

## **CLAIMANT RIGHTS AND RESPONSIBILITIES**

### **RULES FOR FILING A CLAIM AND APPEAL RIGHTS**

1. It is your responsibility to file this claim form promptly after you stop working due to your disability. Filing your claim before your last day of work will delay its processing. The law requires that claims must be filed within 30 days after the beginning of the disability. Benefits may be denied or reduced if the claim is filed late. If your claim is filed beyond the thirty day period, please use the space provided on the reverse side of Part A to give your reasons for the late filing.
2. If you disagree with a determination on your claim and wish to appeal, you must do so in writing within ten days from the date the decision was mailed. You do not need a lawyer at the appeal hearing.

### **CLAIMANT RESPONSIBILITIES:**

1. Your signature certifies that you understand any misrepresentation of fact or failure to disclose a material fact may be punishable under the law. This includes any changes to the Medical Certificate or the Employer's Statement made by you without authorization by your physician or your employer.
2. You must inform us of any other payments you are receiving such as sick pay or wages, a pension from your last employer, worker's compensation benefits, Social Security Disability benefits, or disability benefits from your employer or union.
3. If you receive a request for continued medical certification, you must have your physician complete and sign the form. You should return it promptly.
4. When you recover or return to work, you must report this date immediately to the National Benefit Life Insurance Company.
5. If you are requesting voluntary Federal Income Tax (F.I.T.) deductions to be withheld from your disability benefits, attach Form W-4S (Request for Federal Income Tax Withholding From Sick Pay) to your claim. Forms should be obtained from your employer or the Internal Revenue Service.
6. If your home and/or mailing address changes, you must notify National Benefit Life Insurance Company, JAF Box 2366, New York, NY 10116 immediately in writing. Notification must include your Social Security Number and signature. Disability checks cannot be forwarded by the Post Office.

### **CLAIM ASSISTANCE:**

If you require any assistance with your claim; call:

**1 800 535-2711**

**NATIONAL BENEFIT LIFE INSURANCE COMPANY**

**State Disability Claims**

**JAF 2366**

**New York, NY 10116**

**Fax: 212 615-7321**

**STATE OF NEW JERSEY – DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT  
DIVISION OF TEMPORARY DISABILITY INSURANCE**

**PART A INFORMATION TO BE COMPLETED BY THE CLAIMANT – Print or Type WDS-1(R-1-07)**

<b>1. Name:</b> Last	First	Middle	<b>2. Birth Date</b>	<b>3. Social Security Number</b>
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<b>4. Home Address – required</b> (Street, Apt #, City, State, Zip Code)	<b>5. County</b>
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<b>6. Mailing Address – if different</b> (Street, Apt #, City State, Zip Code)	7. Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>8. Occupation</b>
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9. Are you a citizen of the United States? Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Alien Reg. No.	11. Work Authorization
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12a. What was the last day that you actually worked before your disability began?	From	To	
	Month	Day	Year

12b. Reason for separation: <input type="checkbox"/> Illness/Accident/Maternity <input type="checkbox"/> Terminated <input type="checkbox"/> Quit			
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13. What was the first day you were unable to work due to present disability: (Include Saturday, Sunday, or Holiday) Do not list future dates			
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14. If you have recovered or returned to work from this disability, list date: (Do not use dates in the future)			
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15. Date(s) of emergency room care:	or hospitalization: From	To	
Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year

**16. Describe your disability (How, when, where it happened)** \_\_\_\_\_

**17. Was this injury/illness caused by your job?** Yes  or No  (This question must be answered.)  
If Yes, date of work related injury/illness: \_\_\_\_\_  
Was your employer notified that your injury was caused by your job? Yes  or No

**18. Identify the physician or hospital treating you for this disability: Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Telephone:** (\_\_\_\_) \_\_\_\_\_

**Employment Information – Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If you had more than 2 employers, list the remaining employers on the reverse side of this form in the space provided.**

<b>19a. Name and address of your most recent employer:</b>	Period of employment: From _____ To _____ month/day/year month/day/year
(Street) _____ (City) _____ (State) _____ (Zip) _____	Work Location _____ City _____ State _____

Occupation: \_\_\_\_\_ Full time  Part time  Union \_\_\_\_\_ Division \_\_\_\_\_

Check the days of the week you normally work. SUN  MON  TUE  WED  THUR  FRI  SAT

<b>19b. Name and address:</b>	Period of employment: From _____ To _____ month/day/year month/day/year
(Street) _____ (City) _____ (State) _____ (Zip) _____	Work Location _____ City _____ State _____

Occupation: \_\_\_\_\_ Full time  Part time  Union \_\_\_\_\_ Division \_\_\_\_\_

Check the days of the week you normally work. SUN  MON  TUE  WED  THUR  FRI  SAT

**20. Other Benefits – You Must Answer Each Question Listed Below For the Period of Disability Covered By This Claim:**

a. Have you worked after your disability began? (Including self-employment) Yes  No

b. Have you been receiving sick or vacation pay? Yes  No

c. Have you been involved in a labor dispute? Yes  No

**21. Since your last day of work have you received, claimed or applied for:**

a. Federal Social Security Disability Benefits? Yes  No

b. Pension benefits from your most recent employer? Yes  No

c. Temporary Disability Benefits from another State? Yes  No

d. Any other disability benefits provided by your employer or union? Yes  No

e. Unemployment Insurance Benefits? Yes  No

**BE SURE TO COMPLETE AND SIGN PART A1**

<b>Claimant's Name:</b> _____ <b>Claimant's Telephone No:</b> (____) _____	<b>Social Security Number</b>            
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<b>PART A1</b>	<b>CLAIMANT'S AUTHORIZATION AND CERTIFICATION STATEMENTS</b> <b>MUST BE COMPLETED AND SIGNED BY THE CLAIMANT</b>
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1. Please designate a representative to obtain claim information for you if you cannot call this Agency yourself. The Law only permits claim information to be given to you or your representative.

