

CLAIMANT RIGHTS AND RESPONSIBILITIES

RULES FOR FILING A CLAIM AND APPEAL RIGHTS

- 1 It is your responsibility to file this claim form promptly. The law requires that claims must be filed within 30 days of the beginning of the disability. Benefits may be denied or reduced if the claim is filed late. However, if your claim is filed beyond the thirty day period, please attach a statement giving your reasons for the late filing.
- 2 If you disagree with a determination on your claim and wish to appeal, you must do so in writing within ten days from the date the decision was mailed. You do not need a lawyer at the appeal hearing.

CLAIMANT RESPONSIBILITIES:

- 1 When you sign the claim form, you certify that you understand any misrepresentation of fact or failure to disclose a material fact may be punishable under the law.
- 2 If you receive a request for continued medical certification, you must have your physician complete the form and return it to continue benefit payments.
3. When you recover or return to work, you must report this date immediately to the Zurich American Insurance Company.

CLAIM ASSISTANCE:

If you require any assistance with your claim, call the Zurich American Insurance Company, telephone number (631) 845-2200.

For your convenience you may FAX this form to (631) 845-2270.

NOTE: If your disability is expected to last for one year or longer, you may be eligible for Federal Social Security Disability Benefits.

READ THE FOLLOWING INSTRUCTIONS BEFORE COMPLETING THE ATTACHED FORM CLAIM FOR DISABILITY BENEFITS - DS-1

Complete the first page of this form (Part A.) You are responsible for having Part B completed by your doctor and Part C by your last employer. If you cannot have all three parts completed, mail the claim form anyway. ANY MISSING OR INCORRECT ENTRIES ON THIS FORM WILL DELAY PROCESSING OF YOUR CLAIM.

- 2 Read all questions carefully! Print or write clearly since this information is used to determine your right to benefits. If you need any assistance in completing this form, please call the Zurich American Insurance Company at (631) 845-2200.

Instructions for Part A - Claimant's Statement

- Items 1, 3, 4, & 5 Include your full name and complete address.
- Item 2 Please print or type your Social Security Number CLEARLY. An incorrect or illegible number will cause a delay in processing your claim.
- Item 6 You must complete this item. If your answer to this question is "No," you must complete Items 6A, 6B and 6C.
- Items 7a & b & 8 Please give exact dates. Remember to include the dates of any Emergency Room care you may have received for this disability.
- Item 9 Starting with your most recent employer, list all employers, including those for whom you worked part-time, for the last 18 months. If you had more than three employers, list the others with the dates you worked on a separate piece of paper and attach it to the claim form. Give business names and addresses as they appear on your pay envelopes, pay checks, employers stationery or as listed in the telephone book.
- Items 11, 12, 13 Please answer all questions, even if answer is No.
- Item 14 In the event that you are unable to telephone our agency, you may designate a representative in this space to obtain information on your behalf. If there is no one listed, only YOU will be able to obtain information on your claim from this agency.
- Item 15 Be sure to sign and date the claim form. Include your telephone number, if available.

IMPORTANT: Detach this instruction sheet and retain it for your records.

SEE REVERSE SIDE FOR "CLAIMANT RIGHTS AND RESPONSIBILITIES"

PART A

CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT- Print or Type
STATE OF NEW JERSEY - DEPARTMENT OF LABOR - DISABILITY INSURANCE SERVICE

DS-1 (R-1-83)

1. My name is _____
First Middle Last
2. My Social Security Number is:
3. Address _____
Number Street City or Town State Zip Code Apt. No.
- Tel. No _____ 4. My age is _____ 5. Married (Check one) YES NO
6. Are you a citizen of the U.S.? Yes No If No, answer 6A, 6B & 6C .
- 6A. Alien Neg No. _____ 6B. Country of Origin _____
- 6C. Work Authorization from _____ to _____
7. I became disabled on _____ a. I worked on that day YES NO
Mo. Day Year
- b. I have since worked for wages or profit YES NO If "Yes," give dates _____
- c. My disability is (if injury state how, when & where it occurred) _____
8. Was this disability caused by your job? Yes No Describe _____
9. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers.

Employer's			Dates of Employment				Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Business Name	Business Address	Telephone No.	From		Through		
			Mo.	Day	Yr.	Mo.	

