STATE OF NEW JERSEY – DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF TEMPORARY DISABILITY INSURANCE

PART A — INFORMATION TO BE COMPLETED BY THE CLAIMANT – Print or Type

WDS-1(R-2-08)

1. **Name**: Last First Middle
2. **Birth Date** | |
3. **Social Security Number** | |

4. **Home Address – required** (Street, Apt #, City, State, Zip Code)
5. County

6. **Mailing Address – if different** (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
12a. What was the last day that you actually worked before your disability began? 12b. Reason for separation: ☐Illness/Accident/Maternity ☐Terminated ☐Quit			
13. What was the **first day you were unable to work** due to present disability: (Include Saturday, Sunday, or Holiday) Do not list future dates			
14. If you have **recovered or returned to work from this disability, list date:** (Do not use dates in the future)			

15. Date(s) of emergency room care:_________________ (Month/Day/Year) or hospitalization: From __________________ (Month/Day/Year) To __________________ (Month/Day/Year)

16. **Describe your disability (How, when, where it happened)** ____

____

17. Was this injury/illness caused by your job? Yes☐ or No ☐ (This question must be answered.)
If Yes, date of work related injury/illness:_________________
Was your employer notified that your injury was caused by your job? Yes ☐ or No ☐

18. Identify the physician or hospital treating you for this disability: Name: ________________________________

Address: ________________________________ Telephone: (_____)______________________

Employment Information – Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If you had more than 2 employers, list the remaining employers on the reverse side of this form in the space provided.

19a. Name and address of your most recent employer:
____
____
(Street) (City) (State) (Zip)

Period of employment: From _______________ (month/day/year) To____________ (month/day/year)
Telephone: ____________________ Work Location ________________ (City) (State)

Occupation: ________________________________ Full time ☐ Part time ☐ Union _____________ Division__________________

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

19b. Name and address:
____
____
(Street) (City) (State) (Zip)

Period of employment: From _______________ (month/day/year) To____________ (month/day/year)
Telephone: ____________________ Work Location ________________ (City) (State)

Occupation: ________________________________ Full time ☐ Part time ☐ Union _____________Division__________________

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

20. **Other Benefits – You Must Answer Each Question Listed Below For the Period of Disability Covered By This Claim:**
   a. Have you worked after your disability began? (Including self-employment) Yes ☐ No ☐
   b. Have you been receiving sick or vacation pay? Yes ☐ No ☐
   c. Have you been involved in a labor dispute? Yes ☐ No ☐

21. **Since your last day of work have you received, claimed or applied for:**
   a. Federal Social Security Disability Benefits? Yes ☐ No ☐
   b. Pension benefits from your most recent employer? Yes ☐ No ☐
   c. Temporary Disability Benefits from another State? Yes ☐ No ☐
   d. Any other disability benefits provided by your employer or union? Yes ☐ No ☐
   e. Unemployment Insurance Benefits? Yes ☐ No ☐

BE SURE TO COMPLETE AND SIGN PART A1

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Claimant's Name:____

Claimant's Telephone No: (_____)___________________________

Social Security Number

| |

PART A1

CLAIMANT'S AUTHORIZATION AND CERTIFICATION STATEMENTS

MUST BE COMPLETED AND SIGNED BY THE CLAIMANT

1. Please designate a representative to obtain claim information for you if you cannot call this Agency yourself. The Law only permits claim information to be given to you or your representative.

Representative Name: ____Birth Date:___________________________

Phone (______)___________________________________

2. **Certification and Signature** I was unable to work during the period for which benefits are claimed and hereby certify that I have read and understand my benefit rights and responsibilities. I am aware that if any of the foregoing statements made by me are known to be false, or 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 entitlement information that is necessary to determine my eligibility for benefits.

Sign Here ____Date____________________________

Witness signature if claimant writes an "X" ____

Phone No. (_____)_____________________________ E-Mail Address ____

Note: The NJ Temporary Disability Benefits Program is not a "covered entity" under the Federal Health Information Portability & 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 & 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.

USE THIS SPACE TO LIST ADDITIONAL EMPLOYERS FOR QUESTION 19.

Name and address:

____

____

(Street) (City) (State) (Zip)

Period of employment: From ______________ To____________

month/day/year month/day/year

Telephone: _____________ Work Location ______________________

City State

Occupation: ______________________________ Full time ☐ Part time ☐ Union ____________Division___________________

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

Name and address:

____

____

(Street) (City) (State) (Zip)

Period of employment: From ______________ To____________

month/day/year month/day/year

Telephone: _____________ Work Location ______________________

City State

Occupation: ______________________________ Full time ☐ Part time ☐ Union ____________Division___________________

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION FOR QUESTIONS ON PART A

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

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Claimant's Name: ______________________________

Claimant's Address: ______________________________

Claimant's Telephone No: (_______) ______________________________

Social Security Number

| |

PART B

MEDICAL CERTIFICATE

(TO BE COMPLETED BY YOUR DOCTOR AFTER YOU BECOME DISABLED)

