Sedgwick CMS

Sedgwick CMS, Inc. / P.O. BOX 9830 / CALABASAS, CA 91372-0830 / TEL: (800) 495-9301 / FAX: (818) 591-7664

Dear ASRS Member:

Because you have been off work for at least two (2) months due to a disability, it is time for you to consider the enclosed packet of information. Should your disability continue beyond six (6) months, you may be entitled to receive disability benefits from the ASRS Long Term Disability Income Plan (LTD). Benefits which may be payable from the LTD Plan will be integrated with benefits payable from other sources.

If you believe your current disability will exceed six months, you will need to complete a Long Term Disability application. Enclosed are the necessary forms, which must be completed by you. The completed forms should be returned to your employer within 30 days.

Enclosed are the following forms:

1. Long Term Disability Employee Claim Statement
2. Authorization for Release of Information (ROI)
3. W-4
4. A-4
5. Direct Deposit
6. Attending Physician's Statement of Disability
7. Answers to Commonly Asked Questions

Please complete and sign the first six forms listed above. The Attending Physician's Statement needs to be given to your physician's office for completion. Once you have completed your forms, and the physician has completed the Physician's Statement, please return all of the forms to your local Human Resources Department. Your Human Resources Department will then complete their eligibility statement, and forward all of the forms to SEDGWICK CMS for processing.

If you should have any questions regarding this information provided, please feel free to contact us at (800) 495-9301.

Sincerely,

Sedgwick CMS, Inc.
Claims Department

Enclosures

PLEASE NOTE: According to Arizona State Law Section §38-797.12:

Violation classification: A person who knowingly makes any false statement or who falsifies or permits to be falsified any record of the Long Term Disability (LTD) program with an intent to defraud the LTD program is guilty of a class 6 felony.

Sedgwick CMS

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. Nature of sickness or injury (if do to accident, explain when, where and how it happened)
5. Employer
6. Occupation
7. Marital status: ☐Single ☐Widowed ☐Married ☐Divorced
8. Names and birth dates of spouse and of all dependent children under age 18
9. Date on which you were first unable to work
10. Date of first medical treatment for the condition

    If pregnancy, provide expected or actual delivery date.
11. 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.)
12. If still totally disabled, when do you expect to return to work?
13. If you have recovered or returned to work, give date.
14. Have you been confined to a hospital for this disability? ☐ Yes ☐ No (If "Yes" please complete.)

Name of Hospital	City	From	Through

15. Names and addresses of all physicians who have been consulted because of this condition *(attach additional sheets, if necessary)*

Name	Address	Dates of Consultation or Treatment

16. Are you receiving or have you applied for benefits from any of the following?

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

(Do not complete this section if you have returned to work, or if disability is for pregnancy.)

Training, Education & Experience

(For the possible exploration of Rehabilitation services, please complete the following.)

17. 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_____

18. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.

19.	Please list names, addresses and inclusive dates of employers you have worked for the past three years.
20.	What was your occupation when disability commenced and what were the usual duties of your occupation?
21.	.Which of the above job duties are you unable to perform?
22.	Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor? ☐ Yes ☐ No
23.	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?
24.	What accommodations do you feel could be made by your employer to allow you to return to work?
25.	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 1-24) 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 CMS, Inc. from the following authorized persons or organizations: Pacificare Health Systems, Unitied Health Care, Schaller Anderson Healthcare, AZ Foundation for Medical Care, HMA Inc., Assurant Employee Benefits, and Beech Street Corporation. 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 CMS, 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 CMS, 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 CMS, Inc. 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	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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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 CMS 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 CMS 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.SEDGWICK CMSinc.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 CMS, Inc. 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 CMS, 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 CMS, 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.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I may revoke this authorization at any time before its expiration date by notifying SEDGWICK CMS, Inc. 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

Form W-4 (2009)

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 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

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-earner/multiple job 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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 $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . F _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 $61,000 ($90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children. 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 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 ($25,000 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.

---------- **Cut 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
2009

1 Type or print 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 2009, 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
(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** (2009)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction.

1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over $166,800 ($83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . 1 $ _____

2 Enter: { $11,400 if married filing jointly or qualifying widow(er) / $ 8,350 if head of household / $ 5,700 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 2009 adjustments to income and any additional standard deduction. (Pub. 919) . . . . . 4 $ _____

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) . 5 $ _____

6 Enter an estimate of your 2009 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 $3,500 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 $50,000 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 4–9 below to calculate 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 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. 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 - $4,500	0	$0 - $6,000	0
4,501 - 9,000	1	6,001 - 12,000	1
9,001 - 18,000	2	12,001 - 19,000	2
18,001 - 22,000	3	19,001 - 26,000	3
22,001 - 26,000	4	26,001 - 35,000	4
26,001 - 32,000	5	35,001 - 50,000	5
32,001 - 38,000	6	50,001 - 65,000	6
38,001 - 46,000	7	65,001 - 80,000	7
46,001 - 55,000	8	80,001 - 90,000	8
55,001 - 60,000	9	90,001 - 120,000	9
60,001 - 65,000	10	120,001 and over	10
65,001 - 75,000	11		
75,001 - 95,000	12		
95,001 - 105,000	13		
105,001 - 120,000	14		
120,001 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 - $65,000	$550	$0 - $35,000	$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. 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 also 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 using it 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.

