Guardian®

Instructions for filing your Guardian - New Jersey TDB Claim (NJ TDBDS -1)

This packet contains the forms that are needed to process your claim for New Jersey State Disability Benefits. Please keep this page for future reference and for the Guardian contact information.

Employee / Claimant Responsibilities:

1). It is your responsibility to file your claim within 30 days following the start of your disability. Late filing could result in a claim denial or reduction.
2). Your employer should complete and sign their portion (Part C) of the claim form and return it to you for your completion and filing.
3). You should fully complete your portion of the claim form (Parts A and A1), and then supply your treatment provider with the form so that they can fully complete their section (Part B)
4). We recommend that you submit ALL sections of the claim (employee, employer and treatment provider) at the same time. Separate submissions could delay the handling of your claim.
5). It is very important that ALL sections are completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of your claim.
6). Your signature acknowledges that, to the best of your knowledge, the forms have been completed accurately and truthfully.

Employer Responsibilities:

1) As the employer, you should fully complete your portion (Part C) of the claim and return it to your employee for further completion and submission.
2) It is very important that ALL sections are completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of the claim
3) As you may be aware, effective 1/1/2020, the State of New Jersey has changed the method for calculating the NJ TDB benefit amounts. Questions 7 and 8 of Part C reflect this change. Be sure to follow the example provided in recording the employee's earnings information. This will help to ensure that your employee's benefits are calculated correctly.
4) Some employers require that their employees contribute to the cost of their NJ TDB coverage. This arrangement is addressed in question 5 of Part C. Please complete this question fully and accurately as it could impact the taxation of the benefits payable.

Guardian Contact / Claim Filing Information

Guardian Insurance
State Disability Claims
P.O. Box 14332
Lexington KY 40512

Customer Service # 1-800-268-2525 Fax # 610-807-2953 Email: State_Disability_Claims@glic.com

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STATE OF NEW JERSEY – TEMPORARY DISABILITY INSURANCE CLAIM FORM

PART A	INFORMATION TO BE COMPLETED BY THE CLAIMANT – Print or Type	Guardian Plan # _____

1. Claimant's Name: Last First Middle	2. Birth Date	3. Member ID/Social Security Number

4. Home Address – required (Street, Apt #, City, State, Zip Code)	5. County

6. Mailing Address – if different (Street, Apt #, City State, Zip Code)	7. ☐ Male ☐ Female	8. Occupation

9.Phone No. (_____)_____ E-Mail Address _____

	Month	Day	Year
10a. What was the last day that you actually worked before your disability began? 10b. Reason for separation: ☐ Illness/Accident/Maternity ☐ Terminated ☐ Quit →			
11. What was the first day you were unable to work due to present disability: (Include Saturday, Sunday, or Holiday) Do not list future dates →			
12. If you have recovered or have a possible return to work date from this disability, list date: ☐ Actual ☐ Possible →			

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

14. Describe your disability (How, when, where it happened) _____
_____

15. Was this injury/illness caused by your job? ☐ Yes or ☐ No (This question must be answered.) If Yes, date of work related injury/illness:_____ If yes, have you or your employer filed or intend to file a WC claim? ☐ Yes or ☐ No

16. Identify the physician or hospital treating you for this disability: Name: _____
Address: _____ Telephone: (_____)_____

17. Other Benefits – You must answer each question listed below for the period of disability covered by this claim:

a. Have you tried working any days since you became disabled? ☐ Yes ☐ No
If yes, Employer Name _____ Dates Worked _____ to _____

b. Have you been paid for any days after your last day of work? ☐ Yes ☐ No
If yes, give dates _____ to _____ and amount $_____ per _____. Check box for type of pay received below.

1. ☐ Paid Time Off (sick, vacation, personal, etc)?
2. ☐ Difference between regular wages and disability benefits?
3. ☐ Other pay from your employer? (explain _____)
4. ☐ Severance Pay? With Notice? ☐ Yes ☐ No In lieu of Notice? ☐ Yes ☐ No
5. ☐ Donated Leave?
6. ☐ Other – Explain _____

18. 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
f. Workers Compensation Benefits?	☐ Yes ☐ No

BE SURE TO COMPLETE AND SIGN PART A1 (next page)

Claimant's Name:_____ Plan #_____ | Social Security Number | |

PART A1

CLAIMANT'S AUTHORIZATION AND CERTIFICATION STATEMENTS

MUST BE COMPLETED AND SIGNED BY THE CLAIMANT

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

Representative Name: _____ Birth Date: _____ Phone: (____)_____

Representative Email Address: _____ Relationship to Claimant: _____

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" _____

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.

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 3 employers, list the remaining employers in the space provided below.

