Mail the completed form to your Hartford
Benefit Management Service Center

Hartford Fire Insurance Company
Hartford Life Insurance Company
Hartford Life and Accident Insurance Company

NOTICE OF NEW JERSEY TEMPORARY DISABILITY BENEFITS CLAIM

PART A CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE

1. Name (Last, First, Middle) as shown on your Social Security card.	2. Social Security Number	3. Birth Date

4. Sex	5. Home Telephone Number	6. Marital Status
☐ Male ☐ Female	( )	☐ Single ☐ Married

7. Mailing address (Street, City or Town, State, Zip Code)

8. Employer Name	9. Employer Telephone Number
	( )

10. Employer Address (Street, City, State & Zip Code)	11. Occupation

12. Are you a citizen of the United States? ☐ Yes ☐ No **If "No," complete block number's 13 & 14, and give country of origin.**

13. Alien Registration Number	14. Work Authorization
	From: _____ *To:* _____

15. Country of origin

16. The last day you worked before your disability began **(Include Saturday, Sunday, or Holiday)**	17. The first day you were unable to work due to present disability

18. If now recovered, date of your recovery or return to work	19. If due to accident, give date:

20. Date(s) of emergency room care	21. Date of hospitalization
_____ _____ _____	From: _____ To: _____

22. Describe your disability:

23 Was this disability caused by your job? ☐ Yes ☐ No If "Yes," describe:

24. Name of physician or hospital treating you for this disability:

25. Address of physician or hospital treating you for this disability: Telephone Number: ( )

PART A (Continued)

Employment information - Other employers you have worked for during *the past 18 months.* Include full-time and part-time employment. If you had more than 3 employers, list on a separate sheet and attach to this form.

26. Name:	27. Telephone Number: ( )	28. Period of Employment: From: _____ To: _____
29. Address: (Street, City, State & Zip Code)	30. Work Location:	
31. Occupation:	32. Union Name:	33. Division:
34. Name:	35. Telephone Number: ( )	36. Period of Employment: From: _____ To _____
37. Address (Street, City, State & Zip Code)	38. Work Location	
39. Occupation:	40. Union Name:	41. Division:

42. **Other Benefits: (You must answer each question listed below for the period of disability covered by this claim.)**

a. Have you been working (including self-employment)? ☐Yes ☐No

b. Have you been receiving remuneration, i.e., wages, salary or vacation pay? ☐Yes ☐No

43. Since your last day of work have you received, claimed or applied for

a. Social Security benefits? ☐Yes ☐No

b. Social Security Retirement benefits? ☐Yes ☐No

c. Pension benefits from your most recent employer? ☐Yes ☐No

d. Any other disability benefits provided by your employer or Union? ☐Yes ☐No.

e. Workers' Compensation benefits? ☐Yes ☐No

f. Unemployment insurance benefits? ☐Yes ☐No

44. I request voluntary Federal Tax Withholding ☐Yes ☐No If "Yes," indicate the amount to be withheld from weekly benefits.

($20.00 minimum withholding per week) _____

45. 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 right. Also, I certify that the foregoing statements made by me on this form are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to penalties, which include criminal prosecution. You are hereby authorized to obtain any medical and employment information that is necessary to determine the eligibility of this claim.

If your employer has agreed to continue your regular pay while you are unable to work, do you agree to have the benefits available to you under this policy routed through your employer? ☐Yes ☐No. Please sign: _____

Note: A "No" answer could impact you continuing to receive your regular pay from your employer in exchange for the benefits available to you from this policy.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

SIGN HERE _____ _____

(Claimant's Signature) (Date)

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PART B MEDICAL CERTIFICATE (To be completed by your doctor)

1. Patient was first treated by me on:

2. Patient was last treated by me on:

3. Is the patient unable to perform his/her regular work? ☐ Yes ☐ No

   If "Yes," please enter the date the disability began: _____

4. Estimate recovery (give the approximate date claimant will be able to return to work) _____

5. If now recovered, on what date was the claimant first able to work? _____

6. Diagnosis (nature and cause of this disability which prevents claimant from working): ICD Code: _____

7. Clinical data and test to support diagnosis:

8. (a) If pregnant, provide estimated date of delivery: _____ Month/Day/Year

   Complications, if any: _____

   (b) If pregnancy has terminated, enter the date: _____ Month/Day/Year

   and the reason: ☐ Vaginal ☐ C-Section ☐ Miscarriage ☐ Others _____

9. Date(s) of emergency room care or hospitalization: From: _____ To: _____

10. Type of Surgery: _____ CPT Code: _____

    Date of Surgery: _____ Date Surgery Contemplated: _____

11. 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?

Print Doctor's Name and Degree:	**Doctor's Signature:**	
Address: (Street, City, State and Zip Code)		**Telephone Number:** ( )
Specialty:	**Certificate, License Number and State:**	**Date Signed:**

PART C TO BE COMPLETED BY YOUR EMPLOYER

1. Employee's Name: | 2. Social Security Number: | 3. Policy / Plan Number:

4. Employee Status: ☐Full Time ☐Part Time ☐ Intermittent ☐Seasonal ☐Other Explain:

5. Employment Date: | 6. Effective Date of Insurance:

7. Date Regarding Last Day Worked:
   (a) Claimant's last day worked before this disability: _____
   (b) Exact reason for separation from work on the date listed _____
   (c) Is lack of work ☐ Temporary? ☐ Permanent?
   (d) Has claimant returned to work? ☐Yes ☐No If "Yes," give date: _____
   If the work was intermittent, list dates: _____

8. Continued Pay
   (a) Have you paid the claimant since the last day of work? ☐Yes ☐No
   (b) These monies represent pay From: _____ To: _____
   (c) Total gross paid for the above period: $_____ Amount per week $_____
   (d) Check or Circle the number that best describes the monies paid in item (c)
   ☐ 1. Regular weekly wage 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. Supplemental benefits or gratuities
   ☐ 6. Payments required to be made under the State mandated temporary disability benefit plan pursuant to the New Jersey Disability law
   (e) Do you wish to have benefit payments (made payable to claimant) routed to you during wage continuation period?
   ☐Yes ☐No (Please note: employee must agree and provide signature in claimant section in order to process this request.) **Note: Items (d) 1, 2, and 3 may reduce benefits to the claimant.**

9. Worker' Compensation Liability
   (a) Did the claimant's disability happen in connection with his / her work or while on 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," give Workers' Compensation carrier Name _____
   Address _____ Telephone number (____) _____

10. Base Weeks And Base Gross Wages
    In how many calendar weeks did this claimant earn $144* or more with you n NEW JERSEY EMPLOYMENT during his/her base year, which is the 52 weeks immediately preceding the week in which the disability began? *1999 BASE WEEK AMT $144. Changes Jan 1st each year. *(Include all wages earned by the claimant.)*
    (a) Total number of Base Weeks _____ (b) Total Gross Wages in Base Year _____

11. Regular Weekly Wage _____

12. Weekly Wages Indicate below: Dates and claimant's Gross Earnings in NJ employment during the eight calendar weeks prior to the week in which the disability began.

Description of Calendar Week	Calendar Week Ending Date	Gross Paid
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		$
Total Gross Wages For the Above Eight Weeks		$

13. Is employee enrolled in a Hartford LTD Plan? ☐Yes ☐No If "Yes," effective date: _____

Based on the employer / employee premium contributions made over the last 3 years, what percentage of the Weekly Disability_____% LTD_____% benefit is considered taxable? If blank, we will assume the benefit is 100% taxable.

I certify that the above information is correct.

Firm Name | Signed

Address | Official Title

Telephone Number: ( ) | Date Signed: