DETACH THIS PAGE AND KEEP FOR YOUR RECORDS

CLAIMANT RIGHTS AND RESPONSIBILITIES

RULES FOR FILING A CLAIM AND APPEAL RIGHTS

1. It is **your** responsibility to file this claim form promptly **after** you stop working due to your disability. Filing your claim before your last day of work will delay its processing. The law requires that claims must be filed within 30 days after the beginning of the disability. **Benefits may be denied or reduced if the claim is filed late.** If your claim is filed beyond the thirty day period, please use the space provided on the reverse side of Part A to give 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 (10) days from the date the decision was mailed. You do not need a lawyer at the appeal hearing.

CLAIMANT RESPONSIBILITIES:

1. Your signature certifies that you understand any misrepresentation of fact or failure to disclose a material fact may be punishable under the law. This includes any changes to the Medical Certificate or the Employer's Statement made by you without authorization by your physician or your employer.

2. You must inform us of any other payments you are receiving such as sick pay or wages, a pension from your last employer, worker's compensation benefits, Social Security Disability benefits, or disability benefits from your employer or union.

3. If you receive a request for continued medical certification (Form P30), you must have your physician complete and sign the form. You should return it promptly.

4. When you recover or return to work, you must report this date immediately to the Division of Temporary Disability Insurance.

5. If you are requesting voluntary Federal Income Tax (F.I.T.) deductions to be withheld from your disability benefits, attach Form W-4S (Request for Federal Income Tax Withholding From Sick Pay) to your claim. Forms should be obtained from your employer or the Internal Revenue Service.

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

Toll Free number for Social Security: 1-800-772-1213

CLAIM ASSISTANCE:

If you require any assistance with your claim, call:

Phone: 844-368-6485 *(Admin: Option 1) (Claims: Option 2)*
Fax: 607-773-2276
Email: groupclaims@renaissancefamily.com

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

1. **Complete both sides of the claimant's portion of this form (Part A & A1.)** YOU ARE RESPONSIBLE for having Part B completed by your doctor and Part C by your last employer. If you have worked for more than one employer during the past year, you may copy Part C for completion by the other employer(s) to avoid processing delays**. Any missing or incorrect entries on this form will delay processing of your claim.** If you cannot have Parts B and/or C completed timely, complete Part A and A1 and return the application as soon as possible.
2. Read all questions carefully! Print or write clearly since this information is used to determine your right to benefits.

3. **BE SURE TO WRITE YOUR SOCIAL SECURITY NUMBER AND NAME ON EACH PORTION OF YOUR CLAIM.**

Instructions For Part A and A1 – Claimant's Statement – Please complete all questions

Items 1, 4 & 6	Include your full name and complete address (this information is required). If your mailing address is different than your home address, be sure to complete Item 6.
Item 3	Please print or type your Social Security Number **CLEARLY**. An incorrect or illegible number will cause a delay in processing your claim.
Item 9	You must complete this item. If your answer to this question is "No," you must complete Items 10 and 11 and give your country of origin.
Items 12 –15	Please give exact dates. Remember to include the dates of any Emergency Room care you may have received for this disability. If available, provide proof of emergency room care.
Item 19	List the name and address of the physician who treated you for this disability. You must be under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist, chiropractor, certified nurse midwife or advanced practice nurse.
Item 22	**Sign and date the claim form. Include your telephone number.**
Item 23	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.**
Part A1 **Item 1**	Starting with your most recent employer, list all employers, including those for whom you worked part-time, for the last **18 months**. Give business names and addresses as they appear on your pay envelopes, pay checks, employers' stationery or as listed in the telephone book.

Important: We suggest that you keep a copy of the completed claim form for your records.

Please send all claims related correspondence to the following address:

Renaissance Life & Health Insurance Company of New York
2 Court Street, Suite 102
Binghamton, NY 19301
Phone: 844-368-6485 Fax: 607-773-2276
Email: groupclaims@renaissancefamily.com

Claimant's Name _____

Claimant's Address _____

Claimant's Phone ( ) _____

Social Security Number

__ __ __- __ __- __ __ __ __

PART A-1 CLAIMANT'S EMPLOYMENT INFORMATION

Instructions: Beginning with your last employer, list all of your employers for full-time, part-time, per diem work, etc. that you worked for over the past year. Any missing employment will delay your claim.

1a Name and address of your most recent employer:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|____|____ to ____|____|____
month day year month day year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

1b Employer Name and address:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|____|____ to ____|____|____
month day year month day year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

1c Employer Name and address:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|____|____ to ____|____|____
month day year month day year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

1d Employer Name and address:

_____

_____
(Street) (City) (State) (ZIP)

Period of employment: from ____|____|____ to ____|____|____
month day year month day year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

If you are submitting this claim more than 30 days after your first day of disability, please give your reason:

_____

_____

_____

_____

_____

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

IMPORTANT TAX INFORMATION

If you choose to have federal income tax withheld from your disability benefits, you should complete a W-4S. List the specific dollar amount you would like withheld weekly from your benefits. Do not give a % amount.

