



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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P.O. Box 14332
Lexington KY 40512

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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 _____
4. Home Address – <u>required</u> (Street, Apt #, City, State, Zip Code) _____		3. Member ID/Social Security Number _____ _____ _____
6. Mailing Address – if different (Street, Apt #, City State, Zip Code) _____		5. County _____
7. ☐ Male ☐ Female		8. Occupation _____
9. Phone No. (____) _____ E-Mail Address _____		
10a. What was the last day that you actually worked before your disability began? 10b. Reason for separation: ☐ Illness/Accident/Maternity ☐ Terminated ☐ Quit		Month Day Year
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		Month Day Year
12. If you have recovered or have a possible return to work date from this disability, list date: ☐ Actual ☐ Possible		Month Day Year
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 _____
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PART A1	CLAIMANT'S AUTHORIZATION AND CERTIFICATION STATEMENTS MUST BE COMPLETED AND SIGNED BY THE CLAIMANT
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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
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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 _____
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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
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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.



Direct Pay Enrollment and Authorization

If you are unable to provide a handwritten signature due to technical limitations resulting from the COVID-19 pandemic, Guardian will accept a typewritten name in lieu of your signature on an interim basis. You must check the box below each signature line certifying that you understand that your typewritten name has the same force and effect as your signature.

For **faster** service please:

1. Complete this form on-line
2. Print, sign and scan it or use interim accommodation of typing your name in the signature line
3. Save the completed form to your computer
4. Upload via our [Secure Channel](#)

To mail this form:

Guardian State Disability Claims
PO Box 14332, Lexington KY 40512

To fax the form:

(610)-807- 2953

For direct deposit of your State Disability (SMD) benefit payments to your checking or savings account, please include all of the information requested. Please allow up to 10 business days for processing, upon receipt of completed documentation. If you have any questions about completing this form, please contact us at (800) 268-2525.

**** Please be advised that not all SMD plans are subject to direct deposit availability ****

1. Claim Information Required fields:

Claimant Name:

Group #:

Claim Number (if known):

2. REQUIRED:

Account Type:

☐ Checking Account **or** ☐ Savings Account

Bank Name:

Bank Routing Number (ABA#):

Bank Account Number:

**Required Information*

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Name on Bank Account
Street Address
City, State, Zip

Date

Pay to the order of: _____

DOLLARS

Memo

0000067894 623456789 0101

Nine-digit Routing Number Account Number Do not include the check sequence number

3. Sign and date this authorization:

I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. **This request will also stay in effect should my SMD claim transition into an approved LTD claim, if applicable.** I understand that I have the opportunity to view my EOBs and payment history via registration on GuardianAnytime.com.

☐ Check this box to discontinue receiving paper EOBs.

Claimant Signature

Date

☐ I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.

4. Joint Account Holder Agreement (Please check here if you are the sole account holder) ☐

I understand and agree that any funds deposited after the date of death of the Claimant that are not otherwise payable under the plan are to be immediately returned to Guardian Life Insurance Company of America.

Joint Account Holder Signature

Date