

**DSDSDS**



**PART A** YOUR INFORMATION

Internal Code 	Social Security Number <table style="display:inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>								

**Profile Information**

1 Last name	First name	Middle	4 Date of Birth	5 Gender
			____ ____ ____ mm   dd   yy	_____
2 Home Address(Street, Apt #, City, State, ZIP Code)			6 County	
3 Mailing Address-if different from home address(Street, Apt #, City, State, ZIP Code)			7 Phone(____)_____	

*Questions 8 and 9 are for statistical purposes only and do not affect eligibility*

8 With which racial/ethnic group(s) do you most identify? <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	9 Check the highest level of schooling you have completed. <input type="checkbox"/> Have not graduated high school <input type="checkbox"/> Associates/Bachelor's Degree <input type="checkbox"/> High School Graduate/GED <input type="checkbox"/> Graduate Degree
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**Disability Information**

10 First date you were unable to work and under medical care for this disability (Include Saturday, Sunday or holiday)	____ ____ ____ mm   dd   yy
11 Date you recovered or returned to work	____ ____ ____ mm   dd   yy
12 Date(s) of emergency room care or hospitalization (If dates are provided, attach proof: e.g. discharge papers)	from ____ ____ ____ to ____ ____ ____ mm   dd   yy      mm   dd   yy
13 Describe your disability (for injuries, explain how and where it happened) _____	
14 Physician's Name _____ City _____ State _____ Phone(____)_____	
15 Was this injury or illness caused by your job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you or your employer(s) filed or intend to file a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Additional Benefit Information**

16 Do you want federal income tax withheld weekly from your benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter the weekly dollar amount to be withheld (not percentage) \$ _____ (amount must be at least \$20)
17 During the period of disability covered by this claim, have you received or applied for:
a Federal Social Security Disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, enter start/application date ____ ____ ____
b Pension benefits from your current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, enter start date ____ ____ ____ Monthly amount \$ _____
c Temporary Disability benefits from another state? <input type="checkbox"/> Yes <input type="checkbox"/> No
d Unemployment Insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Certification and Signature**

18 I certify I was unable to work during the period for which I am claiming benefits. I am aware that if I provide any information in this application that I know to be false, or if 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 Number, and obtain any medical, employment and Social Security benefit information necessary to determine my eligibility for benefits.

Sign Here \_\_\_\_\_ Date \_\_\_\_|\_\_\_\_|\_\_\_\_  
 Witness signature if claimant writes an "X" \_\_\_\_\_

You may assign a representative to obtain claim information for you if you cannot call us yourself. We can only give claim information to you and your representative.

19 Approved Representative Name \_\_\_\_\_ Date of Birth \_\_\_\_|\_\_\_\_|\_\_\_\_  
 Representative Phone Number (\_\_\_\_) \_\_\_\_\_

Note: All medical records, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law, are confidential. We protect 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.

Name _____	Social Security Number								
Address _____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>								
Phone (____) _____									

**PART B EMPLOYMENT INFORMATION**

Instructions: Starting with your last employer, provide information for all your employers in the 6 months before your leave began. If you need to list more employers, make a copy of this page. Be sure to state the first and last day you physically reported to work. Do not write "present" or "current."

1 Name of your most recent employer Company _____ Street _____	2 Federal Employer Identification Number (FEIN) <i>see instructions</i> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table> City _____ State _____								

3 Date of hire _____ to Last physical day of work before your disability _____ <small>mm   dd   yy</small>	4 <input type="checkbox"/> Full time <input type="checkbox"/> Part time
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5 Union <input type="checkbox"/> Yes <input type="checkbox"/> No	6 Occupation _____	7 Work Location City _____ State _____
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8 Separation from this employer is <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent	9 Which days do you normally work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat	10 Regular Weekly Earnings \$ _____
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11 Supervisor's Name _____	12 Phone (____) _____
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13 Have you tried working any days for this employer since you became disabled? (see box 10 on Part A)  Yes  No

If yes, give dates \_\_\_\_\_ to \_\_\_\_\_

14 Have you been paid for any days after your last day of work?  Yes  No

If yes, from \_\_\_\_\_ to \_\_\_\_\_

Total amount paid \$ \_\_\_\_\_

This pay represents:

- Paid time off (vacation, sick, personal, etc.)
- Difference between regular wages and disability benefits
- Other pay from your employer (explain) \_\_\_\_\_
- Severance pay  With notice  In lieu of notice
- Donated Leave

1 Name of other employer (if applicable) Company _____ Street _____	2 Federal Employer Identification Number (FEIN) <i>see instructions</i> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table> City _____ State _____								

3 Date of hire _____ to Last physical day of work before your disability _____ <small>mm   dd   yy</small>	4 <input type="checkbox"/> Full time <input type="checkbox"/> Part time
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5 Union <input type="checkbox"/> Yes <input type="checkbox"/> No	6 Occupation _____	7 Work Location City _____ State _____
--	--------------------	--

8 Separation from this employer is <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent	9 Which days do you normally work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat	10 Regular Weekly Earnings \$ _____
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11 Supervisor's Name _____	12 Phone (____) _____
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13 Have you tried working any days for this employer since you became disabled? (see box 10 on Part A)  Yes  No

If yes, give dates \_\_\_\_\_ to \_\_\_\_\_

14 Have you been paid for any days after your last day of work?  Yes  No

If yes, from \_\_\_\_\_ to \_\_\_\_\_

Total amount paid \$ \_\_\_\_\_

This pay represents:

- Paid time off (vacation, sick, personal, etc.)
- Difference between regular wages and disability benefits
- Other pay from your employer (explain) \_\_\_\_\_
- Severance pay  With notice  In lieu of notice
- Donated Leave



# FILE ONLINE FOR FASTER CLAIM PROCESSING AT

**<https://sslnjtdbclaim.com/>**

## How to Complete the Claim for Temporary Disability Benefits

- This application (form DS-1) is for disability leave.
- You must complete both sections of the form (Parts A and B).
- You will need to provide your employer's Federal Employer Identification Number on **Part B**. You can get this number from either your last year's W-2 form or your Human Resources office. Your employer is not required to complete this form but you can ask them to help you with any questions on **Part B**.
- You have 30 days from the first day of your disability to file your claim. If your claim form is received more than 30 days from the first day of your leave, you must provide a reason why the claim was not filed on time. Benefits may be reduced or denied for late applications.

## Remember

- You must complete every question accurately and write legibly.
- **Any missing information may cause your claim to be denied.**
- Demographic questions have no effect on the approval or denial of your claim.
- Write your name and Social Security number on each page of your claim and on all attachments.
- Exact dates must be given. Do not write "present" or "current."
- If you need to list more than 2 employers, make a copy of Part B to list additional employment.
- If you return to work while you are claiming Temporary Disability benefits, report this date immediately to Standard Security Life/Absolve at 800-401-2691.

## How to Send Us Your Claim Form

There are 2 options for you to submit this form. **Choose only one, as sending multiple copies will delay processing.** If you filed your claim online, do not also submit a paper application.

1. Fax this completed form to 800-728-7028

**- OR -**

2. Mail this completed form to: AbSolve / P.O. Box 1328 / Mt Laurel, NJ 08054

## After Submitting Your Claim

- After you have received notification that your claim has been created, you can find information and check your claim status at <https://absolve-portal.force.com/>
- For more help on your claim, call Customer Service at 800-401-2691