

Dear ASRS Member:

Because you have been off work or working in a limited capacity 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 Arizona State Retirement System (ASRS) Long Term Disability (LTD) Plan. Benefits that 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. Employee Claim Statement
2. Medical and Sensitive Information Release Form
3. W-4 IRS Tax Form
4. A-4 State of Arizona Tax Form
5. Direct Deposit Authorization Form
6. Reimbursement Agreement
7. Attending Physician Statement

This packet also includes answers to Frequently Asked Questions

Please complete and sign the first six forms listed above. The Attending Physician's Statement should be given to your physician's office for completion. Once you have completed your forms, and the physician has completed the Attending Physician's Statement, please return all of the forms to your local Human Resources Department. Your Human Resources Department will then complete the Employer Claim Statement and forward all of the forms to Broadspire 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 have any questions regarding this information provided, please contact us at 877-232-0596.

Sincerely,

The Broadspire Disability and Leave Team

*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 6felony.*



<b>TO BE COMPLETED BY THE EMPLOYEE</b>		New Claim:    Yes    No	
Full Name of Employee (Please Print)	Male  Female	Date of Birth	Social Security Number
Marital Status    Single                  Widowed  Married                  Divorced	Employer		
Date on which you were first unable to work:			
If still totally disabled, when do you expect to return to work?	Occupation		
Have you engaged in any work, part-time or otherwise, since your sickness or injury began? Yes                                  No  <i>If Yes, please explain and give dates.</i>	Names and birth dates of spouse and of all dependent children under age 18		
If you have recovered or returned to work, please provide date.			
Are you receiving or have applied for benefits from any of the following?		Yes    No	
<ol style="list-style-type: none"> <li>1. Social Security Disability</li> <li>2. Social Security or Railroad Retirement</li> <li>3. Sick/ Vacation pay from your employer</li> <li>4. Arizona State Retirement System</li> <li>5. Veterans Administration</li> <li>6. Workers Compensation</li> <li>7. Short Term Disability</li> <li>8. Unemployment Benefits</li> <li>9. Other</li> </ol>			



For each question answered yes please provide 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 provide a copy of the benefit award (or denial letter, if applicable)

**Training, Education & Experience – Vocational Rehabilitation Services**

What is your level of Education?

1. Have you received a high school diploma or the equivalent of a high school diploma?      Yes      No  
    a. If No, please what was the last grade completed? \_\_\_\_\_
2. Have you attended college?      Yes      No  
    a. If Yes, please check one:      Some College      College Graduate      Post graduate  
    b. Major field of study: \_\_\_\_\_  
    c. Degree Earned: \_\_\_\_\_  
    d. Date last attended: \_\_\_\_\_
3. Have you attended any trade schools or received any other special training?      Yes      No  
    a. If Yes, please specify the type of training: \_\_\_\_\_  
    b. Date last attended: \_\_\_\_\_

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



Please list names, addresses and inclusive dates of employers you have worked for the past three years.

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

Which of the above job duties are you unable to perform?

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

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?

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

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

I certify that the above statements are true and accurate to the best of my knowledge and belief.

Employee's or Legal Representative Signature \_\_\_\_\_ Date signed \_\_\_\_\_

Legal Representatives Name and Relationship \_\_\_\_\_

Please complete and return to Broadspire using either the fax or address above.

**AUTHORIZATION TO RELEASE, SHARE, AND USE MEDICAL AND SENSITIVE INFORMATION**

Employers Name: **Arizona State Retirement System**  
Client Program Number: **022082**  
Employee Name:  
Date of Birth:  
Address:

In accordance with state and federal statutes and regulations, I authorize all providers, including but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service, health plan, rehabilitation professional, vocational evaluator; insurance company, reinsurer, insurance service provider, third party administrator, government organization and employer ("Record Holders") to release my complete health information, including any and all information and records in the possession of Record Holder, whether rendered prior to or after this authorization, pertaining to diagnosis, treatment and education related to drug and/or alcohol abuse; communicable infectious diseases, including sexually transmitted diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus ("HIV")/Acquired Immune Deficiency Syndrome ("AIDS"); psychiatric and other mental health services; and financial or credit history, professional license, earnings, employment history, or other insurance claims and benefits, including Social Security benefits. ("Information").

