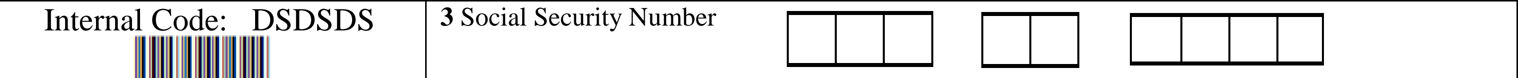
DS-1 Part A

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.* WDS-1 (1/17)

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 _____|_____|_____ (Month Day Year) to _____|_____|_____ (Month Day Year)
If dates are provided, please attach proof (eg. discharge papers)

17 Describe your disability (How, when, 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 worked, from _____|_____|_____ to_____|_____|_____

21 Since your last day of work, have you received, claimed 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, 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. You are hereby authorized 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.

WDS-1 (1/17)

Claimant's Name ______________________________

Claimant's Address ______________________________

Claimant's Phone (   ) ______________________________

Social Security Number

__ __ __- __ __- __ __ __ __

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. 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

Phone ____________________ Work 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

Phone ____________________ Work 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

Phone ____________________ Work 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

Phone ____________________ Work 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.

IMPORTANT TAX INFORMATION

If you choose to have federal income tax withheld from your disability benefits, you should complete a W-4S. List the specific dollar amount you would like withheld weekly from your benefits. Do not give a % amount.

WDS-1 (1/17)

Claimant's Name ______________________________

Claimant's Address ______________________________

Claimant's Phone ( ) ______________________________

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** ___|___|___ (first date of treatment) **TO** ___|___|___ (most recent treatment) _____ (frequency)

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

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______________________________

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 ___|___|___ (Month Day Year) to ___|___|___ (Month Day Year)

9 Type of surgery __________ Date of Surgery ___|___|___ (Month Day Year) Anticipated Surgery Date ___|___|___ (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, in my opinion, truly describe the patient's disability and the estimated duration thereof

______________________________ Print Doctor's Name

______________________________ License No. and State*

______________________________ Specialty

______________________________ Street Address

Phone ( ) ______________________________

______________________________ City State ZIP Code

Fax ( ) ______________________________

______________________________ **Signature of Doctor**

___|___|___ **Date Signed**
Must be signed on or after the date in Question 2, unless a pregnancy claim.

☐ Check, if Resident.

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

WDS-1 (1/17)

Claimant's Name ______________________________ Phone ( )__________________

Social Security Number

__ __ __- __ __- __ __ __ __

Claimant's Address ____

PART C

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

2 EMPLOYER STATUS

Your Federal Employer Identification Number (FEIN) ______________________

3 PRIVATE PLAN COVERAGE

a Do you have a New Jersey approved Private Plan? ☐ Yes ☐ No

b If Yes, is the claimant covered under this plan? ☐ Yes ☐ No

4 Check the days of the week that the claimant normally works.

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

5 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 ________________________________

6 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 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.

7 GOVERNMENT EMPLOYERS

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

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

8 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____

9 BASE WEEKS / BASE YEAR WAGES

A base week is a calendar week in which the N.J. employee had gross earnings of **$168** or more.

a Total number of **Base Weeks** __________

b Total **Gross Wages** in Base Year $ __________

(52 weeks prior to first day of disability)

10 Weekly Wage (base hrs x rate) $__________

Hourly Rate $_______/hr

11 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.

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) ________|_________|_________

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

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

- ▷ 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 last employer complete part C.
- ▷ If you worked for more than one employer during the past year, you may 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: *nj.gov/labor*

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