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

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PART A *YOUR INFORMATION*

Internal Code

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Profile Information

1 Last name First name Middle

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

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

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

5 Gender _____

6 County

7 Phone (____) _____

Questions 8 and 9 are for statistical purposes only and do not affect eligibility

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

☐ Caucasian ☐ Native Hawaiian/Pacific Islander
☐ African American ☐ American Indian/Alaskan Native
☐ Asian Latino/Hispanic ☐ Yes ☐ No

9 Check the highest level of schooling you have completed.

☐ Have not graduated high school ☐ Associates/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 (Include Saturday, Sunday or holiday) ____|____|____ mm | dd | yy

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

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

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 percentage) $ _____ (amount must be at least $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. Be sure to state the first and last day you physically reported to work. Do not write "present" or "current."

1 Name of your most recent employer

Company_____

Street_____City_____State_____

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

☐☐ — ☐☐☐☐☐☐☐

3 Date of hire ____|____|____ (mm | dd | yy) to Last physical day of work *before* your disability ____|____|____ (mm | dd | yy)

4 ☐ Full time ☐ Part time

5 Union ☐ Yes ☐ No

6 Occupation_____

7 Work Location City _____ State _____

8 Separation from this employer is
☐ Temporary ☐ Permanent

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

10 Regular Weekly Earnings
$_____

11 Supervisor's Name _____

12 Phone (____)_____

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

If yes, give dates ____|____|____ to ____|____|____

14 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

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1 Name of other employer *(if applicable)*

Company_____

Street_____City_____State_____

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

☐☐ — ☐☐☐☐☐☐☐

3 Date of hire ____|____|____ (mm | dd | yy) to Last physical day of work *before* your disability ____|____|____ (mm | dd | yy)

4 ☐ Full time ☐ Part time

5 Union ☐ Yes ☐ No

6 Occupation_____

7 Work Location City _____ State _____

8 Separation from this employer is
☐ Temporary ☐ Permanent

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

10 Regular Weekly Earnings
$_____

11 Supervisor's Name _____

12 Phone (____)_____

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

If yes, give dates ____|____|____ to ____|____|____

14 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 (_____) _____