede the investigation or processing of your claim and may result in a delay or denial of benefits.

If you have questions regarding your claim, visit us on the web at www.SEDGWICKinc.com or call us at (800)495-9301.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify all of the information above (except as corrected) is to the best of my knowledge true, correct and complete. I hereby authorize the use or disclosure of my personal health information upon request by Sedgwick from the following authorized persons or organizations: Workers' Compensation Carrier, Long-Term Disability Carrier, and Health Carrier. I hereby further authorize the above persons or organizations, any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, claims administrator, and my employer(s) to disclose or furnish to SEDGWICK, my employer, or any of their authorized representatives, all facts concerning my medical condition and disability (including physical, mental health, alcohol, substance abuse and HIV related information), wages or earnings, that are within their knowledge and to allow inspection of and provide copies of any medical records (including diagnosis, prognosis, prescriptions or medication, psychiatric, drug or alcohol abuse treatment). I understand that this information will be used to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer, which requires evaluation for physical or mental condition, including, but not limited to, a leave from work for medical reasons. I further authorize disclosure of my personal health information to others by SEDGWICK, my employer, or any of their authorized representatives, in order to determine my eligibility for, process, evaluate and administer all claims for benefits or compensation for which I may be entitled. I acknowledge my right to make a copy of this authorization. I understand this authorization is valid for the duration of my claim for disability benefits or twenty-four months, whichever is earlier. A photocopy of this authorization is as valid as the original.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I may revoke this authorization at any time before its expiration date by notifying Sedgwick in writing, but the revocation will not have any affect on any actions the party took before it received the revocation. I understand that my personal health information may be released to others in accordance with the terms of this release.

Employee's Signature	Date Signed
Name of Personal Representative who has Authority to Sign on Behalf of the Employee	Signature of Personal Representative who has Authority to Sign on Behalf of the Employee

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Page 1

Employee Consent To Pima County's Disclosure of Employment Information and Release of Liability

I, _____ (print name), authorize and give my consent for Pima County Government (PCG) to release any information regarding my education, training, experience, and job performance, including, but not limited to, the reason for any termination, professional conduct and evaluation, if contacted by:

Provide name of specific carrier:
Sedgwick
Humana Life Insurance

Or:

Any prospective employer (initial if desired) _____

According to Arizona Revised Statutes §23-1361, a copy of which appears on the reverse side, any employer that provides written communication regarding my current employment must send me a copy at my last known address. I acknowledge that some supervisors may be unwilling to provide factual written references concerning a current or past employee unless they may do so confidentially, without revealing the references to the employee.

I waive_____/do not waive _____ (initial only one) my right to receive a copy of any written communication furnished by PCG.

Whether or not I have waived my right to see or to receive copies of written references furnished by PCG, I release, hold harmless and agree not to sue or file any claim of any kind against PCG or any current or former officer, agent or employee of PCG, who in good faith, furnishes written or oral references to a prospective employer.

A photocopy or facsimile ("fax") copy of this form that shows my signature shall be as valid as an original.

_____ _____
Current/Prior Employee **Date**

_____
Address: (if a copy of written communication is desired)

_____
(Street, PO Box, or Apartment number)

_____
City, State, Zip Code)

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Page 1

STANDARD AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is not valid for pre-enrollment activities.

NAME OF MEMBER WHOSE PROTECTED HEALTH INFORMATION WILL BE DISCLOSED:
Last Name, First Name (please print) _____
Member SS Number _____

MEMBER INFORMATION TO BE USED OR DISCLOSED

☐ By checking this box, I allow the person noted below to act upon and/or make changes to my member information (e.g., primary care physician change, change in network, residential address/telephone change*).

☐ By checking this box, I allow for only use and disclosure of the following member information (e.g., certain claims from a provider with specified dates of service, all information held by the Insurer, etc.). Please list

_____

*Only address and telephone changes in the same county will be accepted from member with this form.

Important: This authorization excludes enrollment and disenrollment purposes in which case a valid Power of Attorney must be on file.

