DS-1

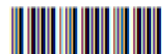
New Jersey Temporary Disability Benefits Application

Division of Temporary Disability & Family Leave Insurance
P.O. Box 387, Trenton, NJ 08625-0387
Fax: 609-984-4138

myLeaveBenefits.nj.gov

PART A: YOUR INFORMATION

DSDSDS



Internal Code	Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Profile Information

1 Last name First name Middle

2 Date of Birth ____|____|____ mm | dd | yy

3 Gender ______________

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 Phone (_____) ______________

Questions 8 and 9 are for statistical purposes only

8 With which racial/ethnic group(s) do you most identify?

☐ Caucasian ☐ Asian
☐ African American ☐ Native Hawaiian/Pacific Islander
☐ Latino/Hispanic ☐ American Indian/Alaskan Native

9 Check the highest level of schooling you have completed.

☐ Have not graduated high school ☐ Associate's/Bachelor's Degree
☐ High School Graduate/GED ☐ Graduate Degree

Disability Information

10 **First date you were unable to work** and under medical care for this disability ____|____|____ mm | dd | yy
(Include Saturday, Sunday or holiday)

11 Date you recovered or returned to work ____|____|____ mm | dd | yy

12 Date(s) of emergency room care or hospitalization from ____|____|____ mm | dd | yy to ____|____|____ mm | dd | yy
(If dates are provided, attach proof i.e. discharge papers)

13 Describe your disability (for injuries, explain how and where it happened) ______________________________

14 Physician's Name ______________ City ______________ State ________ Phone (_____) ______________

15 Was this injury or illness caused by your job? ☐ Yes ☐ No
If yes, have you or your employer(s) filed or intend to file a Workers' Compensation claim? ☐ Yes ☐ No

Additional Benefit Information

16 Do you want federal income tax withheld *weekly* from your benefits? ☐ Yes ☐ No
If yes, enter the *weekly* dollar amount to be withheld (not %) $ ________ (amount must be greater than $20)

17 During the period of disability covered by this claim, have you received or applied for:

a **Federal** Social Security Disability benefits? ☐ Yes ☐ No If Yes, enter start/application date ____|____|____
b Pension benefits from your current employer? ☐ Yes ☐ No If Yes, enter start date ____|____|____ Monthly amount $________
c Temporary Disability benefits from another state? ☐ Yes ☐ No
d Unemployment Insurance benefits? ☐ Yes ☐ No

Certification and Signature

18 I certify I was unable to work during the period for which I am claiming benefits. 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. You are hereby authorized to verify my Social Security 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" ________________________________

You may assign a representative to obtain claim information for you if you cannot call us yourself. We can only give claim information to you and your representative.

19 Approved Representative Name ________________________ Date of Birth ____|____|____

Representative Phone Number (_____) ________________________

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.

Name: ______________________________
Address: ______________________________
Phone: (_____)______________________________

Social Security Number
☐☐☐ ☐☐ ☐☐☐☐

PART B: EMPLOYMENT INFORMATION

Instructions: Starting with your last employer, provide information for all your employers in the 6 months before your leave began. If you need to list more employers, make a copy of this page. When listing your employment dates be sure to state the first and last day you physically reported to work. The last day you worked before your leave is critical in the determination of your claim.

1 Name of your most recent employer

Company______________________________

2 Federal Employer Identification Number (FEIN) *(see instructions)*
☐☐ — ☐☐☐☐☐☐☐

Street______________________________City______________State______________

3 Employed from _____|_____|_____ (mm | dd | yy) to _____|_____|_____ (mm | dd | yy)

4 ☐ Full time ☐ Part time ☐ Union

5 Occupation______________________________

6 Work Location City ______________ State ______________

7 Separation from this employer is
☐ Temporary ☐ Permanent

8 Which days do you normally work?
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

9 Regular Weekly Earnings
$______________

10 Supervisor's Name ______________________________

11 Phone (_____)______________________________

12 Have you tried working any days for this employer since your doctor disabled you? (see box 10 on Part A) ☐ Yes ☐ No

If yes, give dates _____|_____|_____ to _____|_____|_____

13 Have you been paid for any days after your last day of work? ☐ Yes ☐ No

If yes, from _____|_____|_____ to _____|_____|_____

Total amount paid $______________

This pay represents:

- ☐ Paid time off (vacation, sick, personal, etc.)
- ☐ Difference between regular wages and disability benefits
- ☐ Other pay from your employer (explain)______________
- ☐ Severance pay ☐ With notice ☐ In lieu of notice
- ☐ Donated Leave