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WDS-1 (1/17)

Claimant's Name _____

Claimant's Address _____

Claimant's Phone ( ) _____

Social Security Number

__ __ __- __ __- __ __ __ __

PART B

MEDICAL CERTIFICATE – Have your healthcare provider complete Part B.

N.J.S.A 12:18-1.6 prohibits charging a fee to complete this form.

1 Patient has been under my care for this disability **FROM** _____|_____|_____ **TO** _____|_____|_____ _____
first date of treatment most recent treatment frequency

2 Date the patient was unable to perform regular work due to this disability _____|_____|_____
(Doctor's signature date must be on or after this date unless this is a pregnancy claim) Month Day Year

3 Estimated recovery date (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 (what is the disabling condition)_____

_____ **ICD Code**_____

6 Do you believe this patient is mentally capable of handling their own affairs, including the use of benefits? ☐ Yes ☐ No

7a 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

8 Date(s) of emergency room care or hospitalization: from _____|_____|_____ to _____|_____|_____
Month Day Year Month Day Year

9 Type of surgery _____ Date of Surgery _____|_____|_____ Anticipated Surgery Date _____|_____|_____
Month Day Year Month Day Year

Is surgery for cosmetic purposes only? ☐ Yes ☐ No

10 Was this disability ☐ Due to an accident at work ☐ Due to the nature of the work ☐ Not related to their work

11a Was this patient referred to you? ☐ Yes ☐ No If Yes, name of referring doctor _____

Referring doctor's phone ( ) _____ **11b** Name of any specialist treating the patient _____

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 License No. and State* Specialty

_____ Phone ( ) _____
Street Address

_____ Fax ( ) _____
City State ZIP Code

_____ _____|_____|_____ ☐ Check, if Resident.
Signature of Doctor **Date Signed**
Must be signed on or after the date in Question 2, unless a pregnancy claim.

***If completed by a Physician's Assistant (PA-C), provide the license number of the supervising doctor.**

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WDS-1 (1/17)

Claimant's Name _____ Phone ( )_____ Social Security Number __ __ __- __ __- __ __ __ __

Claimant's Address _____

PART C — EMPLOYER STATEMENT – Have your employer or company representative complete Part C.

2 EMPLOYER STATUS

Your Federal Employer Identification Number (FEIN) _____

3 PRIVATE PLAN COVERAGE

a Do you have a New Jersey approved Private Plan? ☐ Yes ☐ No

b If Yes, is the claimant covered under this plan? ☐ Yes ☐ No

4 Check the days of the week that the claimant normally works.

☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Varies

5 LAST ACTUAL DAY WORKED before this disability

(Do not use a payroll week ending date) _____|_____|_____ Month Day Year

a Reason for separation from work _____

b Is separation ☐ Temporary? ☐ Permanent?

c Has claimant returned to work? ☐ Yes ☐ No

If Yes, give date _____|_____|_____

d If the work was intermittent, list dates _____

6 CONTINUED PAY

a Have you paid or do you expect to pay the claimant for any period after the last day of work? ☐ Yes ☐ No

b If Yes, give dates from: _____|_____|_____ to: _____|_____|_____ Month Day Year Month Day Year

c Amount per week $_____ (if amount varies attach a list of dates/amounts)

d Total amount paid for entire given period $_____

e Check the number that best describes the monies paid in item c.

☐ 1. Regular weekly wages or paid time off (vacation, sick, personal, etc.)

☐ 2. Difference between regular wkly wages and disability benefits to be received

☐ 3. Supplemental benefits (unallocated payout will have no impact)

☐ 4. Severance pay With notice ☐ In lieu of notice ☐

☐ 5. Pension (attach pension approval letter)

Note: Items 1, 4, and 5 may reduce benefits to the claimant.

7 GOVERNMENT EMPLOYERS

a Payroll Number (For N.J. state employees) _____

b If claimant has applied for or received donated leave, attach dates and amounts.

8 WORKERS' COMPENSATION LIABILITY

a Did the claimant's disability happen in connection with their work or while on your premises, or was the disability due in any way to their 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

c If Yes, list Workers' Compensation Insurance carrier below:

Name_____ Phone ( ) _____

Address_____

Policy #_____ Claim #_____

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Firm Name _____ Phone ( ) _____

Address _____ Fax ( ) _____

City _____ State _____ ZIP Code _____

Name/Title_____

9 BASE WEEKS / BASE YEAR WAGES

A base week is a calendar week in which the N.J. employee had gross earnings of **$172** or more.

a Total number of **Base Weeks** _____

b Total **Gross Wages** in Base Year $ _____ (52 weeks prior to first day of disability)

10 Weekly Wage (base hrs x rate) $_____

Hourly Rate $_____**/hr**

11 Weekly Wages

Provide claimant's GROSS earnings in New Jersey employment and period ending dates.

Note: If the weeks listed below, include overtime, bonuses, etc., attach an explanation and separate the regular wages earned.

Description of Calendar Week	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	/ /	$
TOTAL GROSS WAGES FOR ABOVE WEEKS		$

Are you exempt from FICA tax? ☐ Yes ☐ No

Signature_____

Do not sign/date before the last day worked

Date (required) _____|_____|_____

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