NAME OF PERSON TO WHOM THE INFORMATION WILL BE DISCLOSED:
Last Name, First Name (please print) _____
If the disclosure is intended for a class or group of individuals rather than a specific individual, please indicate that here (for example, the staff of an office, a company, etc.)

_____

EXPIRATION: This authorization is valid from _____ to _____ or for the period of time or event noted below (for example, an event might be as long as the member remains a member)

_____

REVOCATION OF AUTHORIZATION: As stated in Pima County Notice of Privacy Practices, you have the right to revoke this authorization except for instances that have already taken action based on the authorization. Your revocation must be mailed to:

Human Resources
150 W. Congress, 4th Floor Benefits
Tucson, AZ 85701

You may also notify the Human Resources department by calling (520) 724-8464 during normal business hours and request to revoke this authorization.

CONSEQUENCES OF THIS AUTHORIZATION: Please be advised that once Member Information is disclosed to the authorized individual, there is a potential for it to be re-disclosed by the recipient and no longer protected.

By signing below, I am indicating that, at my request, I am voluntarily agreeing to allow Human Resources employees whose duties involve handling the member information indicated above to disclose my confidential member information to the person designated above. I understand that Human Resources may not condition (withhold) treatment, payment, enrollment, or eligibility of benefits as a result of this authorization.

SIGNATURE(S):
Signature of Member _____ Signature Date _____

If you are a lawful personal representative of the member and are acting on his/her behalf, please sign below.

NAME OF CUSTOMER OR REPRESENTATIVE (IF APPLICABLE):
Last Name, First Name (please print) _____
Signature of Custodian or Representative: _____
Signature Date _____

Description of Authority to act on behalf of the member (for example, Power of Attorney on file or legal guardian of minor).

_____

Attachment B-5
Page 1

Form W-4 (2013)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2013

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2013, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2013)

Attachment B-5
Page 2

Deductions and Adjustments Worksheet

Note. Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2013 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1949) of your income, and miscellaneous deductions. For 2013, you may have to reduce your itemized deductions if your income is over $300,000 and you are married filing jointly or are a qualifying widow(er), $275,000 if you are head of household, $250,000 if you are single and not head of household or a qualifying widow(er), or $150,000 if you are married filing separately. See Pub. 505 for details . . . 1 $

2 Enter: $12,200 if married filing jointly or qualifying widow(er); $8,950 if head of household; $6,100 if single or married filing separately . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . 3 $

4 Enter an estimate of your 2013 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2013 Form W-4* worksheet in Pub. 505.) . . . 5 $

6 Enter an estimate of your 2013 nonwage income (such as dividends or interest) . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . 7 $

8 **Divide** the amount on line 7 by $3,900 and enter the result here. Drop any fraction . . . 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet only if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" . . . 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . 3

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . 4

5 Enter the number from line 1 of this worksheet . . . 5

6 **Subtract** line 5 from line 4 . . . 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2013. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2013. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 13,000	1	8,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 30,000	3
26,001 - 30,000	4	30,001 - 40,000	4
30,001 - 42,000	5	40,001 - 50,000	5
42,001 - 48,000	6	50,001 - 70,000	6
48,001 - 55,000	7	70,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 75,000	9	95,001 - 120,000	9
75,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
$0 - $72,000	$590	$0 - $37,000	$590
72,001 - 130,000	980	37,001 - 80,000	980
130,001 - 200,000	1,090	80,001 - 175,000	1,090
200,001 - 348,000	1,290	175,001 - 385,000	1,290
348,001 - 385,000	1,370	385,001 and over	1,540
385,001 and over	1,540		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Attachment B-6
Page 1

ARIZONA FORM A-4

Employee's Arizona Withholding Percentage Election

2013

Type or print your full name	Your social security number
Home address (number and street or rural route)	
City or town, state, and ZIP code	

Arizona Withholding Percentage Election Options

Choose only one.

