

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: ()	

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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: _____
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4. Employee Status: Full Time Part Time Intermittent Seasonal Other Explain: _____

5. Employment Date: _____	6. Effective Date of Insurance: _____
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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 Temporary? Permanent?

(d) Has claimant returned to work? Yes 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? Yes 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)

1. Regular weekly wage 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. Supplemental benefits or gratuities

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?
 Yes 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? 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," give Workers' Compensation carrier Name _____
Address _____ Telephone number (____) _____

10. Base Weeks And Base Gross Wages

In how many calendar weeks did this claimant earn \$144* or more with you n NEW JERSEY EMPLOYMENT during his/her base year, which is the 52 weeks immediately preceding the week in which the disability began? *1999 BASE WEEK AMT \$144. 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.

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		\$

13. Is employee enrolled in a Hartford LTD Plan? Yes No If "Yes," effective date: _____

Based on the employer / employee premium contributions made over the last 3 years, what percentage of the Weekly Disability _____ % LTD _____ % benefit is considered taxable? If blank, we will assume the benefit is 100% taxable.

I certify that the above information is correct.

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