I allow the Records Holders to give my Information to the following individuals or entities ("Benefit Managers"): the employer named below, Broadspire Services, Inc., their respective benefit plan or claims administrator(s), related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow the Benefit Managers to use and give out the Information only to evaluate, analyze, manage and/or administer a claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"). I also allow the Benefits Managers to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim, or to run the Benefits Program. I expressly waive any and all rights that I may have to be notified of these communications. The Benefits Managers will tell those receiving the Information that the Information is confidential.

This authorization shall expire one hundred and twenty (120) days after the date appearing below or one hundred and twenty (120) days after my final treatment, whichever is later, unless law requires a shorter period. If I change my mind before that time, I can tell my Record Holder in writing that I do not want them to share any more information. If I tell them in writing to stop sharing information, it will not change any actions they took before I told them.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in denial of my request for benefits. I know I can see or copy the records given to the Benefits Managers.

The Information released under this authorization can be submitted to the Records Holders electronically, by phone or fax, or by mail. I agree that a copy of this form may be treated as a signed original.

Employee's Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Employee's or Legal Representative's Signature

\_\_\_\_\_  
Legal Representative's Name and Relationship

**NOTICE TO RECORDS HOLDERS**

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.

# 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](http://www.irs.gov/w4).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b>	
<b>B</b>	Enter "1" if: <span style="font-size: 2em; vertical-align: middle;">{</span> <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b>	
<b>C</b>	Enter "1" for your <b>spouse</b> . 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.) . . . . .	<b>C</b>	
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b>	
<b>F</b>	Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . . ( <b>Note:</b> Do <b>not</b> include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b>	
<b>G</b>	<b>Child Tax Credit</b> (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 <b>less</b> "1" if you have two to four eligible children or <b>less</b> "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 . . . . .	<b>G</b>	
<b>H</b>	Add lines A through G and enter total here. ( <b>Note:</b> This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b>	
	For accuracy, <b>complete all worksheets that apply.</b> <span style="font-size: 2em; vertical-align: middle;">{</span> <ul style="list-style-type: none"> <li>• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul>		

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

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ <b>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.</b></p>	OMB No. 1545-0074  <span style="font-size: 2em; font-weight: bold;">2016</span>
1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> 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. ▶ <input type="checkbox"/>
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 <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> 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)

### Deductions and Adjustments Worksheet

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

<b>1</b>	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 . . . . .	<b>1</b>	\$ _____
<b>2</b>	Enter: $\left\{ \begin{array}{l} \$12,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,300 \text{ if head of household} \\ \$6,300 \text{ if single or married filing separately} \end{array} \right\}$ . . . . .	<b>2</b>	\$ _____
<b>3</b>	<b>Subtract</b> line 2 from line 1. If zero or less, enter “-0-” . . . . .	<b>3</b>	\$ _____
<b>4</b>	Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505)	<b>4</b>	\$ _____
<b>5</b>	<b>Add</b> lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2016 Form W-4</i> worksheet in Pub. 505.) . . . . .	<b>5</b>	\$ _____
<b>6</b>	Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . . .	<b>6</b>	\$ _____
<b>7</b>	<b>Subtract</b> line 6 from line 5. If zero or less, enter “-0-” . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Divide</b> the amount on line 7 by \$4,050 and enter the result here. Drop any fraction . . . . .	<b>8</b>	_____
<b>9</b>	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, page 1 . . . . .	<b>9</b>	_____
<b>10</b>	<b>Add</b> lines 8 and 9 and enter the total here. If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 below. Otherwise, <b>stop here</b> and enter this total on Form W-4, line 5, page 1 . . . . .	<b>10</b>	_____

### 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.

<b>1</b>	Enter the number from line H, page 1 (or from line 10 above if you used the <b>Deductions and Adjustments Worksheet</b> )	<b>1</b>	_____
<b>2</b>	Find the number in <b>Table 1</b> below that applies to the <b>LOWEST</b> paying job and enter it here. <b>However</b> , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3” . . . . .	<b>2</b>	_____
<b>3</b>	If line 1 is <b>more than or equal to</b> 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. <b>Do not</b> use the rest of this worksheet . . . . .	<b>3</b>	_____
<b>Note:</b> If line 1 is <b>less than</b> 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.			
<b>4</b>	Enter the number from line 2 of this worksheet . . . . .	<b>4</b>	_____
<b>5</b>	Enter the number from line 1 of this worksheet . . . . .	<b>5</b>	_____
<b>6</b>	<b>Subtract</b> line 5 from line 4 . . . . .	<b>6</b>	_____
<b>7</b>	Find the amount in <b>Table 2</b> below that applies to the <b>HIGHEST</b> paying job and enter it here . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Multiply</b> line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . .	<b>8</b>	\$ _____
<b>9</b>	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 . . . . .	<b>9</b>	\$ _____