1. ☐ I choose to have Arizona withholding at the rate of
   (check only one box): ☐ 0.8% ☐ 1.3% ☐ 1.8% ☐ 2.7% ☐ 3.8% ☐ 4.2% ☐ 5.1% of my gross taxable wages
   Additional amount to be withheld per paycheck $ _____

2. ☐ I hereby elect an Arizona withholding percentage of zero, and I certify that I expect to have no Arizona tax liability for the current taxable year.

I certify that I have made the percentage election marked above.

SIGNATURE _____ DATE _____

EMPLOYEE'S INSTRUCTIONS

Arizona law requires your employer to withhold Arizona income tax from your wages for work done in Arizona. This amount is applied to your Arizona income tax due when you file your tax return. The amount withheld is a percentage of your gross taxable wages of every paycheck. You may also have your employer withhold an extra amount from each paycheck. Complete this form to select a percentage and any extra amount to be withheld from each paycheck.

What are my "Gross Taxable Wages"?

For withholding purposes, your "gross taxable wages" are the wages that will generally be in box 1 of your federal Form W-2. It is your gross wages less any pretax deductions, such as your share of health insurance premiums.

New Employees

Complete this form in the first five days of employment to select an Arizona withholding percentage. You may also have your employer withhold an extra amount from each paycheck. If you do not file this form, the department requires your employer to withhold 2.7% of your gross taxable wages.

Current Employees

If you want to change the current amount withheld, you must file this form to change the Arizona withholding percentage or change the extra amount withheld.

What Should I do With Form A-4?

Give your completed Form A-4 to your employer.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you expect to have no Arizona income tax liability for the current year. Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date you file the form. Zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. If you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should promptly file a new Form A-4 and choose a percentage that applies to you.

Voluntary Withholding Election by Certain Nonresident Employees

Compensation earned by nonresidents while physically working in Arizona for temporary periods is subject to Arizona income tax. However, under Arizona law, compensation paid to certain nonresident employees is not subject to Arizona income tax withholding. These nonresident employees need to review their situations and determine whether they should elect to have Arizona income taxes withheld from their Arizona source compensation. Nonresident employees may request that their employer withhold Arizona income taxes by completing this form to elect an Arizona withholding percentage.

ADOR 10121 (12)

Attachment B-7
Page 1

sedgwick

Direct Deposit Authorization

PART 1: To be Completed by Employee

Employer: ARIZONA STATE RETIREMENT SYSTEM

Employee: First Name _____ Middle Initial ____ Last Name _____

SSN: _____

Agreement

I authorize Sedgwick and my Employer, at their discretion, to deposit my approved disability benefit payments into my account as indicated below.

This authorization will remain in effect until I give written notice to Sedgwick either to change or cancel this authorization, in such time and in such manner as to afford Sedgwick a reasonable opportunity to act on it. I understand that my deposit will not be posted to my account until the date of my monthly benefit payment.

I have provided Sedgwick with my financial institution information solely for the purpose of verifying my account number and transit/routing information.

I grant Sedgwick and my Employer the right to correct any Electronic Funds Transfer resulting from erroneous overpayment by debiting my accounts to the extent of such overpayment. I further understand that Sedgwick or my Employer is not responsible for any costs or service charges incurred by me as a result of Sedgwick's actions related to Electronic Funds Transfer.

Action Requested

- ☐ Please establish a **NEW** direct deposit to the bank and account listed below.
- ☐ Please **CHANGE** my direct deposit, and direct my benefit payments to the bank and account listed below.
- ☐ Please **CANCEL** the direct deposit of my benefit payments to the bank and account listed below and send my benefit payment check to me in the mail.

_____ Employee Signature _____ Date

PART 2: Financial Institution Information

Name of Financial Institution: _____

Routing #: ☐☐☐☐☐☐☐☐☐ Telephone #: (☐☐☐)☐☐☐-☐☐☐☐

Account #: ☐☐☐☐☐☐☐☐☐☐☐☐ Type of Account: ☐ Checking ☐ Savings

After completing this form, please **fax it to Sedgwick at (818) 591-7664** or mail it to **Sedgwick, PO Box 9830, Calabasas, CA 91372-0830**. Sedgwick only needs one copy of this form, so please choose one method of delivery only.

