Issued by
The Union Labor Life Insurance Company
Washington, DC 20001

Mail Completed Form To
National Elevator Health Benefit Plan
PO Box 476
Newtown Square, PA 19073-0476
Fax (610) 325-9029 Policy # C 4347

NEW JERSEY
TEMPORARY DISABILTY BENEFITS CLAIM

PART A CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE
NOTICE OF NEW JERSEY TEMPORARY DISABILITY BENEFITS CLAIM

1. Name (Last, First, Middle)	2. Birth Date	3. Social Security Number

4. Home Telephone Number	5. Married (Check one) ❒ Yes ❒ No	6. ❒ Male ❒ Female

7. Mailing Address (Street, City or Town, State, Zip Code	8. Occupation

9. Are you a citizen of the United States? ❒ Yes ❒ No "If No," complete blocks #10 & #11, and give country of origin.	10. Alien Reg. No.	11. Work Authorization From _____ To _____

	Month	Day	Year
12. The last day you worked before your disability began.....			
13. The first day you were unable to work due to present disability (Include, Saturday, Sunday, or Holiday).....			
14. If now recovered, date of you recovery or return to work.....			

15. Date(s) of emergency room care _____ (Month/Day/Year) or hospitalization From: _____ (Month/Day/Year) To: _____ (Month/Day/Year)

16. Describe you disability:	If due to accident, give date: _____ (Month/Day/Year)

17. Was this disability caused by your job? ❒ Yes ❒ No If "Yes," describe:

18. Name and address of physician or hospital treating you for this disability:

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.

19a. Name and address _____ _____ (Street) (City) (State) (Zip)	Period of Employment From _____ (Month/Day/Year) To _____ (Month/Day/Year)	Telephone No. ( ) _____ Work Location
Occupation:	Union Name:	Division:

19b. Name and address _____ _____ (Street) (City) (State) (Zip)	Period of Employment From _____ (Month/Day/Year) To _____ (Month/Day/Year)	Telephone No. ( ) _____ Work Location
Occupation:	Union Name:	Division:

20. 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 reenumeration, i.e., wages, salary or vacation pay? ❒ Yes ❒ No

21. 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
c. Pension benefits from your most recent employer? ❒ Yes ❒ No

22. 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)

23. **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 statement 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 medical and employment information that is necessary to determine the eligibility of this claim.

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)

PART B	MEDICAL CERTIFICATE (To be completed by your doctor)	Month	Day	Year
1.	Patient was first treated by me on			
	Patient was last treated by me on			
2.	Is the patient unable to perform his/her regular work? ❒ Yes ❒ No If yes, please enter the date the disability began			
3.	Estimate recovery (give the approximate date claimant will be able to return to work)			
4.	If now recovered, on what date was the claimant first able to return to work?			

5. Diagnosis (nature and cause of this disability which prevents claimant from working? _____
_____ ICD Code: _____
Clinical data and test to support diagnosis: _____

		Month	Day	Year
6.	(a) If pregnant, provide estimated date of delivery..... Complications, if any: _____			
	(b) If pregnancy has terminated, enter the date ..... and the reason: ❒ Vaginal ❒ C-Section ❒ Miscarriage ❒ Others			

		From: Month	Day	Year	To: Month	Day	Year
7.	Date(s) of emergency room care or hospitalization:						

8. Type of Surgery: _____ CPT Code: _____ Date of Surgery: _____ Date Surgery Contemplated: _____

9. 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)

_____ _____
(Street Address) (City) (State and Zip) (Specialty) (Certificate License No. and State)

(Telephone Number) ( ) _____ (Date Signed) _____

PART C TO BE COMPLETED BY YOUR EMPLOYER

1. EMPLOYEE NAME:	Social Security Number / /	Policy/Plan Number

2. EMPLOYEE STATUS: ❒ Full Time ❒ Part Time ❒ Intermittent ❒ Seasonal ❒ Other Explain: _____
EMPLOYMENT DATE: _____ EFFECTIVE DATE OF INSURANCE: _____

3. DATA REGARDING LAST DAY WORKED

Month	Day	Year

(a) Claimant's last day worked before this disability:
(b) Exact reason for separation from work on the date listed in item (a) (include labor dispute): _____
(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 below:

4. CONTINUED PAY
(a) Have you paid the claimant since the last day of work? ❒ Yes ❒ No
(b) These monies represent pay

From: Month	Day	Year	To: Month	Day	Year

(c) Total gross paid for the above period: $ _____
Amount per week: $ _____ If amount varies, attach list of dates and amounts.)
(d) 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

Note: Items (d) 1, 2, and 3 may reduce benefits to the claimant.

5. WORKERS' 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 name, address and phone number of your Workers' Compensation carrier.
_____ _____
(Name) (Telephone No.)
_____
(Address)

7. REGULAR WEEKLY WAGE $_____

8. WEEKLY WAGES Indicate below: Dates and claimant's Gross Earnings in N.J. 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		$

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

Percentage of Weekly Disability premium paid by Employer _____%. (If blank, we will assume the Employer pays 100% of the plan costs.)

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the Weekly Disability _____% LTD _____% benefit is considered taxable? *(See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.)*

Firm Name _____
Address _____
City, State and Zip Code _____

I certify that the above information is correct.
Signed _____
Official Title _____
Telephone No. ( ) _____ Date _____