



# GUARDIAN®

State Disability Claims  
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Secure E-mail: [www.GuardianAnytime.com](http://www.GuardianAnytime.com), click Secure Channel, select State\_Disability\_Claims@glic.com

## STATE OF NEW JERSEY – DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT DIVISION OF TEMPORARY DISABILITY INSURANCE

### PART A INFORMATION TO BE COMPLETED BY THE CLAIMANT – Print or Type WDS-1(R-2-08) Policy #

1. Name: Last First Middle		2. Birth Date	3. Social Security Number	
4. Home Address – <b>required</b> (Street, Apt #, City, State, Zip Code)				5. County
6. Mailing Address – if different (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 If NO, answer #10 & 11 and give country of origin: _____		10. Alien Reg. No.		11. Work Authorization From _____ To _____
12a. What was the last day that you actually worked before your disability began?		<div style="display: flex; justify-content: space-between;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>		
12b. Reason for separation: <input type="checkbox"/> Illness/Accident/Maternity <input type="checkbox"/> Terminated <input type="checkbox"/> Quit				
13. What was the first day you were unable to work due to present disability: (Include Saturday, Sunday, or Holiday) Do not list future dates				
14. If you have recovered or have a possible return to work date from this disability, list date: <input type="checkbox"/> Actual <input type="checkbox"/> Possible				
15. Date(s) of emergency room care: _____ or hospitalization: From _____ To _____ Month/Day/Year Month/Day/Year Month/Day/Year				

16. Describe your disability (How, when, where it happened) \_\_\_\_\_

17. Was this injury/illness caused by your job?  Yes or  No (This question must be answered.) If Yes, date of work related injury/illness: \_\_\_\_\_ Was your employer notified that your injury was caused by your job?  Yes or  No

18. Identify the physician or hospital treating you for this disability: Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

**Employment Information – Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If you had more than 2 employers, list the remaining employers on the reverse side of this form in the space provided.**

19a. Name and address of your most recent employer: _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Location Telephone: _____ City State
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Occupation: \_\_\_\_\_  Full time  Part time  Union \_\_\_\_\_ Division  
Check the days of the week you normally work.  SUN  MON  TUE  WED  THUR  FRI  SAT

19b. Name and address: _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Location Telephone: _____ City State
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Occupation: \_\_\_\_\_  Full time  Part time  Union \_\_\_\_\_ Division  
Check the days of the week you normally work.  SUN  MON  TUE  WED  THUR  FRI  SAT

20. Other Benefits – You Must Answer Each Question Listed Below For the Period of Disability Covered By This Claim:  
a. Have you worked after your disability began? (Including self-employment)  Yes  No  
b. Have you been receiving sick or vacation pay?  Yes  No  
c. Have you been involved in a labor dispute?  Yes  No

21. Since your last day of work have you received, claimed or applied for:  
a. Federal Social Security Disability Benefits?  Yes  No  
b. Pension benefits from your most recent employer?  Yes  No  
c. Temporary Disability Benefits from another State?  Yes  No  
d. Any other disability benefits provided by your employer or union?  Yes  No  
e. Unemployment Insurance Benefits?  Yes  No

**BE SURE TO COMPLETE AND SIGN PART A1**

Claimant's Name: \_\_\_\_\_

PART A1

**CLAIMANT'S AUTHORIZATION AND CERTIFICATION STATEMENTS**  
MUST BE COMPLETED AND SIGNED BY THE CLAIMANT

1. Please designate a representative to obtain claim information for you if you cannot call this Agency yourself. The Law only permits claim information to be given to you or your representative.

Representative Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to Claimant \_\_\_\_\_

2. **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 rights and responsibilities. I am aware that if any of the foregoing statements made by me are known to be false, or 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 obtain any medical, employment and Social Security benefit entitlement information that is necessary to determine my eligibility for benefits.

Sign Here \_\_\_\_\_ Date \_\_\_\_\_

Witness signature if claimant writes an "X" \_\_\_\_\_

Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Note: The NJ Temporary Disability Benefits Program is not a "covered entity" under the Federal Health Information Portability & 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 & 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.

