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 **10** Alien Reg. No. **11** Work Authorization

If **NO**, answer #10 & 11 and give country of origin: _____ 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 (eg. discharge papers) Month Day Year Month Day Year

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.

Claimant's Name _____ Social Security Number

Claimant's Address _____ ___-___-____

Claimant's Phone ( ) _____

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

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.

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.

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Claimant's Name _____ Social Security Number

Claimant's Address _____ ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Claimant's Phone ( ) _____

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 (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_____

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** ☐ Check, if Resident.

Must be signed on or after the date in Question 2, unless a pregnancy claim.

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