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$6,000	0	\$0 - \$9,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
6,001 - 14,000	1	9,001 - 17,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 25,000	2	17,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
25,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 75,000	5	405,001 and over	1,600		
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						

**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.

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.

**EMPLOYEE DIRECT DEPOSIT AUTHORIZATION**  
BROADSPIRE – A CRAWFORD COMPANY DISABILITY &  
LEAVE MANAGEMENT OPERATIONS  
PO BOX 14773, Lexington, KY 40512  
TEL: 877-232-0596 FAX: 859-550-2744



**INSTRUCTIONS:**

This document must be completed and signed by the employee requesting automatic deposit of paychecks and retained on file by Broadspire. This form may be faxed to fax number listed above or mailed to the address above.

\*\*\*\*\*Please include a voided copy of your check\*\*\*\*\*

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**ACCOUNT 1**

Account 1 type:  Checking  Savings

Bank routing number (ABA number): \_\_\_\_\_

Account number: \_\_\_\_\_

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**Authorization**

This authorizes Broadspire Services Inc. (the "Company"), to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my account indicated above and to other accounts I identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Authorized signature: \_\_\_\_\_

Employee ID #: \_\_\_\_\_

Print name: \_\_\_\_\_

Date: \_\_\_\_\_



## REIMBURSEMENT AGREEMENT

***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



**EMPLOYEE INFORMATION**

**Section 1: Employee Information**

EMPLOYEE NAME:				EMPLOYER NAME:		
CLAIM NUMBER:		SSN:		DATE OF BIRTH:		
JOB TITLE/DESCRIPTION:						

**TO BE COMPLETED BY ATTENDING PHYSICIAN:**

**Section 2: Complete this Section for Pregnancy, then go to Section 4**

Expected Delivery Date (mm/dd/yyyy):	Actual Delivery Date (mm/dd/yyyy):	Delivery Type: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	Date of first visit for this pregnancy (mm/dd/yyyy):	Date Hospitalized (mm/dd/yyyy):
Diagnosis:	ICD Code:	Did you advise your patient to cease working prior to delivery? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what date? (mm/dd/yyyy):	
Were there any complications that caused your patient to cease working prior to the expected delivery date? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide explanation:				

**Section 3: Complete this section for all conditions except pregnancy, then go to Section 4**

Primary Diagnosis:			Primary ICD Code:	
Secondary Diagnosis:			Secondary ICD Code:	
Please describe symptoms, including frequency, severity, and duration:				
Date of first visit for the current condition(s) (mm/dd/yyyy):	Date of last visit (mm/dd/yyyy):	Date of next visit (mm/dd/yyyy):	Frequency of treatment: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	
Has the patient been treated for the same or similar condition in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	If Yes, provide treatment dates: From: _____ Through: _____	Is the patient's condition work related? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	Did you advise the patient to stop working? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, date: _____	
Has the patient been hospitalized for this condition? <input type="checkbox"/> YES <input type="checkbox"/> No If Yes, provide date hospitalized: From: _____ Through: _____		Patients Height:	Patients Weight:	
Was surgery performed? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, what was the procedure?		CPT Code:	Date Surgery performed (mm/dd/yyyy):	
Please describe your current treatment plan and include all medications with prescribed dosage:				
Please comment on how cooperative and compliant the patient has been with current treatment plan:				