**USE THIS SPACE TO LIST ADDITIONAL EMPLOYERS FOR QUESTION 19.**

Name and address: _____ _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Telephone: _____ Location _____ City State
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Occupation: \_\_\_\_\_  Full time  Part time  Union \_\_\_\_\_ Division \_\_\_\_\_

Check the days of the week you normally work.  SUN  MON  TUE  WED  THUR  FRI  SAT

19b. Name and address: _____ _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Telephone: _____ Location _____ City State
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Occupation: \_\_\_\_\_  Full time  Part time  Union \_\_\_\_\_ Division \_\_\_\_\_

Check the days of the week you normally work.  SUN  MON  TUE  WED  THUR  FRI  SAT

**USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION FOR QUESTIONS ON PART A**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If more space is needed, attach an additional sheet of paper. Be sure your Social Security Number appears on all pages.

Claimant's Name: _____	WDS-1(R-2-08)	Social Security Number 
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<b>PART B</b>	<b>MEDICAL CERTIFICATE (TO BE COMPLETED BY YOUR DOCTOR AFTER YOU BECOME DISABLED)</b>
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1a. Patient has been under my care for this period of disability: FROM \_\_\_\_\_ TO \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

b. Frequency of treatment: \_\_\_\_\_

c. Patient was last treated by me on: \_\_\_\_\_  
Month Day Year

2. Enter the date the patient was unable to perform his/her regular work due to this disability: \_\_\_\_\_  
Month Day Year

3. Estimated Recovery: (Give the approximate date patient will be able to return to work.) \_\_\_\_\_  
Month Day Year

4. If now recovered, on what date was the patient first able to work? \_\_\_\_\_  
Month Day Year

5. Diagnosis: (nature and cause of this disability which prevents patient from working) \_\_\_\_\_  
 \_\_\_\_\_ ICD Code: \_\_\_\_\_

Clinical data and tests to support diagnosis: \_\_\_\_\_

6a. If pregnancy, provide estimated date of delivery: \_\_\_\_\_  
Month Day Year

b. Complications, if any, \_\_\_\_\_

c. If pregnancy terminated, enter the date: \_\_\_\_\_  
Month Day Year

And identify the reason:  Birth  C-Section  Miscarriage  Abortion

7a. Date(s) of emergency room care or hospitalization: FROM \_\_\_\_\_ TO \_\_\_\_\_

b. Name and address of any specialist treating patient: \_\_\_\_\_

8. Type of surgery: \_\_\_\_\_ Date of Surgery \_\_\_\_\_ Anticipated Surgery Date \_\_\_\_\_  
 Is surgery for cosmetic purposes only?  Yes  No

9. In your opinion, was this disability: Due to an accident at work?  Yes  No Not related to his/her work  Yes  No  
 Due to a condition which developed because of the nature of the work?  Yes  No

10. Was this patient referred to you?  Yes  No If yes, please supply the information below if available.  
 Name of referring doctor \_\_\_\_\_ Referring doctor's telephone #: \_\_\_\_\_

11. I certify that the above statements, in my opinion, truly describe the patient's disability and the estimated duration thereof:

_____	_____	_____
<small>(Print Doctor's Name and Medical Degree)</small>	<small>(Original Signature of Doctor Required)</small>	<small>(Date Signed)</small>
_____	_____	If Resident, check <input type="checkbox"/>
<small>(Address)</small>	<small>(Certificate License No. and State)</small>	
_____	_____	_____
<small>(Address)</small>	<small>(Specialty of Treating Physician)</small>	
_____	_____	_____
<small>(City)</small>	<small>(State)</small>	<small>(Zip Code)</small>
Telephone Number: ( _____ ) _____		FAX Number: ( _____ ) _____