1 Name of your employer

Company______________________________

2 Federal Employer Identification Number (FEIN) *(see instructions)*
☐☐ — ☐☐☐☐☐☐☐

Street______________________________City______________State______________

3 Employed from _____|_____|_____ (mm | dd | yy) to _____|_____|_____ (mm | dd | yy)

4 ☐ Full time ☐ Part time ☐ Union

5 Occupation______________________________

6 Work Location City ______________ State ______________

7 Separation from this employer is
☐ Temporary ☐ Permanent

8 Which days do you normally work?
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

9 Regular Weekly Earnings
$______________

10 Supervisor's Name ______________________________

11 Phone (_____)______________________________

12 Have you tried working any days for this employer since your doctor disabled you? (see box 10 on Part A) ☐ Yes ☐ No

If yes, give dates _____|_____|_____ to _____|_____|_____

13 Have you been paid for any days after your last day of work? ☐ Yes ☐ No

If yes, from _____|_____|_____ to _____|_____|_____

Total amount paid $______________

This pay represents:

- ☐ Paid time off (vacation, sick, personal, etc.)
- ☐ Difference between regular wages and disability benefits
- ☐ Other pay from your employer (explain)______________
- ☐ Severance pay ☐ With notice ☐ In lieu of notice
- ☐ Donated Leave

Name: ____________________
Address: ____________________
Phone: (_____) ____________________
Patient's Date of Birth: ____________________

Social Security Number

☐☐☐ ☐☐ ☐☐☐☐

PART C: MEDICAL CERTIFICATE

Have your healthcare provider complete this page. 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 ____|____|____ (first date of treatment) TO ____|____|____ (most recent treatment) ________ (frequency)

2 Date the patient was unable to perform regular work due to this disability ____|____|____ (mm | dd | yy)

3 Has your patient recovered from this disability? If so, provide recovery date ____|____|____ (mm | dd | yy)

4 Estimated recovery date
(If patient has not recovered, provide approximate date patient will be able to return to work) ____|____|____ (mm | dd | yy)

5 Diagnosis (describe 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

7 If disability is due to pregnancy, provide the estimated date of delivery ____|____|____ (mm | dd | yy)

a Pre-term complications ____________________ Postpartum complications ____________________

b If patient has delivered, enter the delivery date ____|____|____ (mm | dd | yy)

Identify the type of delivery ☐ Birth ☐ C-Section ☐ Miscarriage ☐ Abortion

8 Date(s) of emergency room care or hospitalization from ____|____|____ (mm | dd | yy) to ____|____|____ (mm | dd | yy)

9 Type of surgery ____________________ Date of Surgery ____|____|____
Anticipated Surgery Date ____|____|____ Is surgery for cosmetic purposes only? ☐ Yes ☐ No

10 Was this patient referred to you? ☐ Yes ☐ No If yes, name of referring doctor ____________________

HEALTHCARE PROVIDER CERTIFICATION AND SIGNATURE

I certify the above statements describe the patient's disability period:

Print Name ____________________ Signature ____________________ Date __________

Certificate License No. and State ____________________ Physician Specialty ____________________

Street Address ____________________ ☐ Check, if Resident

City ____________________ State __________ ZIP Code __________

Phone (_____) ____________________ Fax (_____) ____________________

FILE ONLINE FOR FASTER CLAIM PROCESSING AT

myLeaveBenefits.nj.gov

How to Complete the Claim for Temporary Disability Benefits

- This application is for disability leave. If you are claiming benefits for family caregiving or bonding, complete form (FL-1) Family Leave Benefits application. You cannot use one application (DS-1 or FL-1) to file for both programs.
- You must complete the first 2 pages of the form. **(Parts A and B)**
- You will need to provide your employer's Federal Employer Identification Number on **Part B.** You can get this number from either your last year's W-2 form or your Human Resources office. Your employer is not required to complete this form but you can ask them to help you with any questions on Part B.
- **Part C** must be completed by your healthcare provider.
- You have 30 days from the first day of your disability to file your claim. If your claim form is received more than 30 days from the first day of your leave, you must provide a reason why the claim was not filed on time.
- Benefits may be reduced or denied for late applications.

Remember

- You must complete every question accurately and write legibly.
- **Any missing information may cause your claim to be denied.**
- Demographic questions have no effect on the approval or denial of your claim.
- Write your name and Social Security number on each page of your claim and on all attachments.
- Exact dates must be given. Do not write "present" or "current."
- If you need to list more than 2 employers, make a copy of Part B to list additional employment.
- If you return to work while you are claiming Temporary Disability benefits, report this date immediately to the Division of Temporary Disability Insurance to avoid overpayment.

How to Send Us Your Claim Form

There are 2 options for you to submit this form. Choose only one, as sending multiple copies will delay processing. If you filed your claim online, do not also submit a paper application.

1. Fax this completed form to 609-984-4138.
2. Mail this completed form to: Division of Temporary Disability Insurance / P.O. Box 387 / Trenton, NJ 08625-0387.

After Submitting Your Claim

- After being approved for Temporary Disability benefits, you may receive a form (P-30) "Request to Claimant For Continued Claim Information." Use this form to claim additional benefits. You and your healthcare provider can complete your parts online to ensure uninterrupted benefits.
- You can find information and check your claim status at *myLeaveBenefits.nj.gov.*
- For more help on your claim, call Customer Service: 609-292-7060.