Disability Claim Form

Return to TIPP Customer Care
P. O. Box 299093
Lewisville, TX 75029-9093
Toll-Free: 1-855-604-6230
Fax: 1-847-554-1853

Instructions for Employees Enrolled in the Texas Income Protection Plan℠ (TIPP)

Step 1: Complete the **Employee's Preliminary Statement of Disability** (pages 3 and 4).

Step 2: Have your Benefits Coordinator complete the **Employer's Section** (page 2). Your Benefits Coordinator is part of your Human Resources department.

Step 3: Submit these completed documents to TIPP Customer Care at the address or fax number listed in the top-right corner. We must receive the completed documents within 12 months of the date your total disability began.

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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________________

Paid Parental Leave (PPL)

Is this leave eligible as PPL? ____Y _____N Duration: ________days

If yes, provide the employee's work hours:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Total Hours							

Eligible for sick leave or extended sick leave?___Y___N Duration ________________________

Confirm date short-term disability 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. Also, please provide the **date sick leave 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________________%

 Revised Aug 2024

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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: _______________

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).

Employee's Preliminary Statement of Disability (cont.)

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

Any claim adjustment described above for Employees Retirement System of Texas (ERS) is performed by Reed Group Management LLC (“ReedGroup”), a licensed, third-party administrator. ReedGroup is licensed in Texas for the administration of Texas Employees Group Benefits Program (“GBP”) according to Chapter 1551, Texas Insurance Code.