DS-1

Part A

New Jersey – Temporary Disability Insurance Application

You are responsible for having your healthcare provider and employer complete Parts B & C of this application. ***Print clearly and answer ALL questions or your benefits may be delayed.***

FILE ONLINE FOR FASTER CLAIM PROCESSING! DS-1(1/19)

1 Name: Last First Middle

DSDSDS

2 Date of Birth _____|_____|_____

Internal Code: DSDSDS

3 Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

4 Home Address (Street, Apt #, City, State, ZIP Code)

5 County

6 Mailing Address – *if different from home address* (Street, Apt #, City, State, ZIP Code)

7 ☐ Male ☐ Female

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
12 What was the last day that you actually worked before your disability began?			
13 Reason for separation: ☐ Illness/Accident/Maternity ☐ Terminated ☐ Quit			
14 What was the **first day you were unable to work and under medical care** due to this disability? (Include Saturday, Sunday or holiday.)			
15 If you have **recovered or returned to work from this disability, give the date** (Do not use dates in the future)			

16 Date(s) of emergency room care or hospitalization: from _____|_____|_____ to _____|_____|_____
If dates are provided, please attach proof (i.e. discharge papers) Month / Day / Year Month / Day / Year

17 Describe your disability (If an injury, state how and where it happened)_____

18 Was this injury or illness caused by your job? **(This question must be answered.)** ☐ Yes or ☐ No

If Yes, date of work related injury or illness: _____|_____|_____
Was your employer notified that your injury was caused by your job? ☐ Yes ☐ No

19 Physician's Name _____Address _____Phone ( )_____

20 Other Benefits – During the period of disability covered by this claim, have you:

a Received any sick or vacation pay? ☐ Yes ☐ No

b Worked any days, including self-employment? ☐ Yes ☐ No

If yes, specify employer_____ and dates, from _____|_____|_____ to_____|_____|_____

21 Since your last day of work, have you received or applied for:

a Federal Social Security Disability benefits? ☐ Yes ☐ No
If yes, enter start/application date _____|_____|_____
If you received a Social Security award letter, please attach a copy.

b Pension benefits from most recent employer? ☐ Yes ☐ No

c Temporary Disability benefits from another state? ☐ Yes ☐ No

d Unemployment Insurance benefits? ☐ Yes ☐ No

22 Certification and Signature: I was unable to work during the period for which I am claiming benefits. I certify that I have read and understand my benefit rights and responsibilities. I am aware that if I provide any information in this application that I know to be false, or if I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution. I authorize the State of NJ to verify my Social Security Account Number, and obtain any medical, employment and Social Security benefit information necessary to determine my eligibility for benefits.

Sign Here _____ **Date**_____|_____|_____

Witness signature if claimant writes an "X" _____

Phone ( ) _____ Alternate Phone ( )_____ E-Mail _____

You may designate a representative to obtain claim information for you if you cannot call us yourself. The law permits us to give claim information only to you or your representative.

23 Representative Name _____ Date of Birth_____|_____|_____

Note: The NJ Temporary Disability Benefits program is not a "covered entity" under the Federal Health Information Portability and 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 and 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 and the records may only be used in proceedings arising under the law.

Claimant's Name _____

Claimant's Address _____

Claimant's Phone ( ) _____

Social Security Number

__ __ __- __ __- __ __ __ __

IMPORTANT TAX INFORMATION

If you choose to have Federal Income Tax withheld from your disability benefits, list the specific dollar amount you would like withheld weekly from your benefits. Do not give a % amount.

Weekly amount to be withheld for Federal Income Tax: $_____ (must be greater than $20)

PART A-1 CLAIMANT'S EMPLOYMENT INFORMATION

Instructions: Beginning with your last employer, list all of your employers for full-time, part-time, per diem work, etc. that you worked for over the past year. For each employer in the last six (6) months, have Part C completed or complete Part C-1 yourself. Any missing employment will delay your claim.

1a Name and address of your most recent employer:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|_____|_____ to____|_____|____
month / day / year month / day / year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

1b Employer Name and address:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|_____|_____ to____|_____|____
month / day / year month / day / year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

1c Employer Name and address:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|_____|_____ to____|_____|____
month / day / year month / day / year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

1d Employer Name and address:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|_____|_____ to____|_____|____
month / day / year month / day / year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

If you are submitting this claim more than 30 days after your first day of disability, please give your reason:

_____

_____

_____

If more space is needed, attach an additional sheet of paper. Be sure your name and Social Security number appears on all pages.

Claimant's Name _____

Claimant's Address _____

Claimant's Date of Birth _____

Social Security Number

__ __ __- __ __- __ __ __ __

PART B

MEDICAL CERTIFICATE – Have your healthcare provider complete Part B.

N.J.S.A 12:18-1.6 prohibits charging a fee to complete this form.