Attachment B-8
Page 1

sedgwick

Attending Physician's Statement of Disability

The patient is responsible for the completion of this form without expense to Sedgwick

PART ONE: TO BE COMPLETED BY EMPLOYEE PRIOR TO PROVIDING TO PHYSICIAN TO COMPLETE

Employee Name (last name, first name, middle initial) | Social Security Number

Employee Street Address | Apt/Suite/Bldg No | City | State | Zip Code | Country | Telephone Number

Participating Employer | Date of Birth

I certify all of the information above (except as corrected) is to the best of my knowledge true, correct and complete. I hereby authorize the use or disclosure of my personal health information upon request by Sedgwick from the following authorized persons or organizations: Pacific Care, Inc., and Cigna, Inc. I hereby further authorize the above persons or organizations, any physicians, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, claims administrator, and my employer(s) to disclose or furnish to Sedgwick, my employer, or any of their authorized representatives, all facts concerning my medical condition and disability (including physical, mental health, alcohol, substance abuse and HIV related information), wages or earnings that are within their knowledge and to allow inspection of and provide copies of any medical records (including diagnosis, prognosis, prescriptions or medications, psychiatric, drug or alcohol abuse treatment). I understand that this information will be used to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer, which requires an absence for physical or mental condition, including, but not limited to, a leave from work for medical reasons. I further authorize disclosure of my personal health information to others by Sedgwick, the employer, or any of their authorized representatives, in order to determine my eligibility for, process, evaluate and administer all claims for benefits or compensation for which I may be entitled. I acknowledge my right to receive a copy of this authorization. I understand that authorization is valid for the duration of my claim for disability benefits or twenty-four months, whichever is earlier. A photocopy of this authorization is as valid as the original. I may revoke this authorization at any time before its expiration date by notifying Sedgwick in writing, but the revocation will not have any effect on any actions the party took before it received the revocation. I understand that my personal health information may be released to others in accordance with the terms of this release.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member, or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Signature _____ Date Signed _____

Name of Personal Representative who has Authority to Sign on Behalf of the Employee | Signature of Personal Representative who has Authority to Sign on Behalf of the Employee

PART TWO: TO BE COMPLETED BY PHYSICIAN (Please print or type and sign and initial where indicated.)

History

Patient's symptoms result from (*Check all that apply*): ☐ Employment ☐ Illness

☐ Auto Accident (*state in which accident occurred*) _____ ☐ Other accident

☐ Pregnancy (*expected/actual delivery date*) ___/___/___ Type of delivery _____

Date symptoms first appeared ___/___/___ Patient's height _____ Weight _____

First visit of this condition ___/___/___ Last visit ___/___/___ Most recent comp exam ___/___/___

Did you recommend patient stop working? ☐ Yes ☐ No. If "Yes", when ___/___/___

Name(s) and address(es) of other treating or referring physician(s)

Hospital Name _____ Confinement dates ___/___/___ through ___/___/___

Diagnosis

Diagnoses (*including complications*)

ICD-9 code primary condition _____

ICD-9 code secondary condition _____

Subjective symptoms

Objective findings (*including results/copies of x-rays, lab tests, EKGs, MRIs and scans*)

Treatment

Describe treatment program and give dates of any surgery, medications, physical therapy or psychotherapy

Medications (*Provide dosage and frequency*)

Surgery Date/Type

Prognosis

1. Patient is expected to return to work ___/___/___ Full-time ___/___/___ Part time
2. Has patient reached maximum medical improvement? ☐ Yes ☐ No. If "No", when ___/___/___ ☐ Unknown
3. What limitations prevent the patient from returning to employment?
4. Would job modification enable patient to work with impairments? ☐ Yes ☐ No

This is a two page form – Initial and date here and continue to next page:

