TheStandard®

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

Your New Jersey State Disability Benefit Claim

This packet contains the forms that will help us to process your claim for New Jersey State Disability Benefits. **Please save a copy of this material for your future reference.** For specific information about your New Jersey State Disability Benefits coverage, please contact your employer's benefits administrator or call our customer service line at 800.368.2859.

How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete the Employer Statement before giving the packet to you.
2. Complete and sign the Employee Statement. Compare your responses to those of your employer to make sure you agree on all information, including **last day of work**.
3. Enter your full name and employer name in the Employee section of the Attending Physician's Statement, and have your treating physician complete the remainder of the form. If more than one physician is treating you for your disabling condition, each must complete a form. Additional forms are available from your employer's benefits administrator.
4. Sign and date the Authorization and send it, along with the claim forms, to The Standard at the above address. This authorization allows us to request further information about your claim, if necessary.

Once we receive your completed claim application, it will take approximately one week to make a claim decision. If we have not reached a decision within one week, you will be notified with the details.

How To Submit Your Claim Form

1. Email: STDForms@standard.com
2. Fax: 800.378.6053
3. Mail: PO Box 2800 Portland OR 97208

Other Benefits That May Affect Your New Jersey State Disability Benefits

Other benefits you receive, or may be eligible to receive, may affect the amount of New Jersey State Disability Benefits due you. These benefits may include, but are not limited to, unemployment compensation and Workers' Compensation.

To avoid a possible overpayment of your claim, please inform The Standard if you receive other benefits.

Tax Withholding

Benefits payable under the Temporary Disability Benefits Law are considered to be "third party sick pay." Federal law provides that the portion of gross disability benefits paid, which is attributable to the chargeable employer's contributions for disability insurance coverage, is subject to federal taxation for Social Security, Medicare, F.U.T.A. and federal income tax. Please consult your own tax advisor or the State of New Jersey Department of the Treasury, Division of Taxation for information regarding New Jersey state income tax laws.

When You Return To Work

Your disability benefits usually stop when you return to work. **Be sure that you or your employer notify The Standard immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

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Reset

New Jersey State Disability Claim Employee's Statement

To Be Completed By Employee

Full Name	Social Security No.	Phone No.	Birthdate	Sex ☐ M ☐ F
Mailing Address		City	State	ZIP

1. Is your disability work related? ☐ Yes ☐ No

2. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

3. Do you intend to file for Workers' Compensation? ☐ Yes ☐ No

4. Last active day at work

5. Date you became unable to work at your occupation because of disability

6. Date you returned or expect to return to work

7. Is your disability due to:
   ☐ Accident. When and where did it happen?

   ☐ Illness. When did you first notice and what is the nature of your disability?

8. How does your disability prevent you from working?

9. Have you had a previous disability claim with Standard Insurance Company? ☐ Yes ☐ No

10. Pregnancy Expected delivery date _____
    Actual delivery date _____
    Type of delivery: ☐ Vaginal ☐ C-section

Employment Information ***Beginning with your most recent employer, list all employment (full and part-time) in the last 18 months. If you had more than 2 employers, list on a separate sheet of paper and attach to this form.***

11a. Name and address of your most recent employer

(Street) (City) (State) (ZIP)

Period of Employment From _____ (Month/Day/Year) To _____ (Month/Day/Year)

Phone No.

Work Location

(City) (State)

Occupation	Union Name	Division

11b. Name and address of your most recent employer

(Street) (City) (State) (ZIP)

Period of Employment From _____ (Month/Day/Year) To _____ (Month/Day/Year)

Phone No.

Work Location

(City) (State)

Occupation	Union Name	Division

12. **Other Benefits – You must answer each question listed below for the period of disability covered by this claim**
   a. Have you worked since your disability began? **(Including self-employment)** ☐ Yes ☐ No
   b. Have you been receiving remuneration i.e., wages, salary or vacation pay? ☐ Yes ☐ No
   c. Have you been involved in a labor dispute? ☐ Yes ☐ No

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

14. **CERTIFICATION AND SIGNATURE**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

SIGN HERE → Claimant's Signature: _____ Date: _____ Phone No.: _____

Witness signature and explanation if claimant is unable to sign and writes an "X"

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New Jersey State Disability Claim Attending Physician's Statement

To Be Completed By Employee

Full Name	Employer	Policy No.

The following information is needed to document the patient's inability to work. The patient is responsible for completing this form at their own expense. Please complete this form and mail it to The Standard at the address listed above.

