

**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.*

FD-1001-1 (4/1/79)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                      |  |                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 1 Name: Last _____ First _____ Middle _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | DOB/DOB _____<br> |  | 2 Date of Birth _____ / _____ / _____                           |  |
| Internal Code: DSDSDS<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 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 <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. _____                                                                              |  | 11 Work Authorization _____                                     |  |
| 12 What was the last day that you actually worked before your disability began? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | From _____ to _____<br>Month Day Year                                                                |  |                                                                 |  |
| 13 Reason for separation: <input type="checkbox"/> Illness/Accident/Maturity <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? (Exclude Sunday, Tuesday or holiday.) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                      |  |                                                                 |  |
| 15 If you have returned 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: _____<br>If dates are provided, please attach proof (eg. discharge papers)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | From _____ to _____<br>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<br>If Yes, date of work-related injury or illness: _____<br>Was your employer notified that your injury was caused by your job? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                    |  |                                                                                                      |  |                                                                 |  |
| 19 Physician's Name _____ Address _____ Phone: ( ) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                      |  |                                                                 |  |
| 20 Other Benefits – During the period of disability covered by this claim, have you:<br>a Received any sick or vacation pay? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b Worked any days, including self-employment? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, specify employer _____ and dates worked, from _____ to _____                                                                                                                                                                                                                                                     |  |                                                                                                      |  |                                                                 |  |
| 21 Since your last day of work, have you received, claimed or applied for:<br>a Federal Social Security Disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, when was application date _____<br>If you received a Social Security award letter, attach a copy.<br>b Pension benefits from most recent employer? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>c Temporary Disability benefits from another state? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>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 attach any medical, employment and Social Security benefit information necessary to determine my eligibility for benefits.       |  |                                                                                                      |  |                                                                 |  |
| Sign Here _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                      |  | Date _____ / _____ / _____                                      |  |
| Witness signature if claimant is under 18: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                      |  |                                                                 |  |
| Phone: ( ) _____ Alternate Phone: ( ) _____ E-Mail _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                      |  |                                                                 |  |
| You may designate a representative to obtain claim information for you if you cannot call as 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 Insurance program is not a "covered entity" under the Federal Health Information Privacy 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.                                                              |  |                                                                                                      |  |                                                                 |  |

# Sample Ds 1form

**Padhraic Smyth**



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