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-1-93)

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 Wages** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
			From			Through			
Business Name	Business Address	Telephone No.	Mo.	Day	Yr.	Mo.	Day	Yr.	

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 ________ → Month Day Year
and identify the reason: ☐ Birth ☐ C-Section ☐ Miscarriage ☐ Abortion

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.

REGULAR WEEKLY WAGE

$ ________

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 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

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 ________

MAIL TO: Zurich American Insurance Company P.O. Box 9102, Plainview, New York 11803-9002

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"