



sedgwick®

**INSTRUCTIONS TO THE EMPLOYER UNIT
FOR COMPLETION OF THE ASRS LONG TERM DISABILITY
CLAIM PACKET**

1. After your employee has been off work or working in a limited capacity for 2 months due to their disability, please give them the Employee LTD Claim Packet to complete. The packet should contain the following:
 - a. Cover Letter
 - b. Employee Claim Statement
 - c. Request for information (ROI)
 - d. W-4
 - e. A-4
 - f. Right of Reimbursement (ROR)
 - g. Attending Physician's Statement
 - h. Answers to Commonly Asked Questions
2. Tell the employee to complete and sign the first five forms. Then, the employee will need to take the Attending Physician's Statement to their doctor's office and have their physician complete and sign those forms. Once this is done, all of the forms should be returned to you as soon as possible.
3. Once you receive a completed packet from the employee, you will need to complete and sign the Employer's Notice of Claim forms.
4. After steps 2 and 3 are done, you will need to scan and email the entire employee's packet, along with the Employer's Notice form to Sedgwick through the Employers secure email function on the ASRS website. You will need to select "LTD Documents" for the subject line. Please keep in mind the document size needs to be less than 2MB. You may also fax the packet to (818) 591-7664.
5. Sedgwick CMS will keep you informed of the status of the claim through Monthly Claims Activity Reports and with email notices of the claims when they are approved, denied or terminated. You can also call Sedgwick CMS's voice response unit at (800) 495-9301, 24 hours a day, 7 days a week, to find out the status of your employee's claim. The only information you will need is the employee's Social Security Number and year of birth. If you do not receive the information you are looking for through the voice response unit, you may call between the hours of 5:00 a.m. and 5:00 p.m. Pacific Time, Monday through Friday, to speak to a Customer Service Representative.
6. If you have any questions regarding the packet, how to complete it, etc., please feel free to call Sedgwick CMS at (800) 495-9301 and you will be walked through the process.

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



Employer's Notice of Claim

- Be sure to answer all questions
- **Email completed forms using the ASRS Employer Secure Email**
- You can also Fax completed forms to: (818) 591-7664

MAILING ADDRESS

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

TO BE COMPLETED BY THE EMPLOYER

New claim: Yes No

1. Full name of employee <i>(Please print)</i>	2. Date employed	3. Effective date of protection under ASRS plan
4. Social Security number	6. Employee'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? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of Pay periods per year _____	
5. 1/12 th of annual compensation from which ASRS contributions would be withheld \$ _____ Gross Monthly Compensation (If school district this would also include: pay for performance, 301 monies, and extra contracts.)		
7. Date last worked (no. of hours that date)	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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please explain.		
12. Has employee resigned or been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give exact date? _____		
13. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" on what date? _____ <input type="checkbox"/> Regular duties <input type="checkbox"/> With restrictions Current work schedule: _____ Days per week _____ Hours per day		
14. Has the employee ever made a prior claim for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," are the premiums paid by the <input type="checkbox"/> Employee <input type="checkbox"/> Employer. If by the employer, please complete Question 18.		
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

Employer Name _____

ASRS Employer No. _____

Contact/Title _____

Telephone No. _____

Signature _____

Fax No. _____

Date _____

E-mail Address. _____