ARIZONA FORM
A-4

Employee's Arizona Withholding Percentage Election

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 ☐ My annual compensation is $15,000 or more. I choose to have Arizona withholding at the rate of *(check only one box):* ☐ 21.9% ☐ 26.5% ☐ 28.8% ☐ 35.7% ☐ 42.6% of the federal tax withheld.

2 ☐ My annual compensation is less than $15,000. I choose to have Arizona withholding at the rate of *(check only one box):* ☐ 11.5% ☐ 21.9% ☐ 26.5% ☐ 28.8% ☐ 35.7% ☐ 42.6% of the federal tax withheld.

3 ☐ I hereby elect an Arizona withholding percentage of zero, and I certify that I meet BOTH of the following qualifying conditions for this election:
- I had NO Arizona tax liability for the prior taxable year, AND
- 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 _____

ADOR 91-0041 (rev. 4/09)

ARIZONA FORM A-4

EMPLOYEE'S INSTRUCTIONS

Arizona Revised Statutes (ARS) §43-401 requires your employer to withhold Arizona income tax from your compensation paid for services performed in Arizona for application toward your Arizona income tax liability. Arizona withholding is a percentage of the amount of federal income tax withheld. Complete this form to elect an Arizona withholding percentage.

New Employees

Complete this form within the first five days of employment to elect an Arizona withholding percentage. If you do not complete this form, your employer must withhold the minimum withholding percentage based on your annual compensation. If your annual compensation is less than $15,000, the minimum withholding percentage is 11.5 percent. If your annual compensation is $15,000 or more, the minimum withholding percentage is 21.9 percent.

Current Employees

Complete this form to elect a different Arizona withholding percentage. If you want to increase or decrease the amount of Arizona withholding, you must complete this form to change the Arizona withholding percentage.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you meet BOTH of the qualifying conditions for the election. You qualify for the election if: (1) you had no Arizona income tax liability for the prior taxable year, AND (2) you expect to have no Arizona income tax liability for the current taxable year. Note that Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, welfare 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 of your election. You should be aware that 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. Keep in mind that in order to elect zero withholding, you must meet BOTH conditions listed above. Therefore, 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 immediately complete a new Form A-4 and choose a withholding percentage that is applicable to your situation.

Voluntary Withholding Election by Certain Nonresident Employees

Compensation earned by nonresidents while physically performing work or services in Arizona for temporary periods is subject to Arizona income tax. However, under the provisions of ARS §43-403(A)(5), 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 wages or compensation. Nonresident employees may request that their employer withhold Arizona income taxes from their compensation by completing this form to elect an Arizona withholding percentage.

ADOR 91-0041 (rev. 4/09)

Sedgwick CMS

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 CMS 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 CMS either to change or cancel this authorization, in such time and in such manner as to afford Sedgwick CMS 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 CMS with a form completed by my financial institution solely for the purpose of verifying my account number and transit/routing information.

I grant Sedgwick CMS 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 CMS or my Employer is not responsible for any costs or service charges incurred by me as a result of Sedgwick CMS' 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: To Be Completed By Employee's Financial Institution

Name of Financial Institution: _____

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

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

Bank Employee Signature: _____ Date: _____

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

For Sedgwick CMS Use Only

Prenote Completed By: _____ Date: _____

Sedgwick CMS

Attending Physician's Statement of Disability

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

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./Street 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 CMS, Inc. from the following authorized persons or organizations: Pacific Care, Inc., and Cigna, Inc. 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 CMS, 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 CMS, 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 CMS, Inc. 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

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

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** (Circle 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 (¼ to 2 ½ hours)	Frequently (2 ½ to 5 ½)	Continuously (5 ½ 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

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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.

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

When will I receive my LTD payments?
ASRS and Sedgwick CMS 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 CMS 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 mailed directly to your home 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 CMS** 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 CMS determines your LTD benefit based on your eligible pay, which is provided by the Arizona State Retirement System.
- Sedgwick CMS 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 CMS can tell you how your LTD benefit was calculated.

How can I check the status on my claim?
Once Sedgwick CMS has received your completed claim packet from your employer, you can call Sedgwick CMS'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 CMS'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 CMS, 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 of the 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 CMS sends to you.
- Stay in touch with Sedgwick CMS and provide information as requested.

What happens if Sedgwick CMS 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 CMS 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 CMS 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 CMS.
- The later of the following:
  - Your normal retirement date;
  - 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 CMS at (800) 495-9301 If You Have Additional Questions