Name and address:
_____
_____
(Street) (City) (State) (Zip)

Period of employment: From _____ To_____
month/day/year month/day/year

Telephone: _____ Work Location _____
City State

Occupation: _____ ☐ Full time ☐ Part time ☐ Union _____ Division_____

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

Name and address:
_____
_____
(Street) (City) (State) (Zip

Period of employment: From _____ To_____
month/day/year month/day/year

Telephone: _____ Work Location _____

Occupation: _____ ☐ Full time ☐ Part time ☐ Union _____ Division_____

Check the days of the week you normally work. ☐ SUN ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐ VARIES

Name and address:
_____
_____
(Street) (City) (State) (Zip)

Period of employment: From _____ To_____
month/day/year month/day/year

Telephone: _____Work Location _____
City State

Occupation: _____ ☐ Full time ☐ Part time ☐ Union _____Division_____

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

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION

_____

_____

_____

_____

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

Claimant's Name: _____ Plan #_____ | Social Security Number |_____|

PART B

MEDICAL CERTIFICATE
(TO BE COMPLETED BY YOUR DOCTOR AFTER YOU BECOME DISABLED)
(N.J.S.A 12:18-1.6 prohibits charging a fee to complete this form)

1a. Patient has been under my care for this period of disability: FROM _____ (Month/Day/Year) TO _____ (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 their 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 or condition which developed due to 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. Do you believe this patient is mentally capable of handling their own affairs, including the use of benefits? ☐ Yes ☐ No

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

_____ (Print Doctor's Name and Medical Degree) _____ (Original Signature of Doctor Required) _____ (Date Signed)

_____ (Address) _____ (Certificate License No. and State) If Resident, check ☐

_____ (Address) _____ (Specialty of Treating Physician)

_____ (City) (State) (Zip Code)

Telephone Number: (_____)_____ FAX Number: (_____)_____

Claimant's Name: _____ Plan #_____ | SOCIAL SECURITY NUMBER | |

PART C | TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE

1. PRIVATE PLAN COVERAGE (NJ approved plan/replaces State Plan coverage)
a. Is claimant covered under your Guardian NJ TDB Plan? ☐ Yes ☐ No
If Yes, employee's coverage effective date _____|_____|_____ (Month / Day / Year)
b. Is claimant also covered by a Guardian Short Term Disability plan? ☐ Yes ☐ No
If Yes, please supply the Guardian 6-digit STD plan # _____

2. LAST ACTUAL DAY WORKED before this disability (do not use payroll week ending dates) ➡ _____|_____|_____ (Month / Day / Year)
a. Reason for separation from work if other than disability _____
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: _____

3. Check the days of the week the employee normally works.
☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐ VARIES

4. CONTINUED PAY (do not enter wages earned prior to disability)
a. Have you paid or expect to pay the claimant for any period after the last day of work? ☐ Yes ☐ No
b. If "yes" give dates: FROM _____|_____|_____ (Month / Day / Year) TO _____|_____|_____ (Month / Day / Year)
c. Amount per week $_____, if amount varies attach list of dates and amounts.
d. Check the box 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
5. ☐ Full salary advanced to effect #4 above
6. ☐ Supplemental benefits or gratuities

Note: Items 1, 2, and 3 may reduce benefits to the claimant

5. Does the employee contribute to the cost of the NJ TDB coverage? ☐ Yes ☐ No
If No, skip to question #6
a. If Yes, is the employee contributing at the current maximum State allowable employee contribution? ☐ Yes ☐ No (If Yes, skip to "c" below.)
b. If No to "a" above, what monthly dollar amount does the employee contribute to their NJ TDB premium? $ / month
c. Does this claimant contribute to their NJ TDB premiums on a:
☐ Pre-tax basis (Benefit is fully taxable)
☐ Post-tax basis (Benefit is taxable in proportion to the employer's contribution)

IMPORTANT: This information is needed to accurately tax any benefits payable

6. WORKERS' COMPENSATION LIABILITY
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? ☐ Yes ☐ No
b. If "Yes", has a Workers' Compensation claim been filed on behalf of this claimant?
☐ Filed ☐ Intend to file ☐ Not filing (reason)_____

7. HOW TO DETERMINE BASE WEEKS AND BASE YEAR GROSS WAGES

A BASE WEEK is earnings in a calendar week of not less than 20 times the State minimum as of October 1 of the previous year.

A BASE YEAR is the period consisting of the first four of the last five completed quarters prior to the start of disability.

Example: Disability began 1/23/202**2**, the BASE YEAR is 10/1/20**20** through 9/30/20**21**

Quarter 1 = 10/1/**20**20 to 12/31/20**20**
Quarter 2 = 01/01/20**21** to 03/31/20**21**
Quarter 3 = 04/01/20**21** to 06/30/20**21**
Quarter 4 = 07/01/20**21** to 09/30/20**21**
Quarter 5 = 10/1/20**21** to 12/31/20**21**

a. Did claimant have at least 20 base weeks of earnings in the base year? ☐ Yes ☐ No
b. If not, did claimant have alternative earnings of at least 1000 times the State minimum as of 10/1 of the previous calendar year? ☐ Yes ☐ No

8. Base Year wages – see example in 7 above

Base Year Wages	Quarter Ending Date	Quarterly Gross Wages ($)	Number of Base Weeks
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			
Quarter 5			

a. Total gross wages for the first 4 out of the last 5 COMPLETE quarters $_____
b. Total number of base weeks for the first 4 out of the last 5 COMPLETE quarters _____

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

Firm Name and Division # _____ I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Address _____ Signed _____ Date_____

City, State, Zip_____ Print or Type Name _____

Federal Employer Identification Number: _____ Official Title_____

FAX No.( ) _____ Telephone( ) _____E-Mail Address_____