Physician Initials _____ Date _____

Sedgwick / P.O. Box 9830 / Calabasas, CA 91372-0830 / Phone (800) 495-9301 / Fax (818) 591-7664

Attachment B-8
Page 2

Attending Physician's Statement of Disability (Page 2 of 2) **Patient's Name** _____

Cardiac

Functional Capacity (American Heart Association) (Complete only if applicable)

☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood pressure (latest reading) _____ / _____ As of (date) _____ / _____ / _____

Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

Physical Limitations

Functional Capabilities (Complete only if applicable)

1. **In terms of an 8-hour workday, patient can** (Check full capacity for each activity)

A. Sit	Number of hours	1	2	3	4	5	6	7	8
B. Stand	Number of hours	1	2	3	4	5	6	7	8
C. Walk	Number of hours	1	2	3	4	5	6	7	8

2. **In terms of an 8-hour workday**

On the job, patient can	Not at all	Occasionally (1% to 2% hours)	Frequently (2.5% to 5%)	Continuously (5% to 8 hours)
A. Bend/Stoop	☐	☐	☐	☐
B. Climb	☐	☐	☐	☐
C. Push/Pull	☐	☐	☐	☐
D. Lift/Carry	☐	☐	☐	☐
1. Up to 10 pounds	☐	☐	☐	☐
2. 11-20 pounds	☐	☐	☐	☐
3. 21-50 pounds	☐	☐	☐	☐

Mental Impairment

Do you believe a legal guardian or conservator should be appointed for this patient? ☐ Yes ☐ No

Check appropriate response (Complete only if applicable)

Judgment	☐ No deficits noted	☐ Mildly impaired	☐ Moderately	☐ Severely	☐ Obvious impairment
Memory, short-term	☐ No deficits noted	☐ Mildly impaired	☐ Moderately	☐ Severely	☐ Obvious impairment
Memory, long term	☐ No deficits noted	☐ Mildly impaired	☐ Moderately	☐ Severely	☐ Obvious impairment
Concentration	☐ No deficits noted	☐ Mildly impaired	☐ Moderately	☐ Severely	☐ Obvious impairment
Affect	☐ Normal range	☐ Constricted			
Mood	☐ Neutral	☐ Cheerful	☐ Depressed	☐ Manic	
Psychosis	☐ No symptoms noted	☐ Delusions	☐ Thought disorder	☐ Bizarre ideas	☐ Hallucinations
Sleep	☐ Increase	☐ Decrease	☐ No change		
Appetite	☐ Increase	☐ Decrease	☐ No change		
Energy	☐ Increase ☐ Decrease	☐ No change			

Work Capabilities

Please describe fully how patient's symptoms/limitations affect ability to work, e.g., how are work schedule or duties restricted and why?

Remarks

Name

Physician's Name _____ Degree/Specialty _____

Street Address _____ Telephone Number ( ) _____

City _____ State _____ Zip code _____ Fax Number ( ) _____

Physician's Signature _____ Date ____ / ____ / ____
DO NOT PREDATE

PHYSICIAN'S LICENSE NUMBER

SEDGWICK / P.O. Box 9830 / Calabasas, CA 91372-0830 / Phone (800) 495-9301 / Fax (818) 591-7664

Attachment B-9
Page 1

ASRS LONG TERM DISABILITY (LTD) PROGRAM

Answers to Commonly Asked Questions

What are my LTD benefits?
After being off work for six months due to your disability, eligible employees will receive benefits under Arizona State Retirement System's (ASRS) Long Term Disability Income Plan (LTD) equal to 66 2/3% of your monthly earnings, less deductions for any other income you may receive.

Because the LTD plan is partially funded by your employer, 50% of any benefits that you receive will be subject to taxes.

When should I file my LTD claim?
Your LTD claim should be filed as soon as you are aware that you will be unable to perform the duties of your job position for a period of six months. You do not need to be completely out of work – time you are working limited duty, or working with restrictions, will count toward your six month period.

