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 of 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 attach a statement giving 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. If you receive a request for continued medical certification, you must have your physician complete and sign the form. You should return it promptly.

3. When you recover or return to work, you should report this date immediately to the Division of Temporary Disability Insurance.

4. 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.

5. If your mailing address changes, you must notify the Division of Temporary Disability Insurance, PO Box 387, Trenton, NJ 08625-0387 immediately in writing. Notification must include your Social Security Number and signature. Disability checks cannot be forwarded by the Post Office.

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 & the records may only be used in proceedings arising under the Law.

CLAIM ASSISTANCE:

If you require any assistance with your claim, call:

- **Customer Service Section (609) 292-7060.**
- **Telecommunication Device for the Deaf (TDD) (609) 292-8319**
- **New Jersey Relay Service: TT user 1-800-852-7899**
  Voice User: 1-800-852-7897

Division of Temporary Disability Insurance FAX number: (609) 984-4138

NOTE: If your disability is expected to last for one year or longer, you may be eligible for Federal Social Security Disability Benefits.
Toll Free number for Social Security: 1-800-772-1213.

READ THE FOLLOWING INSTRUCTIONS BEFORE COMPLETING THE CLAIM FOR DISABILITY BENEFITS – DS-1

1. Complete the first page of this form (Part A.) YOU ARE RESPONSIBLE for having Part B completed by your doctor and Part C by your last employer. If you have worked for more than one employer during the past year, you may print Part C for completion by the other employer(s) to avoid processing delays. **ANY MISSING OR INCORRECT ENTRIES ON THIS FORM WILL DELAY PROCESSING OF YOUR CLAIM.** If you cannot have Parts B and/or C completed timely, complete Part A and return the application as soon as possible.
   REMEMBER SENDING IN SEPARATE PARTS OF THE APPLICATION WILL DELAY YOUR CLAIM. MAIL OR FAX PART A, PART B AND PART C TOGETHER TO:

   Division of Temporary Disability Insurance
   PO Box 387
   Trenton, NJ 08625-0387
   FAX No: (609) 984-4138

2. Read all questions carefully! Print or write clearly since this information is used to determine your right to benefits. IF YOU NEED ANY ASSISTANCE IN COMPLETING THIS FORM, PLEASE CALL THE CUSTOMER SERVICE SECTION IN TRENTON AT (609) 292-7060 AND HOLD FOR AN AGENT.

3. **BE SURE TO WRITE YOUR SOCIAL SECURITY NUMBER AND NAME ON EACH PORTION OF YOUR CLAIM.**

Instructions For Part A – Claimant's Statement

Items 1, 4 & 7	Include your full name and complete address (this information is required). If your mailing address is different than your home address, be sure to complete Item 7.
Item 3	Please print or type your Social Security Number **CLEARLY**. An incorrect or illegible number will cause a delay in processing your claim.
Item 9	You must complete this item. If your answer to this question is "No," you must complete Items 10 and 11 and give your country of origin.
Items 12 –15	Please give exact dates. Remember to include the dates of any Emergency Room care you may have received for this disability. If available, provide proof of emergency room care.
Items 18	List the name and address of the physician who treated you for this disability. You must be under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist or chiropractor. If you have been treated by more than one physician, attach a separate piece of paper with their names and addresses.
Item 19	Starting with your most recent employer, list all employers, including those for whom you worked part-time, for the last **18 months**. If you had more than three employers, list the others with the dates you worked on a separate piece of paper and attach it to the claim form. Give business names and addresses as they appear on your pay envelopes, pay checks, employers' stationery or as listed in the telephone book.
Item 22	In the event that you are unable to telephone our agency, you may designate a representative in this space to obtain information on your behalf. **If there is no one listed, only YOU will be able to obtain information on your claim from this agency.**
Item 23	**Sign and date the claim form. Include your telephone number.**

Important: Keep a copy of the completed claim form and this instruction sheet for your records.

PART A **INFORMATION TO BE COMPLETED BY THE CLAIMANT – Print or Type** WDS1(10-03)

STATE OF NEW JERSEY– DEPARTMENT OF LABOR–DIVISION OF TEMPORARY DISABILITY INSURANCE

1. **Name**: (Last, First, Middle)

2. **Birth Date**

3. **Social Security Number**

4. **Home Address – required** (Street, Apt #, City, State, Zip Code)

5. County

6. Male ☐ Female ☐

7. **Mailing Address – if different** (Street, Apt #, City State, Zip Code)

8. Occupation

9. Are you a citizen of the United States? Yes ☐ No ☐
If **NO**, answer #10 & 11 and give country of origin: _____

10. Alien Reg. No.

11. Work Authorization
From _____ To _____

	Month	Day	Year
12a. Reason for separation: ☐Illness/Accident/Maternity ☐Terminated ☐Quit 12b. What was the last day that you actually worked before your disability began?			
13. The **first day you were unable to work** due to present disability: (Include Saturday, Sunday, or Holiday) Do not list future dates			
14. **Date you recovered or returned to work:** (Do not use dates in the future)			

15. Date(s) of emergency room care: _____ (Month/Day/Year) or hospitalization: From _____ (Month/Day/Year) To _____ (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 3 employers, list the remaining employers on a separate sheet of paper and attach to this form.

19a. Name and address of your most recent employer:
_____
_____
(Street) (City) (State) (Zip)
Period of employment: From _____ To _____
Telephone: _____ Work Location _____ City State
Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

19b. Name and address:
_____
_____
(Street) (City) (State) (Zip)
Period of employment: From _____ To _____
Telephone: _____ Work Location _____ City State
Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

19c. Name and address:
_____
_____
(Street) (City) (State) (Zip)
Period of employment: From _____ To _____
Telephone: _____ Work Location _____ City State
Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

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 remuneration i.e., wages, salary 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. Any other disability benefits provided by your employer or union? Yes ☐ No ☐
d. Unemployment Insurance Benefits? Yes ☐ No ☐

22. 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 ( ) _____

23. **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 obtain any medical and employment information that is necessary to determine my eligibility for benefits.

Sign Here _____ Date _____
Witness signature if claimant writes an "X" _____ Phone No. ( ) _____

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Claimant's Name: _____

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** _____ (Month/Day/Year) **TO** _____ (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. 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) ( ) _____ (Phone Number) ( ) _____ (FAX Number)

1. CLAIMANT'S NAME:
CLAIMANT'S TELEPHONE NO:

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SOCIAL SECURITY NUMBER

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
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** ____|____|____ (Month/Day/Year) **TO** ____|____|____ (Month/Day/Year)
c. Total gross paid or to be paid for the above period: $_____

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 #_____

8. BASE WEEKS AND BASE YEAR GROSS WAGES A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of $103 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

Firm Name _____
Address _____
City, State, Zip_____
Mailing Address, If Different_____
FAX No. ( ) _____

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT
Signed_____ Date_____
Print or Type Name _____
Official Title_____
Telephone ( ) _____