



1. Claimant's Name: _____ Clt's Tele # (____) _____ **SOCIAL SECURITY NUMBER**
 Clt's Address: _____

PART C TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE WDS-1(R-1-07)

2. EMPLOYER STATUS
 What is your Federal Employer Identification Number: _____

3. PRIVATE PLAN COVERAGE (NJ approved plan/replaces State Plan coverage)
 a. Do you have a New Jersey approved Private Plan? Yes No
 b. If "Yes", is claimant covered under this approved Private Plan? Yes No

4. LAST ACTUAL DAY WORKED before this disability
 (do not use payroll week ending dates)  _____
 (Month / Day / Year)
 a. Exact reason for separation from work (include labor dispute) _____
 b. Is lack of work: temporary? permanent?
 c. Has claimant returned to work? Yes No
 If "Yes", give date  _____
 (Month / Day / Year)
 d. If the work was intermittent, list dates: _____

5. CONTINUED PAY (do not enter wages earned prior to disability)
 a. Have you paid or expect to pay the claimant for any period after the last day of work? Yes No
 b. If "yes" give dates: **FROM** _____ **TO** _____
 Month / Day / Year (Month / Day / Year)
 c. Amount per week \$ _____, if amount varies attach list of dates and amounts.
 d. Check the number that best describes the monies paid in item c.
 1. Regular weekly wages and/or sick pay
 2. Regular vacation (if designated for a specific time period)
 3. Pension
 4. Difference between regular weekly wage and disability benefits to be received
 5. Full salary advanced to effect #4 above
 6. Supplemental benefits or gratuities
Note: Items 1, 2, and 3 may reduce benefits to the claimant

6. GOVERNMENT EMPLOYEES (Complete this section)
 a. Payroll number (For N.J. State Employees) _____
 b. Number of earned sick leave days as of the last day worked. _____
 c. Has the claimant filed for or received Employment Disability Leave (SLI)? Yes No
 d. If claimant has applied for or received donated leave, attach dates and amounts on a separate sheet of paper.

7. WORKERS' COMPENSATION LIABILITY
 a. Did the claimant's disability happen in connection with his/her work or while on your premises, or was the disability due in any way to his/her occupation? Yes No
 b. If "Yes", have you filed or do you intend to file a Workers' Compensation claim on behalf of this claimant? Yes No
 c. If "Yes," list Workers' Compensation insurance carrier below:
 Name _____ Telephone () _____
 Address _____
 Policy # _____ Claim # _____


8. BASE WEEKS AND BASE YEAR GROSS WAGES A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of \$143 or more during the Base Year. The BASE YEAR is the 52 calendar weeks preceding the week in which the disability occurred.

a. Total Number of **Base Weeks** _____
 b. Total **Gross Wages in Base Year** _____
 Include all wages earned by the claimant

9. REGULAR WEEKLY WAGE \$ _____

10. Weekly wages
 Indicate below: dates and claimant's GROSS earnings in N.J. employment during the listed calendar weeks.

Description of Calendar Week	Calendar Week Ending Date	Gross Wages
Week Disability Began		\$
Week Before Disability		\$
2nd Week Before Disability		\$
3rd Week Before Disability		\$
4th Week Before Disability		\$
5th Week Before Disability		\$
6th Week Before Disability		\$
7th Week Before Disability		\$
8th Week Before Disability		\$
9th Week Before Disability		\$
10th Week Before Disability		\$

TOTAL GROSS WAGES FOR ABOVE WEEKS  \$ _____
 Are you exempt from FICA tax? Yes No

11. Check the days of the week the employee normally works. SUN MON TUE WED THUR FRI SAT

Firm Name _____ **I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT**
 Address _____ Signed _____ Date _____
 City, State, Zip _____ Print or Type Name _____
 Mailing Address, If Different _____ Official Title _____
 FAX No. () _____ Telephone () _____ E-Mail Address _____

Return completed form to: NATIONAL BENEFIT LIFE INS CO
 PO Box 1946
 Long Island City, NY 11101