10. My job is or was _____
Occupation Name of Union and Local No., if Member
- 10A. Job location _____
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began YES NO
- If Yes, fill in the following: I have been paid by _____ From _____ To _____

12. 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 remuneration i.e., wages, salary or vacation pay? Yes No
- c. Have you been involved in a labor dispute? Yes No

13. Since your last day of work have you received, claimed or applied for:
- a. Social Security Disability 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
- f. Unemployment Insurance benefits? Yes No
- g. Damages for personal injury? Yes No

14. In the event that you are unable to call the Zurich American Insurance Company, please designate a representative to obtain information on your behalf.

Print Name: _____ Phone: () _____

15. **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 statements 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 any medical and employment information that is necessary to determine the eligibility of this claim.

SIGN HERE → Claimant's Signature _____ Date _____ Phone: () _____

Witness signature and explanation if claimant is unable to sign and writes an "X"

★ ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

PART B

MEDICAL CERTIFICATE (TO BE COMPLETED BY YOUR DOCTOR)

1. Patient has been under my care for this period of disability (See #7, Part A) and has been seen every (frequency) _____ FROM

Month	Day	Year
-------	-----	------

Month	Day	Year
-------	-----	------

 Patient was last treated by me on _____

Month	Day	Year
-------	-----	------

2. Please enter the date the disability began. _____

Month	Day	Year
-------	-----	------

3. Estimated Recovery: (Give the approximate date claimant will be able to return to work.) _____

Month	Day	Year
-------	-----	------

4. If now recovered, on what date was the claimant first able to work? _____

Month	Day	Year
-------	-----	------

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

6. (a) If pregnancy, provide estimated date of delivery: _____

Month	Day	Year
-------	-----	------

 Complications, if any: _____
 (b) If pregnancy was terminated, enter the date and identify the reason: Birth C-Section Miscarriage Abortion _____

Month	Day	Year
-------	-----	------

7. Date(s) of emergency room care or hospitalization FROM

Month	Day	Year
-------	-----	------

 TO

Month	Day	Year
-------	-----	------

8. Type of Surgery Elective Acute 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?

10. I affirm that I am a _____ Licensed or Certified in the State of _____ License No. _____
 (Physician, Chiropractor, Dentist, Nurse-Midwife, Podiatrist or Psychologist)
 Health Care Provider's Signature _____ Date _____
 Health Care Provider's Name (Please Print) _____ Tel. No. _____
 Office Address _____
 Number Street City or Town State Zip Code

PART C

TO BE COMPLETED BY YOUR EMPLOYER

Not required if claimant was unemployed more than 14 days before this disability commenced.

1. **EMPLOYEE Name:** _____ Social Security Number: _____

2. **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) Check 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.

3. **BASE WEEKS AND BASE YEAR GROSS WAGES**
 In how many calendar weeks did this claimant earn \$103.00 or more with you in NEW JERSEY EMPLOYMENT during his/her base year, which is the 52 weeks immediately preceding the week in which the disability began?
 (a) Total number of Base Weeks _____
 (b) Total Gross Wages in Base Year _____
 Include all wages earned by the claimant.

4. **GOVERNMENT EMPLOYEES**
 If claimant is employed by a government entity, complete this section.
 (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)? Yes No

5. **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 Wages
1st Week		\$
2nd Week		\$
3rd Week		\$
4th Week		\$
5th Week		\$
6th Week		\$
7th Week		\$
8th Week		\$

6. **DATA REGARDING LAST DAY WORKED**
 (a) Claimant's last day worked before this disability: _____

Month	Day	Year
-------	-----	------

 (b) Exact reason for separation from work on the date listed item (a) (include labor dispute) _____
 (c) Is lack of work temporary permanent
 (d) Has claimant returned to work? Yes No
 If "Yes," give date: _____

Month	Day	Year
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 If the work was intermittent, list dates below.

7. **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," have you filed or do you intend to file a Workers' Compensation claim on behalf of this claimant? Yes No

8. **EMPLOYER STATUS**
 What is your New Jersey Registration Number? _____ Private Plan Policy # _____

Firm Name _____ Address _____ City, State and Zip Code _____ Mailing Address, if Different _____

I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT
 Signed _____ Official Title _____ Phone Number () _____ Date _____