1 Patient has been under my care for this disability **FROM** _____|_____|_____ **TO** _____|_____|_____ _____
first date of treatment most recent treatment frequency

2 Date the patient was unable to perform regular work due to this disability _____|_____|_____
(Doctor's signature date must be on or after this date unless this is a pregnancy claim) Month Day Year

3 Estimated recovery date (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 (what is the disabling condition)_____

_____ **ICD Code**_____

6 Do you believe this patient is mentally capable of handling their own affairs, including the use of benefits? ☐ Yes ☐ No

7a If pregnancy, provide estimated date of delivery: _____|_____|_____
Month Day Year

b Complications, if any pre-term_____postpartum_____

c If pregnancy terminated, enter the date: _____|_____|_____
Month Day Year

And identify the reason: ☐ Birth ☐ C-Section ☐ Miscarriage ☐ Abortion

8 Date(s) of emergency room care or hospitalization: from _____|_____|_____ to _____|_____|_____
Month Day Year Month Day Year

9 Type of surgery _____ Date of Surgery _____|_____|_____ Anticipated Surgery Date _____|_____|_____
Month Day Year Month Day Year

Is surgery for cosmetic purposes only? ☐ Yes ☐ No

10 Was this disability ☐ Due to an accident at work ☐ Due to the nature of the work ☐ Not related to their work

11a Was this patient referred to you? ☐ Yes ☐ No If Yes, name of referring doctor _____

Referring doctor's phone ( ) _____ **11b** Name of any specialist treating the patient _____

12 I certify that the above statements describe the patient's disability and the estimated duration thereof

_____ _____ _____
Print Doctor's Name License No. and State* Specialty

_____ Phone ( ) _____
Street Address

_____ Fax ( ) _____
City State ZIP Code

_____ _____|_____|_____ ☐ Check, if Resident.
Signature of Doctor **Date Signed**

The date signed must be on or after the date in Question 2, unless this is a pregnancy claim.

***If completed by a Physician's Assistant (PA-C), provide the license number of the supervising doctor.**

Claimant's Name _____ Phone ( ) _____ Social Security Number __ __ __- __ __- __ __ __ __

Claimant's Address _____

PART C — EMPLOYER STATEMENT – Have your employer or company representative complete Part C.

1 EMPLOYER STATUS

Your Federal Employer Identification Number (FEIN) _____

2 WORK LOCATION

Provide the location that the employee physically reports to work

City_____ State_____

3 CHECK DAYS OF THE WEEK that the employee normally works

☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Varies

4 LAST ACTUAL DAY WORKED before this disability

(Do not use a payroll week ending date) _____|_____|_____ Month Day Year

a Reason for separation from work _____

b Is separation ☐ Temporary? ☐ Permanent?

c Has claimant returned to work? ☐ Yes ☐ No

If Yes, give date _____|_____|_____

d If the work was intermittent, list dates _____

5 CONTINUED PAY

a Have you paid or do you expect to pay the claimant for any period after the last day of work? ☐ Yes ☐ No

b If yes, give dates from: _____|_____|_____ to: _____|_____|_____ Month Day Year Month Day Year

c Amount per week $_____ (if amount varies please attach a list of dates/amounts)

d Total amount paid for entire given period $_____

e Check the number that best describes the monies paid in item c.

☐ 1. Paid time off (vacation, sick, personal, etc.)

☐ 2. Difference between regular wkly wages and disability benefits to be received

☐ 3. Supplemental benefits (unallocated payout will have no impact)

☐ 4. Severance pay With notice ☐ In lieu of notice ☐

☐ 5. Pension (attach pension approval letter)

Note: Items 1, 4, and 5 may reduce benefits to the claimant.

6 GOVERNMENT EMPLOYERS

a Payroll Number (For N.J. state employees) _____

b If claimant has applied for or received donated leave, attach dates and amounts.

7 WORKERS' COMPENSATION LIABILITY

a Did the claimant's disability happen in connection with their work or while on your premises, or was the disability due in any way to their 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_____ Phone ( ) _____

Address_____

Policy #_____ Claim #_____

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Firm Name _____ Phone ( ) _____

Address _____ Fax ( ) _____

City _____ State _____ ZIP Code _____

Name/Title_____

8 BASE WEEKS / BASE YEAR WAGES

A base week is a calendar week in which the N.J. employee had gross earnings of **$172** or more.

a Total number of **Base Weeks** _____

b Total **Gross Wages** in Base Year $ _____ (52 weeks prior to first day of disability)

9 Weekly Wage (base hrs x rate) $_____

Hourly Rate $_____/hr

10 Weekly Wages

Provide claimant's GROSS earnings in New Jersey employment and period ending dates.

Note: If the weeks listed below include overtime, bonuses, etc., attach an explanation and separate the regular wages earned. **Payroll records will not be accepted in place of completing this statement.**

Description of Calendar Week	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

Signature_____

Do not sign/date before the last day worked

Date (required) _____|_____|_____

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Claimant's Name _____

Claimant's Address _____

Social Security Number

__ __ __- __ __- __ __ __ __

Part C-1

CLAIMANT CERTIFICATION OF WAGES & EMPLOYMENT – If any of your employers in the last six (6) months refuse to complete Part C, or if you are unable to reach them, you are required to use this form to provide proof of wages & employment in place of Part C. You must also attach proof of wages (paystubs, W-2 forms, tip records, etc.).

