sedgwick

Sedgwick / P.O. BOX 9830 / CALABASAS, CA 91372-0830 / TEL: (818) 591-9444 / FAX: (818) 591-7664

Dear ASRS Member:

Because you have been off work or working in a limited capacity for at least **two (2) months or less** 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. Right of Reimbursement (ROR)
7. Attending Physician's Statement of Disability
8. 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 for processing.

Please Note: ***According to ARS §38-797.07: A participant who files an initial claim for disability benefits more than twelve months after the date of disability is not eligible unless the participant shows ASRS good cause for filing late.***

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

Sincerely,

Sedgwick
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.

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, when 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.

13. 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.

17.	What was your occupation when disability commenced and what were the usual duties of your occupation?
18.	Which of the above job duties are 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: Unitied 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	

Long Term Disability Employee Claim Statement

TO BE COMPLETED BY THE EMPLOYEE

First Name: **Last Name:**

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

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 the application process, please 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

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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 2016. 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 $2,000 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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 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 $50,000 ($20,000 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
2016

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 2016, 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** (2016)

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 2016 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, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 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 2016 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 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 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 $4,050 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 2016. 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 2016. 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 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 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 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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.

SEDGWICK EE FORM JANUARY 2016

Arizona Form

Employee's Arizona Withholding Election

2016

Type or print your Full Name		Your Social Security Number
Home Address – number and street or rural route		
City or Town	State	ZIP Code

Choose either box 1 or box 2:

☐ **1** Withhold from gross taxable wages at the percentage checked **(check only one percentage)**:

☐ 0.8% ☐ 1.3% ☐ 1.8% ☐ 2.7% ☐ 3.6% ☐ 4.2% ☐ 5.1%

☐ Check this box and enter an extra amount to be withheld from each paycheck..... $

☐ **2** I 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 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 Arizona income tax withholding.

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

For Sedgwick Use Only

Prenote Completed By: _____ Date: _____

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RIGHT OF REIMBURSEMENT (ROR)

YOUR CLAIM FOR DISABILITY BENEFITS CANNOT BE PROCESSED WITHOUT THIS FORM

Employee Name:	**Telephone:**	**Date of Birth:**
Sedgwick Client Nbr: 401	**Employer Name: Arizona State Retirement System**	
Program Nbr: 401000	**Program Name: Arizona State Retirement System Long Term Disability Program**	
Last Day Worked:	**Disability Begin Date:**	

The Arizona State Retirement System (ASRS) Long Term Disability (LTD) program may be required to collect any duplicate payments that you may receive from different sources. This form confirms your understanding of the ASRS's right to collect these duplicate payments:

The Agreement-This applies to all claims administrators appointed by ASRS or by my employer, including but not limited to those who administer my employer's Group Health, Short-Term Disability, Long–Term Disability and Workers' Compensation Plans. In connection with an illness or injury, I have applied for LTD program benefits. In return for payment of these benefits, if other payments for the same time period are received, I acknowledge I am obligated to reimburse the program, as stated in the Arizona Revised Statutes, up to 100%, or to the full extent of any net recovery. "Net Recovery" means all other payments received, after reduction of such payments by any attorney's fees that may be incurred in obtaining the recovery. In the event that full reimbursement would be greater than the amount of the net recovery, only the net recovery needs to be repaid. The requirement to reimburse the LTD program applies no matter how the recovery is characterized.

I agree to keep the claims administrator and my employer informed as to the status of my claim against any period or entity so that the claims administrator can take whatever action is necessary to protect the program's or my employer's interest. I also agree to authorize any person, including but not limited to, any insurance company, claims administrator, attorney, hospital, physician, surgeon, or pharmacist to release to the claims administrator appointed by ASRS any information pertaining to this claim.

I attest that my request for LTD program benefits is the result of a valid illness or injury. If I receive a program benefit greater than I should have been paid, I understand that the program's claims administrator and/or ASRS has the right to collect any overpayment as specified in the statutes, including but not limited to, the right to reduce future benefit payments, including future LTD benefits, ASRS retirement benefits, or a forfeiture of my ASRS contributions. Lastly, I acknowledge that this agreement is intended to confirm and clarify my obligations, and I understand that I am required under the terms of the program to reimburse the program in accordance with this agreement.

Name and phone number of Workers' Compensation carrier, attorney, or third party insurance company (if any of these are applicable)_____

_____

Employee's Signature	Employee's Date of Birth	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

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./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 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, 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. 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_____

_____ _____

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

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** (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

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

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 or say the last 4 digits of your social security number and your date 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 ViaOne express, https://claimlookup.com . You can register, and 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