CLAIM FOR CONTINUED BENEFITS - DDU

Division of Temporary Disability Insurance Disability During Unemployment PO Box 956 Trenton, NJ 08625-0956	Name:
	Social Security Number: _______________|________|_______________
	Date of Claim:

You and your doctor must complete this form and return it to the address listed above if you continue to be unable to perform any work after the last day for which you were awarded disability benefits.

☐ My name has changed to:____

☐ My new mailing address is: Street______________________________________ Apt #_________

City__________________________State__________Zip Code________

I was/will be unable to do any work after the last day for which I was awarded disability benefits. I hereby claim benefits for my continued disability. I certify that I continue to meet all eligibility requirements of the Unemployment Compensation Law except for the ability to work as certified below by my doctor. I also certify that I have not claimed or received benefits or payments from any other source(s) for any period for which I have claimed temporary disability benefits. I understand that if any of the foregoing statements made by me are known to be false, or I willingly fail to disclose a material fact, I may be subject to penalties which may include criminal prosecution.

____ ___________________________

(Claimant's Signature) (Date)

MEDICAL CERTIFICATION

What are your objective physical findings?____

What is the current diagnosis?____

What has the treatment been to date?____

List all dates of treatment:______________________________Date of Next Appointment: ___________

Is the claimant able to do any work? ☐ Yes ☐ No. If Yes, as of what date?_______________________

If No, Please complete below:

PROGNOSIS/RECOVERY DATE: ___________________ Please give estimated date. Do not use "Unknown", "Indefinite," "Undetermined." Prognosis may be revised later if necessary.

If claimant is pregnant, please provide: Date pregnancy terminated:______________________________

☐ Normal Delivery ☐ C-Section ☐ Other

Complications, if any_____________________________________

Physician's Name and Degree ____

(Please Print)

Address____Telephone No (______)____________

License No. and State_________________________Medical Specialty______________________________

Physician's **Original** Signature________________________________Date_________________________