



PLEASE DETACH THIS PAGE AND KEEP FOR YOUR RECORDS

CLAIMANT RIGHTS AND RESPONSIBILITIES

RULES FOR FILING A CLAIM AND APPEAL RIGHTS

1. It is **your** responsibility to file this claim form promptly **after** you stop working due to your disability. Filing your claim before your last day of work will delay its processing. The law requires that claims must be filed within 30 days after the beginning of the disability. **Benefits may be denied or reduced if the claim is filed late.** If your claim is filed beyond the thirty day period, please use the space provided on the reverse side of Part A to give your reasons for the late filing.
2. If you disagree with a determination on your claim and wish to appeal, you must do so in writing within ten (10) days from the date the decision was mailed. You do not need a lawyer at the appeal hearing.

CLAIMANT RESPONSIBILITIES:

1. Your signature certifies that you understand any misrepresentation of fact or failure to disclose a material fact may be punishable under the law.
2. You must inform us of any other payments you are receiving such as sick pay or wages, a pension from your last employer, worker's compensation benefits, Social Security Disability benefits, or disability benefits from your employer or union.
3. If you receive a request for continued medical certification (Form P30), you must have your physician complete and sign the form. You should return it promptly.
4. When you recover or return to work, you must report this date immediately to Renaissance.
5. If you are requesting voluntary Federal Income Tax (F.I.T.) deductions to be withheld from your disability benefits, attach Form W-4S (Request for Federal Income Tax Withholding From Sick Pay) to your claim. Forms should be obtained from your employer or the Internal Revenue Service.

NOTE: If your disability is expected to last for one year or longer, you may be eligible for Federal Social Security Disability Benefits.

Toll Free number for Social Security: 1-800-772-1213

CLAIM ASSISTANCE:

If you require any assistance with your claim, call:

Phone: 844-368-6485

Fax: 607-773-2276

Email: groupclaims@renaissancefamily.com

**READ THE FOLLOWING INSTRUCTIONS BEFORE COMPLETING THE ATTACHED
FORM, CLAIM FOR DISABILITY BENEFITS**

1. **Complete both sides of the claimant's portion of this form (Part A & A1.)** You are responsible for having Part B completed by your doctor. If you have worked for more than one employer during the past year, you may copy Part B for completion by the other employer(s) to avoid processing delays. **Any missing or incorrect entries on this form will delay processing of your claim.** If you cannot have Part B completed on a timely basis, complete Part A and A1 and return the application as soon as possible.
2. Read all questions carefully. Print or write clearly since this information is used to determine your right to benefits.
3. **BE SURE TO WRITE YOUR SOCIAL SECURITY NUMBER AND NAME ON EACH PORTION OF YOUR CLAIM.**

Instructions For Part A and A1 – Claimant's Statement – Please complete all questions

- Items 1, 4 & 6** Include your full name and complete address (this information is required). If your mailing address is different than your home address, be sure to complete Item 6.
- Item 3** Please print or type your Social Security Number **CLEARLY**. An incorrect or illegible number will cause a delay in processing your claim.
- Item 9** You must complete this item. If your answer to this question is "No," you must complete Items 10 and 11 and give your country of origin.
- Items 12 –15** Please give exact dates. Remember to include the dates of any Emergency Room care you may have received for this disability. If available, provide proof of emergency room care.
- Item 19** List the name and address of the physician who treated you for this disability. You must be under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist, chiropractor, certified nurse midwife or advanced practice nurse.
- Item 22** **Sign and date the claim form. Include your telephone number.**
- Item 23** In the event that you are unable to communicate with us via telephone, you may designate a representative in this space to obtain information on your behalf. **If there is no one listed, only YOU will be able to obtain information on your claim.**
- Part A1**
Item 1 Starting with your most recent employer, list all employers, including those for whom you worked part-time, for the last **18 months**. Give business names and addresses as they appear on your pay envelopes, pay checks, employers' stationery or as listed in the telephone book.

Important: We suggest that you keep a copy of the completed claim form for your records.

Please send all claims related correspondence to the following address:

Renaissance Life & Health Insurance Company of New York
225 South East Street, Ste 360 Indianapolis, IN 46202
Phone: 844-368-6485 Fax: 607-773-2276
Email: groupclaims@renaissancefamily.com



Part A	New Jersey – Temporary Disability Insurance Application		
<p>You are responsible for having your healthcare provider complete Part B of this application. <i>Print clearly and answer ALL questions or your benefits may be delayed.</i> WDS-1 (1/17)</p>			
1 Name: Last _____ First _____ Middle _____		2 Date of Birth _____	
3 Social Security Number _____			
4 Home Address (Street, Apt #, City, State, ZIP Code) _____			5 County _____
6 Mailing Address – <i>if different from home address</i> (Street, Apt #, City, State, ZIP Code) _____			7 <input type="checkbox"/> Male <input type="checkbox"/> Female
8 Occupation _____			
9 Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		10 Alien Reg. No. _____	
If NO, answer #10 & 11 and give country of origin: _____		11 Work Authorization from _____ to _____	
12 What was the last day that you actually worked before your disability began?		Month _____	Day _____
		Year _____	
13 Reason for separation: <input type="checkbox"/> Illness/Accident/Maternity <input type="checkbox"/> Terminated <input type="checkbox"/> 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 _____ <small>If dates are provided, please attach proof (eg. discharge papers)</small> 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.) <input type="checkbox"/> Yes or <input type="checkbox"/> No			
<p style="text-align: center;">If Yes, date of work-related injury or illness: _____</p> <p style="text-align: center;">Was your employer notified that your injury was caused by your job? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b Worked any days, including self-employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		b Pension benefits from most recent employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, enter start/application date _____		c Temporary Disability benefits from another state? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you received a Social Security award letter, attach a copy.		d Unemployment Insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	
<p>Note: The NJ Temporary Disability Benefits program is not a "covered entity" under the Federal Health Information Portability and Accountability Act (HIPAA). Arch 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.</p>			

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** _____ **TO** _____
first date of treatment 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 _____ to _____
Month Day Year Month Day Year

9 Type of surgery _____ Date of Surgery _____ Anticipated Surgery Date _____
Month Day Year 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.