

The Standard Benefit Administrators

800.426.4332 Tel 800.378.8361 Fax
TDBClaims@standard.com Email
PO Box 5031 White Plains NY 10602-5031

New Jersey State Disability Claim

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 800.426.4332. The Standard Benefit Administrators is acting as the claims administrator on behalf of Standard Insurance Company for the New Jersey State Disability Benefits.

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 Benefit Administrators 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: TDBClaims@standard.com
2. Fax: 800.378.8361
3. Mail: PO Box 5031, White Plains, NY 10602-5031

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 Benefit Administrators 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 Benefit Administrators immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

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**New Jersey State Disability Claim
 Attending Physician's Statement**

To Be Completed By Employee

Full Name	Employer	Policy No.
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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 Benefit Administrators 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 <input type="checkbox"/> Vaginal <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____	
D. Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	E. Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>include surgery and medications, if any</i>	
Type of Surgery _____ <input type="checkbox"/> Elective <input type="checkbox"/> 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) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+ Carry (in pounds) <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 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: <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently
C. Is the patient competent to manage insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is the patient competent to appoint someone to help manage the insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Improved <input type="checkbox"/> Not changed <input type="checkbox"/> Retrogressed	
B. When do you anticipate the patient can return to work? <input type="checkbox"/> Date _____ <input type="checkbox"/> Unable to determine, follow up in _____ weeks <input type="checkbox"/> Never	
8. Physician Information <i>Please type or print</i>	
Name of physician completing this form	Phone No. ()
Specialty	Tax ID No.
Mailing Address	Fax No. ()
City	State
ZIP	
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.	
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 <i>Please attach a copy of the job description.</i>	1. Date Employed																																													
2. Work Address																																																
3. Is employee insured for NJ TDB? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Is employee insured for Short Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Is employee insured for Long Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Is employee insured for Group Life Insurance through Standard Insurance Company? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined Has the employee filed for: <input type="checkbox"/> Workers' Compensation Weekly Amount? _____ <input type="checkbox"/> Other _____ Weekly Amount? _____																																														
7. Job status when disability began <input type="checkbox"/> Full-time (____ hours/week) <input type="checkbox"/> Part-time (____ hours/week)		8. LAST DAY WORKED before this disability <i>do not use payroll week ending dates</i> → <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; text-align: center;">Month</td> <td style="width: 30px; text-align: center;">Day</td> <td style="width: 30px; text-align: center;">Year</td> </tr> </table>		Month	Day	Year																																										
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9. Employee's Earnings \$ _____ <i>Check one</i> <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Commission <input type="checkbox"/> Other <input type="checkbox"/> Shift Differential <input type="checkbox"/> Bonuses Date of last increase _____ Earnings prior to increase \$ _____		(a) Exact reason for separation from work <i>include labor dispute</i> _____ (b) Is lack of work <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent (c) Has claimant returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," give date → <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; text-align: center;">Month</td> <td style="width: 30px; text-align: center;">Day</td> <td style="width: 30px; text-align: center;">Year</td> </tr> </table> (d) If the work was intermittent, list dates below.		Month	Day	Year																																										
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10. CONTINUED PAY (a) Have you paid or expect to pay the claimant for any period after the last day of work? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) If "Yes" FROM <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; text-align: center;">Month</td> <td style="width: 30px; text-align: center;">Day</td> <td style="width: 30px; text-align: center;">Year</td> </tr> </table> TO <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px; text-align: center;">Month</td> <td style="width: 30px; text-align: center;">Day</td> <td style="width: 30px; text-align: center;">Year</td> </tr> </table> (c) Check the number that best describes the monies paid. <input type="checkbox"/> 1. Regular weekly wage and/or sick pay <input type="checkbox"/> 2. Regular vacation (if designated for a specific time period) <input type="checkbox"/> 3. Pension <input type="checkbox"/> 4. Difference between regular weekly wage and disability benefits to be received <input type="checkbox"/> 5. Full salary advanced to effect #4 above <input type="checkbox"/> 6. Supplemental benefits or gratuities Note: Items (c) 1, 2 and 3 may reduce benefits to the claimant.		Month	Day	Year	Month	Day	Year	11. WEEKLY WAGES <i>Indicate below dates and claimant's GROSS earnings in N.J. employment during the listed calendar weeks.</i> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 60%;">Description of Calendar Week</th> <th style="width: 20%;">Calendar Week Ending Date</th> <th style="width: 20%;">Gross Wages</th> </tr> </thead> <tbody> <tr> <td>Disability Began</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>2nd Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>3rd Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>4th Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>5th Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>6th Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>7th Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>8th Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>9th Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td>10th Week Before Disability</td> <td></td> <td style="text-align: right;">\$</td> </tr> <tr> <td colspan="2">TOTAL GROSS WAGES FOR ABOVE WEEKS →</td> <td style="text-align: right;">\$</td> </tr> </tbody> </table>		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 →		\$
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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 _____ <i>Include all wages earned by the claimant.</i>		13. Is employee subject to: Social Security taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No																																														
Employer Name		Plan No.																																														
Mailing Address		Phone No. ()																																														
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Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.																																																
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, THE STANDARD BENEFIT ADMINISTRATORS 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 The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators 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.