Representative Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

2. **Certification and Signature** I was unable to work during the period for which benefits are claimed and hereby certify that I have read and understand my benefit rights and responsibilities. I am aware that if any of the foregoing statements made by me are known to be false, or I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution. You are hereby authorized to verify my Social Security Account Number, and obtain any medical, employment and Social Security benefit entitlement information that is necessary to determine my eligibility for benefits.

Sign Here \_\_\_\_\_ Date \_\_\_\_\_

Witness signature if claimant writes an "X" \_\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Note: The NJ Temporary Disability Benefits Program is not a "covered entity" under the Federal Health Information Portability & Accountability Act (HIPAA). All medical records of the Division, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law are confidential & are not open to public inspection. The Division protects all records that may reveal the identity of the claimant, or the nature or cause of the disability and the records may only be used in proceedings arising under the Law.

**USE THIS SPACE TO LIST ADDITIONAL EMPLOYERS FOR QUESTION 19.**

Name and address: _____ _____ _____ <small>(Street) (City) (State) (Zip)</small> Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____	Period of employment: From _____ To _____ <small>month/day/year month/day/year</small> Work Telephone: _____ Location _____ City _____ State _____
Check the days of the week you normally work. SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>	
Name and address: _____ _____ _____ <small>(Street) (City) (State) (Zip)</small> Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____	Period of employment: From _____ To _____ <small>month/day/year month/day/year</small> Work Telephone: _____ Location _____ City _____ State _____
Check the days of the week you normally work. SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>	

**USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION FOR QUESTIONS ON PART A**

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If more space is needed, attach an additional sheet of paper. Be sure your Social Security Number appears on all pages.

Claimant's Name: \_\_\_\_\_  
 Claimant's Address: \_\_\_\_\_  
 Claimant's Telephone No: (\_\_\_\_) \_\_\_\_\_

**Social Security Number**  
 |        |  
 |        |

**PART B**

**MEDICAL CERTIFICATE  
 (TO BE COMPLETED BY YOUR DOCTOR AFTER YOU BECOME DISABLED)**

1a. Patient has been under my care for this period of disability: FROM \_\_\_\_\_ TO \_\_\_\_\_  
 (Month/Day/Year) (Month/Day/Year)  
 b. Frequency of treatment: \_\_\_\_\_  
 c. Patient was last treated by me on: \_\_\_\_\_  
 Month Day Year

2. Enter the date the patient was unable to perform his/her regular work due to this disability: \_\_\_\_\_  
 Month Day Year

3. Estimated Recovery: (Give the approximate date patient will be able to return to work.) \_\_\_\_\_  
 Month Day Year

4. If now recovered, on what date was the patient first able to work? \_\_\_\_\_  
 Month Day Year

5. Diagnosis: (nature and cause of this disability which prevents patient from working) \_\_\_\_\_  
 ICD Code: \_\_\_\_\_

Clinical data and tests to support diagnosis: \_\_\_\_\_

6a. If pregnancy, provide estimated date of delivery: \_\_\_\_\_  
 Month Day Year  
 b. Complications, if any. \_\_\_\_\_  
 c. If pregnancy terminated, enter the date: \_\_\_\_\_  
 Month Day Year  
 And identify the reason:  Birth  C-Section  Miscarriage  Abortion

7a. Date(s) of emergency room care or hospitalization: FROM \_\_\_\_\_ TO \_\_\_\_\_

b. Name and address of any specialist treating patient: \_\_\_\_\_

8. Type of surgery: \_\_\_\_\_ Date of Surgery \_\_\_\_\_ Anticipated Surgery Date \_\_\_\_\_  
 Is surgery for cosmetic purposes only?  Yes  No

9. In your opinion, was this disability:  Due to an accident at work?  Not related to his/her work  
 Due to a condition which developed because of the nature of the work.

10. Was this patient referred to you?  Yes  No If yes, please supply the information below if available.  
 Name of referring doctor \_\_\_\_\_ Referring doctor's telephone #: \_\_\_\_\_

11. I certify that the above statements, in my opinion, truly describe the patient's disability and the estimated duration thereof:

\_\_\_\_\_  
 (Print Doctor's Name and Medical Degree) (Original Signature of Doctor Required) (Date Signed)

\_\_\_\_\_  
 (Address) (Certificate License No. and State) If Resident, check

\_\_\_\_\_  
 (Address) (Specialty of Treating Physician)

\_\_\_\_\_  
 (City) (State) (Zip Code)

Telephone Number: ( ) \_\_\_\_\_ FAX Number: ( ) \_\_\_\_\_

**SOCIAL SECURITY NUMBER**

1. Claimant's Name: \_\_\_\_\_ Clt's Tele # ( ) \_\_\_\_\_

Clt's Address: \_\_\_\_\_

**PART C TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE**

**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 # \_\_\_\_\_

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 \_\_\_\_\_

**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

TDB Policy # \_\_\_\_\_

Send completed form to: National Benefit Life Insurance Company JAF Box 2366 New York, NY 10116

FAX # (212) 615-7321