<b>Additional Providers:</b> Are you aware of or have you referred your patient to any additional treating providers? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, please provide the provider's name and contact information.			
Name:	Specialty:	Address:	Phone:
Has the patient been advised to return to work? <input type="checkbox"/> YES <input type="checkbox"/> NO	What is the expected return to work date? (mm/dd/yyyy): <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Part Time hours per day:		
How is your patient limited from performing his/her occupation and what prevents a return to work with full or partial duties?			
What are the patients restrictions (what the patient should not do) and why?			
What diagnostic tests or clinical exam findings support your patients work restrictions and limitations? Please include results of any examination, lab data, x-rays, EKGs, and MRI:			
Are there any non-medical factors which have a significant impact on functional abilities? <i>(Please consider the following: Work place issues (ie problems with supervisor, performance); Social/Family issues; Alcohol/Drug abuse; Financial/Legal issues)</i>			

**Section 5: Psychological Functions:**

Check Applicable box below: <input type="checkbox"/> Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 – Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 – Patient is unable to engage in stress situations and engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations)
Remarks:
What stress factors or problems with interpersonal skills have affected patient's ability to perform the duties of his or her job?
Is patient competent to endorse checks and direct use of proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 6: Physical Capabilities:**

(1) Patient's ability to: Hours (check) Sit <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently Stand <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently Walk <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently	(2) Patient's ability to: Climb <input type="checkbox"/> Yes <input type="checkbox"/> No Twist/bend/stoop <input type="checkbox"/> Yes <input type="checkbox"/> No Reach above shoulder level <input type="checkbox"/> Yes <input type="checkbox"/> No Operate a motor vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No
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(3) Patient's ability to lift/carry: (check) <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Never 0%</td> <td style="text-align: center;">Occasionally 1-35%</td> <td style="text-align: center;">Frequently 36-66%</td> <td style="text-align: center;">Continuously 67-100%</td> </tr> <tr> <td>Up to 10 lbs.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>11 to 20 lbs.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>21 to 50 lbs.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>51 to 100 lbs.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Over 100 lbs.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Never 0%	Occasionally 1-35%	Frequently 36-66%	Continuously 67-100%	Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(4) Patient's ability to perform repetitively: (check) <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Right Hand</td> <td style="text-align: center;">Left Hand</td> </tr> <tr> <td>Fine finger movements</td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye/hand movements</td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Pushing/pulling</td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Dominant Hand</td> <td style="text-align: center;"><input type="checkbox"/> Right</td> <td style="text-align: center;"><input type="checkbox"/> Left</td> </tr> </table>		Right Hand	Left Hand	Fine finger movements	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye/hand movements	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pushing/pulling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dominant Hand	<input type="checkbox"/> Right	<input type="checkbox"/> Left
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(5) In your opinion, why is the patient unable to perform duties?																																														
(6) Do you expect improvement in any area? ( If so, please comment and give dates/timeframes.)																																														

**Section 4: Attending Physician Signature:**

Physician Name (Last Name, First, MI, Suffix) Please Print:			Specialty/Degree:	
Address:				
City:			State:	Zip:
Telephone Number:	Fax Number:	Physician Tax Id Number:	Are you related to this patient? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe relationship:	
I certify that the above statements are true and accurate to the best of my knowledge and belief.				
Signature:			Date:	

*The Genetic Information Non-Discrimination 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 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 individuals' 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

**Fraud Warning:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material there to may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

Arkansas, Louisiana, West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California – For your protection California law requires the following to appear of this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of life insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds, shall be reported to the Colorado divisions of insurance within the department of regulatory agencies to the extent required by applicable law.

Delaware – Any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii – For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho – Any person who knowingly and with the intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – Any person who knowingly and with the intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime.

Maine – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – A person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey – Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

New Mexico – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio – A person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Oregon – A person who knowingly and with intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars (\$5,000), not to exceed ten thousands dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia, Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

# ASRS LONG TERM DISABILITY (LTD) PROGRAM

## Answers to Frequently Asked Questions

### 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 Broadspire 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. Broadspire 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 **Broadspire** at 877-232-0596 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.

- Broadspire determines your LTD benefit based on your contributions made to the Arizona State Retirement System (ASRS), which is provided by the ASRS.
- Broadspire 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. Broadspire can tell you how your LTD benefit was calculated.

### How can I check the status on my claim?

You will be able to obtain the status of your claim by calling Broadspire's 24/7 Disability Hotline at 877-232-0596.

### What do I have to do during my disability?

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 Broadspire sends to you.
- Stay in touch with Broadspire 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.