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

Renaissance®
DENTAL • VISION • LIFE • DISABILITY

Part A

New Jersey – Temporary Disability Insurance Application

You are responsible for having your healthcare provider complete Part B of this application.
Print clearly and answer ALL questions or your benefits may be delayed. WDS-1 (1/17)

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 – *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 _____|_____|_____ to _____|_____|_____
(Month Day Year) (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). 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.

WDS-1 (1/17)

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

_____ Phone ( ) _____
Street Address

_____ Fax ( ) _____
City State ZIP Code

_____ _____|_____|_____ ☐ Check, if Resident.
Signature of Doctor **Date Signed**
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.**

3