1 EMPLOYER NAME_____

2 EMPLOYER STATUS
Federal Employer Identification Number (FEIN)_____

3 EMPLOYER ADDRESS_____ _____ _____ _____
Street City State Zip

4 EMPLOYER PHONE (_____) _____ (HR Office, if available)

5 LAST DAY WORKED
My last physical day worked was _____|_____|_____
Month Day Year

6 WORK LOCATION
Provide the location that you physically reported to:
City _____ State _____

7 BASE YEAR
During the 52 calendar weeks prior to my first day of being disabled I worked _____weeks (with earnings of $172 per week or more) with this employer. My gross earnings, before deductions, during that time were: $_____

8 WEEKLY WAGES In the eight (8) weeks prior to my disability or family leave I earned the following with this employer:

Calendar Week-ending	Gross Wages	Calendar Week-ending	Gross Wages
1. ____/____/____	$_____	5. ____/____/____	$_____
2. ____/____/____	$_____	6. ____/____/____	$_____
3. ____/____/____	$_____	7. ____/____/____	$_____
4. ____/____/____	$_____	8. ____/____/____	$_____

9 CONTINUED PAY
Have you been paid or do you expect to be paid for any period after the last day of work? ☐ Yes ☐ No
If yes:
Dates paid: from: _____|_____|_____ to: _____|_____|_____ Amount per week $_____ Total amount paid $_____
Month Day Year Month Day Year

Check the number that best describes the monies paid in item c.
- ☐ 1. Paid time off (vacation, sick, personal, etc.)
- ☐ 2. Difference between regular weekly wages and disability benefits to be received
- ☐ 3. Other pay from your employer (explain): _____
- ☐ 4. Severance pay With notice ☐ In lieu of notice ☐
- ☐ 5. Pension (attach pension approval letter)

Note: Items 1, 4, and 5 may reduce your benefits.

10 CERTIFICATION AND SIGNATURE
My signature on this form indicates that the statements made by me are true and correct to the best of my knowledge. I make this statement with knowledge that the wages and employment information set forth herein will be used as a basis for determining the temporary disability/family leave benefits to which I may be entitled and that any willful misrepresentation or false statement made for the purpose of obtaining or increasing benefits will render me liable to penalties provided by Temporary Disability Benefits Law (N.J.S.A. 43:21-55).

Date_____ Claimant's Signature_____ Phone (_____) _____

FILE ONLINE FOR FASTER CLAIM PROCESSING AT:
myleavebenefits.nj.gov

How to complete the Claim for Disability Benefits *(form DS-1)*

— KEEP THIS PAGE FOR YOUR RECORDS — DO NOT RETURN —

- ▷ You (the claimant) must complete the first 2 pages of the application (parts A and A1).
- ▷ ***You*** are responsible for having your doctor complete part B and for having your employer(s) complete part C.
- ▷ If you worked for more than one employer during the past year, you must copy part C for your other employer(s) to complete. This will help us process your claim more quickly.
- ▷ If your doctor and employer(s) submit their parts separately, please complete and return parts A and A1 as soon as possible. If you cannot submit all parts together, we can process your claim quicker if we receive parts A and A1 first.

For quicker processing

- ▷ It is very important that you provide information that is accurate and true. Missing, incorrect, or illegible information will delay payment of your benefits. Print clearly.
- ▷ Write your name and Social Security number on each part of your claim and on all attachments.
- ▷ Give exact dates when dates are requested.
- ▷ If you need help completing the form, call 609-292-7060. You may need to hold to speak to an agent.

Submitting your application

1. Whenever possible, send all parts of your claim together. Sending separate pages will delay your claim. **Sending duplicate copies will also delay your claim.** Send additional copies *ONLY* if information has changed.
2. If you fax your claim, be sure to fax all 4 pages together (but not these instructions).
3. Send all parts (parts A, A1, B, and C) and any attachments to:

   mail: Division of Temporary Disability Insurance / P.O. Box 387 / Trenton, NJ 08625-0387

   fax: 609-984-4138

Claimant's Rights and Responsibilities

To file a claim for temporary disability benefits

It is your responsibility to file this claim *immediately after* you stop working due to your disability. If you file a claim before your last day of work, your benefits will be delayed.

By law, you must file a claim within 30 days after the start of your disability. If you file later, benefits may be denied or reduced. If you file more than 30 days after you disability started, give the reason why on the bottom of part A1.

Other income

You must tell us about any other income you are receiving. This includes sick pay, wages, pension, workers compensation benefits, Social Security Disability benefits, or disability benefits from your employer or union.

Continued medical certification

If you are eligible for TDI benefits, we will periodically send you a request for continued medical certification (form P30) to verify that you are still disabled and under a doctor's care. Return the form promptly to guarantee continuous benefits.

Online information

about temporary disability benefits:myleavebenefits.nj.gov

Return to work

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

Income tax withholding

If you want federal income tax (F.I.T.) deductions withheld from your disability benefits, attach form W-4S (Request for Federal Income Tax Withholding From Sick Pay) to your claim. You can get this form from your employer or the Internal Revenue Service (*irs.gov/pub/irs-access/fw4s_accessible.pdf*).

Help with your claim

Customer Service 609-292-7060