

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.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
		7. <input type="checkbox"/> Male <input type="checkbox"/> Female		
8. Employer (Name, Address and Telephone number)			9. Occupation	
10. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," complete block #11 & #12, and give country of origin.		11. Alien Reg. No.	12. Work Authorization From _____ To _____	
13. The last day you worked before your disability began		Month	Day	Year
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 _____ or hospitalization From: _____ To: _____ Month/Day/Year Month/Day/Year Month/Day/Year				
17. Describe your disability:			If due to accident, give date: _____ Month/Day/Year	
18. Was this disability caused by your job? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		Period of Employment:		Telephone No.
_____ _____ (Street) (City) (State) (Zip)		From _____ To _____ Month/Day/Year Month/Day/Year		() _____
				Work Location
Occupation:		Union Name:		Division:
20b. Name and Address:		Period of Employment:		Telephone No.
_____ _____ (Street) (City) (State) (Zip)		From _____ To _____ Month/Day/Year Month/Day/Year		() _____
				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)?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Have you been receiving remuneration, i.e., wages, salary or vacation pay?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
22. Since your last day of work have you received, claimed or applied for				
a. Social Security benefits?		<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Any other disability benefits provided by your employer or Union?	
b. Social Security Retirement benefits?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Pension benefits from your most recent employer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Workers' Compensation benefits?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			f. Unemployment insurance benefits?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. 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. \$ _____ <i>(\$20.00 minimum withholding per week)</i>				
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
 Patient was last treated by me on

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

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

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

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.....
 Complications, if any: _____
 (b) If pregnancy has terminated, enter the date
 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 _____
 (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 intermittent, 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 _____