Clear Form

Syracuse Benefit Management Services Center
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Hartford Fire Insurance Company
Hartford Life Insurance Company

PART A — CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE
NOTICE OF NEW JERSEY TEMPORARY DISABILITY BENEFITS CLAIM

1. Name (Last, First, Middle) as shown on your Social Security card.
2. Birth Date
3. Social Security Number
4. Mailing address (Street, City or Town, State, Zip Code)
5. Home Telephone Number ( )
6. Married (Check one.) ☐ Yes ☐ No
7. ☐ Male ☐ Female
8. Employer (Name, Address and Telephone number)
9. Occupation
10. Are you a citizen of the United States? ☐ Yes ☐ No **If "No," complete block #11 & #12, and give country of origin.**
11. Alien Reg. No.
12. Work Authorization From ____ To ____

	Month	Day	Year
13. The last day you worked before your disability began			
14. The first day you were unable to work due to present disability **(Include Saturday, Sunday, or Holiday)**			
15. If now recovered, date of your recovery or return to work			

16. Date(s) of emergency room care _____ Month/Day/Year or hospitalization From: _____ Month/Day/Year To: _____ Month/Day/Year
17. Describe your disability: — If due to accident, give date: _____ Month/Day/Year
18. Was this disability caused by your job? ☐ Yes ☐ No If "Yes," describe:
19. Name and address of physician or hospital treating you for this disability:

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.

20a. Name and Address: (Street) (City) (State) (Zip)
Period of Employment: From _____ Month/Day/Year To _____ Month/Day/Year
Telephone No. ( )
Work Location
Occupation:
Union Name:
Division:

20b. Name and Address: (Street) (City) (State) (Zip)
Period of Employment: From _____ Month/Day/Year To _____ Month/Day/Year
Telephone No. ( )
Work Location
Occupation:
Union Name:
Division:

21. Other Benefits: (You must answer each question listed below for the period of disability covered by this claim.)

a. Have you been working (including self-employment)? ☐ Yes ☐ No
b. Have you been receiving remuneration, i.e., wages, salary or vacation pay? ☐ Yes ☐ No

22. Since your last day of work have you received, claimed or applied for

a. Social Security benefits? ☐ Yes ☐ No
b. Social Security Retirement benefits? ☐ Yes ☐ No
c. Pension benefits from your most recent employer? ☐ Yes ☐ No
d. Any other disability benefits provided by your employer or Union? ☐ Yes ☐ No
e. Workers' Compensation benefits? ☐ Yes ☐ No
f. Unemployment insurance benefits? ☐ Yes ☐ No

23. I request voluntary Federal Tax Withholding ☐ Yes ☐ No If "Yes," indicate the amount to be withheld from weekly benefits. $_____
($20.00 minimum withholding per week)

24. **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.

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)

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

1. Patient was first treated by me on ..... Month Day Year

   Patient was last treated by me on ..... Month Day Year

2. Is the patient unable to perform his/her regular work? ☐ Yes ☐ No
   If "Yes," please enter the date the disability began ..... Month Day Year

3. Estimate recovery (give the approximate date claimant will be able to return to work) ..... Month Day Year

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

5. Diagnosis (nature and cause of this disability which prevents claimant from working): _____

   _____ ICD Code: _____

   Clinical data and test to support diagnosis: _____

6. (a) If pregnant, provide estimated date of delivery..... Month Day Year
   Complications, if any: _____
   (b) If pregnancy has terminated, enter the date ..... Month Day Year
   and the reason: ☐ Vaginal ☐ C-Section ☐ Miscarriage ☐ Others

7. Date(s) of emergency room care or hospitalization: ***From:*** Month Day Year ***To:*** Month Day Year

8. Type of Surgery: _____ CPT Code: _____ Date of Surgery: _____ Date Surgery Contemplated: _____

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?

_____ _____
(Print Doctor's Name and Degree) **(Doctor's Signature)**

_____ _____
Street Address **(City)** **(State and Zip)** **(Specialty)** **(Certificate License No. and State)**

(Telephone Number) (_____) _____ **(Date Signed)** _____

PART C | TO BE COMPLETED BY YOUR EMPLOYER

1. EMPLOYEE NAME: | Social Security Number | Policy /Plan Number

2. EMPLOYEE STATUS: ☐ Full Time ☐ Part Time ☐ Intermittent ☐ Seasonal ☐ Other Explain:

   EMPLOYMENT DATE: _____ EFFECTIVE DATE OF INSURANCE: _____

3. DATA REGARDING LAST DAY WORKED
   (a) Claimant's last day worked before this disability Month Day Year
   (b) Exact reason for separation from work on the date listed in item (a) include labor dispute): _____
   (c) Is lack of work ☐ Temporary? ☐ Permanent?
   (d) Has claimant returned to work? ☐ Yes ☐ No If "Yes," give date: _____
   If the work was intermittant, list dates: _____

4. CONTINUED PAY
   (a) Have you paid the claimant since the last day of work? ☐ Yes ☐ No
   (b) These monies represent pay ***From:*** Month Day Year ***To:*** Month Day Year
   (c) Total gross paid for the above period: $ _____
   Amount per week:$ _____ (If amount varies, attach list of dates and amounts.)
   (d) 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.

   Note: Items (d) 1, 2, and 3 may reduce benefits to the claimant.
   (e) Are you requesting to be compensated for wage continuance? ☐ Yes ☐ No

5. WORKERS' 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 name address and telephone number of your Workers' Compensation carrier. (Name) _____ (Tel. No.) _____
   (Address) _____

6. BASE WEEKS AND BASE GROSS WAGES In how many calendar weeks did this claimant earn $144* ***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? *1999 BASE WEEK AMT $144. ***Changes Jan 1 each year.***
   (a) Total number of Base Weeks _____
   (b) Total Gross Wages in Base Year _____
   (Include all wages earned by the claimant.)

7. REGULAR WEEKLY WAGE $ _____

8. 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 $ _____

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?** ***(See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.)*** **If blank, we will assume the benefit is 100% taxable.**

Firm Name _____

Address _____

City, State and Zip Code _____

I certify that the above information is

Signed _____

Official Title _____

Telephone Number ( ) _____ Date _____