1a. Patient has been under my care for this period of disability: **FROM** ____________ **TO** ____________
(Month/Day/Year) (Month/Day/Year)

b. Frequency of treatment: ______________________

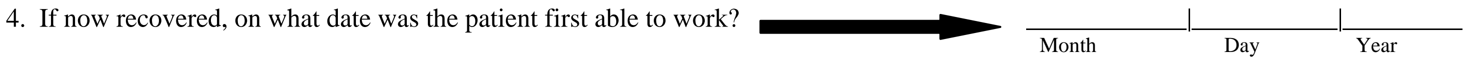
c. Patient was last treated by me on:

_______|_______|_______
Month Day Year

2. Enter the date the patient was unable to perform his/her regular work due to this disability: _______|_______|_______
Month Day Year

3. Estimated Recovery: (Give the 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: (nature and cause of this disability which prevents patient from working) ______________________

______________________ **ICD Code**: ____________

Clinical data and tests to support diagnosis: ______________________

6a. 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

7a. Date(s) of emergency room care or hospitalization: FROM ____________ TO ____________

b. Name and address of any specialist treating patient: ______________________

8. Type of surgery: ____________ Date of Surgery ____________ Anticipated Surgery Date ____________

Is surgery for cosmetic purposes only? ☐ Yes ☐ No

9. In your opinion, was this disability: ☐ Due to an accident at work? ☐ Not related to his/her work
☐ Due to a condition which developed because of the nature of the work.

10. Was this patient referred to you? ☐ Yes ☐ No If yes, please supply the information below if available.

Name of referring doctor ______________________ Referring doctor's telephone #: ____________

11. I certify that the above statements, in my opinion, truly describe the patient's disability and the estimated duration thereof:

______________________ (Print Doctor's Name and Medical Degree)

______________________ (Original Signature of Doctor Required)

____________ (Date Signed)

______________________ (Address)

______________________ (Certificate License No. and State)

If Resident, check ☐

______________________ (Address)

______________________ (Specialty of Treating Physician)

____
(City) (State) (Zip Code)

Telephone Number: ( ) ______________________ FAX Number: ( ) ______________________

1. Claimant's Name: ______________________________ Clt's Tele #(____)_____________

Clt's Address:____

SOCIAL SECURITY NUMBER

| |

PART C | **TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE** WDS-1(R-2-08)

2. EMPLOYER STATUS

What is your Federal Employer Identification Number: ____________________

3. PRIVATE PLAN COVERAGE (NJ approved plan/replaces State Plan coverage)

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

b. If "Yes", is claimant covered under this approved Private Plan? ☐Yes ☐No

4. LAST ACTUAL DAY WORKED before this disability
(do not use payroll week ending dates) ➡ ______|______|______
(Month / Day / Year)

a. Reason for separation from work if other than disability ________________________________

b. Is lack of work: ☐temporary? ☐ permanent?

c. Has claimant returned to work? ☐ Yes ☐ No
If "Yes", give date ➡ _______|_____|______
(Month / Day / Year)

d. If the work was intermittent, list dates:______________________________

5. CONTINUED PAY (do not enter wages earned prior to disability)

a. Have you paid or 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 list of dates and amounts.

d. Check the number that best describes the monies paid in item c.
- ☐ 1. Regular weekly wages and/or sick pay
- ☐ 2. Regular vacation (if designated for a specific time period)
- ☐ 3. Pension
- ☐ 4. Difference between regular weekly wage and disability benefits to be received
- ☐ 5. Full salary advanced to effect #4 above
- ☐ 6. Supplemental benefits or gratuities

Note: Items 1, 2, and 3 may reduce benefits to the claimant

6. GOVERNMENT EMPLOYEES (Complete this section)

a. Payroll number (For N.J. State Employees) ________________________

b. Number of earned sick leave days as of the last day worked. ___________

c. Has the claimant filed for or received Employment Disability Leave (SLI)? ☐ Yes ☐ No

d. If claimant has applied for or received donated leave, attach dates and amounts on a separate sheet of paper.

7. WORKERS' COMPENSATION LIABILITY

a. Did the claimant's disability happen in connection with his/her work or while on your premises, or was the disability due in any way to his/her 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______________________________Telephone (   ) _______________

Address____

Policy #_______________________ Claim #___________________________

8. BASE WEEKS AND BASE YEAR GROSS WAGES A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of $143 or more during the Base Year. The BASE YEAR is the 52 calendar weeks preceding the week in which the disability occurred.

a. Total Number of **Base Weeks** _______________

b. Total **Gross Wages in Base Year** ____________
Include all wages earned by the claimant
____

9. REGULAR WEEKLY WAGE $____________

10. Weekly wages

Indicate below: dates and claimant's GROSS earnings in N.J. employment during the listed calendar weeks.

Description of Calendar Week	Calendar 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

11. Check the days of the week the employee normally works. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

Firm Name ____ **I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT**

Address ____ Signed______________________________Date____________________

City, State, Zip______________________________________ Print or Type Name ___________________________________

Mailing Address, If Different____________________________ Official Title______________________________________

FAX No. (   ) ______________________ Telephone (   ) _____________________E-Mail Address_______________________