Toll Free: 1-855-604-6230

Disability Claim Form

Return to ReedGroup at

TIPP Customer Care at ReedGroup
PO Box 6278
Broomfield, CO 80021
Fax#: 1-847-554-1853

Employee

o Complete the **Employee's Preliminary Statement of Disability** (page 3 of this claim form) and send the form to your Benefits Coordinator for completion of the Employer's section.

o When your Benefits Coordinator returns the claim form to you, complete, sign, and date the form.

o Submit the completed Claim Form to Texas Income Protection Plan (TIPP) Customer Care at ReedGroup at the address or fax number noted above. We must receive the form within 12 months of the date your Total Disability began.

Employer

o Complete the Employer's Section below and attach the employee's job description, including detailed duties, **and** the employee's time records from last day worked to present. **Return claim form and attachments to the employee.**

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Employer's Section

Employee ID#_____

Employee Name _____ Social Security # _____

Date of hire _____ Last day at work _____

Occupation _____

Date returned to work F/T_____P/T_____

Eligible for sick leave or extended sick leave? __ Y __ N Duration _____

Confirm date STD benefits should begin _____

Eligible for salary continuation? ___Y ___ N Amount $_____ Duration _____

Eligible for Short-term Disability benefits from another carrier? ___ Y ___ N

If Yes, Name of carrier _____

Is employee eligible for pension disability? ___ Y ___ N

Is this employee eligible for workers' compensation? ___ Y ___ N

Employer Name_____

Employer Address _____

Representative Name _____ Signature _____

Title _____ Telephone Number _____

Date_____

Has employee exhausted all eligible sick leave, extended sick leave, and sick leave pool? ___ Y ___ N

If not, please continue with the submission of this disability claim regardless if all sick leave has been exhausted.

Did the employer pay any portion of the employee's Short-term Disability premium? ___ Y ___ N

If yes, what _____%

Did the employer pay any portion of the employee's Long-term Disability premium? ___ Y ___ N

If yes, what _____%

ReedGroup

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Employee's Preliminary Statement of Disability *Please print or type*

Describe the symptoms of your disability

_____

_____

_____

Is your disability related to a work injury? ___ Y ___ N

If yes, please give details_____

_____

_____

Date you first noticed symptoms of illness or date of accident _____

Date first treated for these symptoms _____

I have been unable to work because of this illness or injury since _____

Are you currently participating in your employer's in-house Short-term Disability program? ___ Y ___ N

Have you exhausted all sick leave, extended sick leave, and sick leave pool: ___ Y ___ N

Is your injury/illness covered by any other third party or secondary insurance carrier? ___ Y ___ N

If so, please provide the name of the third party or secondary insurance carrier _____

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Are you now eligible for, have you applied for, or are you now receiving income benefits from any of the following (please check all that apply):

___ Social Security ___ Social Security Disability ___ Social Security Retirement

If yes, Indicate your monthly amount awarded $_____ Date of award _____

___ Workers' Compensation

If yes, Indicate your monthly amount awarded $_____ Date of award _____

(If Workers' Compensation is denied, submit a copy of denial letter with this form)

___ERS Disability Retirement Monthly amount awarded $_____ Date of award _____

___ TRS Disability Retirement Monthly amount awarded $_____ Date of award _____

___ Any other Group Disability Monthly amount awarded $_____ Date of award _____

___Federal, ___State, ___(VA) Veteran's Administration

If yes, indicate your monthly amount awarded $_____ Date of award _____

If eligible for any of the above income benefits, please provide a copy of the award letter(s).

Have you ever had the same or similar condition? ___ Y ___ N

If so, when? _____

Name of person completing this form if other than the employee

_____

List all Practitioners you have seen for the past 12 months specifically for your disabling condition:

1) Name _____ Address _____

Telephone _____From _____ To _____

Diagnosis/Condition Treated _____

2) Name _____ Address _____

Telephone _____From _____ To _____

Diagnosis/Condition Treated _____

3) Name _____ Address _____

Telephone _____ From _____ To _____

Diagnosis/Condition Treated _____

I, the undersigned claimant, have read and agree that the above statements and answers are furnished in support of my claim for benefits and are complete, true, and correctly recorded to the best of my knowledge and belief. I understand that incorrect or untrue answers on this form may result in denial of this claim**.**

_____ _____

Employee's signature (required to process the claim) Date