LTD claims must be filed within 12 months of the first date you are unable to perform all of the duties of your job, so it is important that you return your completed application packet to your employer as soon as possible.

When will I receive my LTD payments?
ASRS and Sedgwick want you to receive the LTD benefits for which you may be eligible as quickly as possible. Claim processing timeframes vary depending on what additional information is needed in order to make a decision. Sedgwick tries, whenever possible, to make a claim determination within 90 days of receipt of your application. If this is not possible, you will be notified of the delay, what information is needed, and when we anticipate a decision will be made.

Once your LTD claim has been approved, your benefits will be sent to you on a monthly basis.

Who do I call if I do not receive my check or if I have questions about my payment?
Call **Sedgwick** at (800) 495-9301 if you have *any* questions about your LTD payment.

What if I have questions about the amount of my LTD payment?
The *actual* amount of your LTD paycheck is determined by two factors:

- Sedgwick determines your LTD benefit based on your contributions made to the Arizona State Retirement System (ASRS), which is provided by the ASRS.
- Sedgwick withholds all applicable taxes and offsets (i.e., Social Security, Workers' Compensation, etc.) from your LTD payment to arrive at the *actual* amount of benefit you receive in your check. Sedgwick can tell you how your LTD benefit was calculated.

How can I check the status on my claim?
Once Sedgwick has received your completed claim packet from your employer, you can call Sedgwick's automated voice response unit at (800) 495-9301, 24 hours a day, 7 days a week to check the status on your claim. You will simply need to enter your social security number and year of birth in order to hear information on your claim. If, after listening to the voice response unit, you still have questions on your claim, you can speak to a Customer Service Representative between the hours of 5:00 a.m. and 5:00 p.m., Monday through Friday.

You can also check the status of your claim and get payment information, 24 hours a day, 7 days a week, at Sedgwick's website, www.Sedgwickcms.com/calabasas. In order to use the website, you will need your claim number (which you can get by calling Sedgwick, or by looking at the "Explanation of Benefits" portion of your benefit check), then you can log on to the "Employee" section of the website, and you will be required to create a log-in ID and password for your claim. This allows secured access to your claim information.

What do I have to do during my disability?

You have a very important role in the LTD process. After all, it's your health and your income we're talking about here. To ensure you receive all LTD benefits to which you are entitled, you must:

- Complete, sign and return the initial claim packet to your employer as soon as possible.
- See your doctor on a regular basis and have your doctor complete any Disability Progress Reports that Sedgwick sends to you.
- Stay in touch with Sedgwick and provide information as requested.

You may also be asked to file for Social Security Disability benefits. If this is the case, you will be required to pursue all appeals until you are awarded benefits or have attended a hearing before an Administrative Law Judge.

What happens if Sedgwick cannot get information from my doctor?

Since you are making the claim for LTD benefits, it is *your* responsibility to ensure that your doctor completes the Attending Physician Statement. If Sedgwick does not receive objective clinical information from your doctor that supports your disability, your LTD claim **cannot** be approved. If your doctor refuses to complete the form, then contact Sedgwick for assistance.

When do my LTD benefits end?

Your long term disability payments end on the earliest of the following dates. Benefits will not be payable beyond:

- The date you are no longer considered totally disabled under the plan.
- The date you are no longer under the direct care of a doctor or you do not provide requested satisfactory evidence of your continuing disability upon request from Sedgwick.
- The later of the following:
  - Your earliest normal retirement date according to Arizona Revised Statutes;
  - The month following sixty months of payments, if your disability occurs before age sixty-five;
  - The month following attainment of age seventy, if your disability occurs at age sixty-five but before age sixty-nine;
  - The month following twelve months of payments, if your disability occurs at or after age sixty-nine.
- The date you begin to receive retirement benefits or disability retirement benefits under the ASRS Plan or from any other retirement plan established by state law.
- The date you withdraw employee contributions with interest and cease to be a participant in the ASRS Plan.

Please Read the ASRS Long-Term Disability Brochure or Call Sedgwick at (800) 495-9301 If You Have Additional Questions.