To Be Completed By The Attending Physician

1. Diagnosis

A. Diagnosis	ICDA classification

B. Symptoms	C. Objective Findings Height _____ Weight _____ B/P_____ /_____

2. Pregnancy (if applicable)

A. Expected date of delivery	B. Actual date of delivery	C. Type of delivery ☐ Vaginal ☐ C-section

D. Significant complications, if any

3. History

A. Date the patient was unable to perform his/her regular work	B. When did symptoms appear or accident happen?

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when? _____

D. Is this condition related to the patient's employment? ☐ Yes ☐ No	E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

4. Treatment

A. Date of first visit	B. Date(s) of subsequent visits	C. Date of most recent visit

D. Planned course and duration of treatment ***include surgery and medications, if any***

Type of Surgery _____ ☐ Elective ☐ Acute Date of surgery _____ Date surgery contemplated _____

5. Level of Functional Impairment

A. Describe the patient's physical, mental and cognitive limitations, if any.

B. In a work day given two breaks and a meal break, your patient can:

Lift (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Carry (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total Hours								With positional change
Sit	☐ 8	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	(hrs) _____
Stand	☐ 8	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	(hrs) _____
Walk	☐ 8	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	(hrs) _____
Alternately sit/stand	☐ 8	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	(hrs) _____

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

C. Is the patient competent to manage insurance benefits? ☐ Yes ☐ No
If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

6. Hospitalization (if applicable)

A. Date admitted	B. Date discharged	C. Reason

D. Name and location of hospital (city/state)

7. Prognosis

A. Since onset of symptoms, the patient's condition has ☐ Improved ☐ Not changed ☐ Retrogressed

B. When do you anticipate the patient can return to work? ☐ Date _____ ☐ Unable to determine, follow up in _____ weeks ☐ Never

8. Physician Information ***Please type or print***

Name of physician completing this form			Phone No.
Specialty	Tax ID No.		Fax No.
Mailing Address	City	State	ZIP

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Signature _____ **Date** _____

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New Jersey State Disability Claim Employer's Statement

To Be Completed By Employer

Employee's Full Name	Social Security No.	Job Title *Please attach a copy of the job description.*	1. Date Employed

2. Work Address

3. Is employee insured for NJ TDB? ☐ Yes ☐ No
Effective Date _____

Is employee insured for Short Term Disability? ☐ Yes ☐ No
Effective Date _____

Is employee insured for Long Term Disability? ☐ Yes ☐ No
Effective Date _____

Is employee insured for Group Life Insurance through Standard Insurance Company? ☐ Yes ☐ No

4. What percentage of the NJ TDB premium does the **employer** pay? _____%
What percentage of the STD premium does the **employer** pay? _____%
What percentage of the LTD premium does the **employer** pay? _____%
Has either percentage changed within the last three years? ☐ Yes ☐ No

5. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? ☐ Yes ☐ No

6. Is disability work related? ☐ Yes ☐ No ☐ Undetermined
Has the employee filed for:
☐ Workers' Compensation Weekly Amount? _____
☐ Other _____ Weekly Amount? _____

7. Job status when disability began ☐ Full-time (_____ hours/week) ☐ Part-time (_____ hours/week)

9. Employee's Earnings $ _____
Check one ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐ Commission ☐ Other ☐ Shift Differential ☐ Bonuses
Date of last increase _____
Earnings prior to increase $ _____

8. **LAST DAY WORKED before this disability**
do not use payroll week ending dates → Month | Day | Year
(a) Exact reason for separation from work
include labor dispute _____
(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 below.

10. **CONTINUED PAY**
(a) Have you paid or expect to pay the claimant for any period after the last day of work? ☐ Yes ☐ No
(b) If "Yes"
FROM Month | Day | Year **TO** Month | Day | Year
(c) Check the number that best describes the monies paid.
☐ 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. Full salary advanced to effect #4 above
☐ 6. Supplemental benefits or gratuities
Note: Items (c) 1, 2 and 3 may reduce benefits to the claimant.

11. **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
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 →		$

12. **BASE WEEKS AND BASE YEAR GROSS WAGES**
A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of at least the minimum NJ TDB earnings 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.

13. Is employee subject to:
Social Security taxes? ☐ Yes ☐ No
Medicare taxes? ☐ Yes ☐ No

Employer Name	Plan No.	Phone No.	
Mailing Address	**City**	**State**	**ZIP**

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Signature _____ **Date** _____

Authorization to Obtain and Release Information

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Social Security No. _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.