

Clear Form

NOTICE OF NEW JERSEY TEMPORARY DISABILITY BENEFITS CLAIM

PART A CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE

1. Name (Last, First, Middle) as shown on your Social Security card.		2. Social Security Number	3. Birth Date
4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home Telephone Number ()	6. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
7. Mailing address (Street, City or Town, State, Zip Code)			
8. Employer Name		9. Employer Telephone Number ()	
10. Employer Address (Street, City, State & Zip Code)		11. Occupation	
12. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," complete block number's 13 & 14, and give country of origin.			
13. Alien Registration Number		14. Work Authorization From: _____ To: _____	
15. Country of origin			
16. The last day you worked before your disability began (Include Saturday, Sunday, or Holiday)		17. The first day you were unable to work due to present disability	
18. If now recovered, date of your recovery or return to work		19. If due to accident, give date:	
20. Date(s) of emergency room care _____		21. Date of hospitalization From: _____ To: _____	
22. Describe your disability:			
23. Was this disability caused by your job? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," describe:			
24. Name of physician or hospital treating you for this disability:			
25. Address of physician or hospital treating you for this disability:		Telephone Number: ()	

PART A (Continued)

Employment information - Other employers you have worked for during the past 18 months. Include full-time and part-time employment. If you had more than 3 employers, list on a separate sheet and attach to this form.

26. Name:		27. Telephone Number: ()	28. Period of Employment: From: _____ To: _____
29. Address: (Street, City, State & Zip Code)		30. Work Location:	
31. Occupation:	32. Union Name:	33. Division:	
34. Name:		35. Telephone Number: ()	36. Period of Employment: From: _____ To: _____
37. Address (Street, City, State & Zip Code)		38. Work Location	
39. Occupation:	40. Union Name:	41. Division:	
<p>42. Other Benefits: (You must answer each question listed below for the period of disability covered by this claim.)</p> <p>a. Have you been working (including self-employment)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Have you been receiving remuneration, i.e., wages, salary or vacation pay? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>43. Since your last day of work have you received, claimed or applied for</p> <p>a. Social Security benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Social Security Retirement benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Pension benefits from your most recent employer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Any other disability benefits provided by your employer or Union? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Workers' Compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Unemployment insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>44. I request voluntary Federal Tax Withholding <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate the amount to be withheld from weekly benefits. <div style="text-align: right;">(\$20.00 minimum withholding per week) _____</div></p>			

45. 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 right. Also, I certify that the foregoing statements made by me on this form are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to penalties, which include criminal prosecution. You are hereby authorized to obtain any medical and employment information that is necessary to determine the eligibility of this claim.

If your employer has agreed to continue your regular pay while you are unable to work, do you agree to have the benefits available to you under this policy routed through your employer? Yes No. Please sign: _____

Note: A "No" answer could impact you continuing to receive your regular pay from your employer in exchange for the benefits available to you from this policy.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

SIGN HERE _____ (Claimant's Signature) _____ (Date)

NOTICE OF NEW JERSEY TEMPORARY DISABILITY BENEFITS CLAIM

PART B MEDICAL CERTIFICATE (To be completed by your doctor)

1. Patient was first treated by me on: _____	2. Patient was last treated by me on: _____
3. Is the patient unable to perform his/her regular work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please enter the date the disability began: _____	
4. Estimate recovery (give the approximate date claimant will be able to return to work) _____	
5. If now recovered, on what date was the claimant first able to work? _____	
6. Diagnosis (nature and cause of this disability which prevents claimant from working): _____ ICD Code: _____	
7. Clinical data and test to support diagnosis: _____	
8. (a) If pregnant, provide estimated date of delivery: _____ <div style="text-align: center; font-size: small;">Month/Day/ Year</div> Complications, if any: _____	
(b) If pregnancy has terminated, enter the date: _____ <div style="text-align: center; font-size: small;">Month/Day/ Year</div> and the reason: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Miscarriage <input type="checkbox"/> Others _____	
9. Date(s) of emergency room care or hospitalization: From: _____ To: _____	
10. Type of Surgery: _____ CPT Code: _____ Date of Surgery: _____ Date Surgery Contemplated: _____	
11. In your opinion, was this disability: <input type="checkbox"/> Due to an accident at work <input type="checkbox"/> Not related to his/her work? <input type="checkbox"/> Due to a condition which developed because of the nature of the work?	

Print Doctor's Name and Degree: _____	Doctor's Signature: _____	
Address: (Street, City, State and Zip Code) _____	Telephone Number: () _____	
Specialty: _____	Certificate, License Number and State: _____	Date Signed: _____

PART C TO BE COMPLETED BY YOUR EMPLOYER

1. Employee's Name: _____	2. Social Security Number: _____	3. Policy / Plan Number: _____																														
4. Employee Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Intermittent <input type="checkbox"/> Seasonal <input type="checkbox"/> Other Explain: _____																																
5. Employment Date: _____	6. Effective Date of Insurance: _____																															
7. Date Regarding Last Day Worked: (a) Claimant's last day worked before this disability: _____ (b) Exact reason for separation from work on the date listed _____ (c) Is lack of work <input type="checkbox"/> Temporary? <input type="checkbox"/> Permanent? (d) Has claimant returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give date: _____ If the work was intermittent, list dates: _____																																
8. Continued Pay (a) Have you paid the claimant since the last day of work? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) These monies represent pay From: _____ To: _____ (c) Total gross paid for the above period: \$ _____ Amount per week \$ _____ (d) Check or Circle the number that best describes the monies paid in item (c) <input type="checkbox"/> 1. Regular weekly wage and/or sick pay <input type="checkbox"/> 2. Regular vacation (if designated for a specific time period) <input type="checkbox"/> 3. Pension <input type="checkbox"/> 4. Difference between regular weekly wage and disability benefits to be received <input type="checkbox"/> 5. Supplemental benefits or gratuities <input type="checkbox"/> 6. Payments required to be made under the State mandated temporary disability benefit plan pursuant to the New Jersey Disability law (e) Do you wish to have benefit payments (made payable to claimant) routed to you during wage continuation period? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please note: employee must agree and provide signature in claimant section in order to process this request.) Note: Items (d) 1, 2, and 3 may reduce benefits to the claimant.																																
9. Worker' Compensation Liability (a) Did the claimant's disability happen in connection with his / her work or while on premises, or was the disability due in any way to his / her occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) If "Yes," have you filed, or do you intend to file a Workers' Compensation claim on behalf of this claimant? <input type="checkbox"/> Yes <input type="checkbox"/> No (c) If "Yes," give Workers' Compensation carrier Name _____ Address _____ Telephone number (____) _____																																
10. Base Weeks And Base Gross Wages In how many calendar weeks did this claimant earn \$145* or more with you in NEW JERSEY EMPLOYMENT during his/her base year, which is the 52 weeks immediately preceding the week in which the disability began? *2010 BASE WEEK AMT \$145. Changes Jan 1st each year. (Include all wages earned by the claimant.) (a) Total number of Base Weeks _____ (b) Total Gross Wages in Base Year _____																																
11. Regular Weekly Wage _____																																
12. Weekly Wages Indicate below: Dates and claimant's Gross Earnings in NJ employment during the eight calendar weeks prior to the week in which the disability began.																																
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Description of Calendar Week</th> <th style="text-align: left;">Calendar Week Ending Date</th> <th style="text-align: left;">Gross Paid</th> </tr> </thead> <tbody> <tr><td>Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr><td>2nd Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr><td>3rd Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr><td>4th Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr><td>5th Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr><td>6th Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr><td>7th Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr><td>8th Week Before Disability</td><td></td><td style="text-align: right;">\$</td></tr> <tr> <td colspan="2">Total Gross Wages For the Above Eight Weeks</td> <td style="text-align: right;">\$</td> </tr> </tbody> </table>			Description of Calendar Week	Calendar Week Ending Date	Gross Paid	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		\$	Total Gross Wages For the Above Eight Weeks		\$
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13. Is employee enrolled in a Hartford LTD Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," effective date: _____																																
14. Based on the employer/employee premium contributions made over the last 3 years, what percentage of the Weekly Disability Benefit is considered taxable? _____% LTD _____% (If blank, we will code the benefit as 100% taxable until you submit written notice of the correct taxable %.)																																

I certify that the above information is correct.

Firm Name _____	Signed _____
Address _____	Official Title _____
Telephone Number: () _____	Date Signed: _____