1. Claimant's Name: _____	<b>SOCIAL SECURITY NUMBER</b> 
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<b>PART C</b>	<b>TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE</b>	WDS-1(R-2-08)
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<b>2. EMPLOYER STATUS</b> What is your Federal Employer Identification Number: _____	<b>8. BASE WEEKS AND BASE YEAR GROSS WAGES</b> A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of \$143 or more during the Base Year. The BASE YEAR is the 52 calendar weeks preceding the week in which the disability occurred.																																										
<b>3. PRIVATE PLAN COVERAGE (NJ approved plan/replaces State Plan coverage)</b> a. Do you have a New Jersey approved Private Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No b. If "Yes", is claimant covered under this approved Private Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	a. Total Number of Base Weeks _____  b. Total Gross Wages in Base Year _____ Include all wages earned by the claimant																																										
<b>4. LAST ACTUAL DAY WORKED before this disability (do not use payroll week ending dates)</b> → _____ (Month / Day / Year)	<b>9. REGULAR WEEKLY WAGE \$</b> _____																																										
a. Reason for separation from work if other than disability _____ b. Is lack of work: temporary? permanent? c. Has claimant returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give date → _____ (Month / Day / Year)	<b>10. Weekly wages</b> Indicate below: dates and claimant's GROSS earnings in N.J. employment during the listed calendar weeks.																																										
<b>5. CONTINUED PAY (do not enter wages earned prior to disability)</b> 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" give dates: FROM _____ TO _____ (Month / Day / Year) (Month / Day / Year) c. 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 wages 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 <b>Note:</b> Items 1, 2, and 3 may reduce benefits to the claimant	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Description of Calendar Week</th> <th style="width:20%;">Calendar Week Ending Date</th> <th style="width:50%;">Gross Wages</th> </tr> </thead> <tbody> <tr><td>Week Disability Began</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>2nd Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>3rd Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>4th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>5th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>6th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>7th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>8th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>9th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>10th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr> <td colspan="2" style="text-align: center;"><b>TOTAL GROSS WAGES FOR ABOVE WEEKS</b> →</td> <td style="text-align: center;">\$</td> </tr> <tr> <td colspan="3">Are you exempt from FICA tax? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>	Description of Calendar Week	Calendar Week Ending Date	Gross Wages	Week 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		\$	<b>TOTAL GROSS WAGES FOR ABOVE WEEKS</b> →		\$	Are you exempt from FICA tax? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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<b>6. GOVERNMENT EMPLOYEES (Complete this section)</b> a. Payroll number (For N.J. State Employees) _____ b. Number of earned sick leave days as of the last day worked. _____ c. Has the claimant filed for or received Employment Disability Leave (SLI)? <input type="checkbox"/> Yes <input type="checkbox"/> No d. If claimant has applied for or received donated leave, attach dates and amounts on a separate sheet of paper.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>8th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>9th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>10th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr> <td colspan="2" style="text-align: center;"><b>TOTAL GROSS WAGES FOR ABOVE WEEKS</b> →</td> <td style="text-align: center;">\$</td> </tr> <tr> <td colspan="3">Are you exempt from FICA tax? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	8th Week Before Disability		\$	9th Week Before Disability		\$	10th Week Before Disability		\$	<b>TOTAL GROSS WAGES FOR ABOVE WEEKS</b> →		\$	Are you exempt from FICA tax? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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<b>7. WORKERS' COMPENSATION LIABILITY</b> a. Did the claimant's disability happen in connection with his/her work or while on your premises, or was the disability due in any way to his/her occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No b. If "Yes", have you filed or do you intend to file a Workers' Compensation claim on behalf of this claimant? <input type="checkbox"/> Yes <input type="checkbox"/> No c. If "Yes," list Workers' Compensation insurance carrier below: Name _____ Telephone ( ) _____ Address _____ Policy # _____ Claim # _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>8th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>9th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr><td>10th Week Before Disability</td><td></td><td style="text-align: center;">\$</td></tr> <tr> <td colspan="2" style="text-align: center;"><b>TOTAL GROSS WAGES FOR ABOVE WEEKS</b> →</td> <td style="text-align: center;">\$</td> </tr> <tr> <td colspan="3">Are you exempt from FICA tax? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	8th Week Before Disability		\$	9th Week Before Disability		\$	10th Week Before Disability		\$	<b>TOTAL GROSS WAGES FOR ABOVE WEEKS</b> →		\$	Are you exempt from FICA tax? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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11. Check the days of the week the employee normally works.  SUN  MON  TUE  WED  THUR  FRI  SAT

Firm Name and Division # _____ Address _____ City, State, Zip _____ Mailing Address, If Different _____ FAX No. ( ) _____ Telephone ( ) _____	<b>I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT</b> Signed _____ Date _____ Print or Type Name _____ Official Title _____ E-Mail Address _____
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