EQUITABLE

Equitable Financial Life Insurance Company of America

For Assistance Call (866) 274-9887

New Jersey Temporary Disability Insurance (NJ TDB)
New Jersey Claim for Temporary Disability Benefits Instructions

How to Complete the Claim for Temporary Disability Benefits

- The New Jersey Temporary Disability Benefits Application, Equitable form EBNJTDBDS1 (form DS-1) is for disability leave. If you wish to claim benefits for family caregiving or bonding, complete the application for Family Leave Benefits (form FL-1).
- You must complete the **Parts A and B** of the form.
- 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**
- **Part C** must be completed by your healthcare provider.
- 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.
- **Questions?** Contact Equitable at (866) 274-9887 or ebclaims@equitable.com.

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.
- 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 Family Leave benefits, report this date immediately to the Equitable to avoid overpayment.

How to Send Us Your Claim Form

You can fax, mail or email your completed claim form to us:

Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

After Submitting Your Claim

- After being approved for Temporary Disability benefits, you may receive a form (P-30) "Request to Claimant for Continued Claim Information." Use this form to claim additional benefits. You and your healthcare provider can contact Equitable at ebclaims@equitable.com or at (866) 274-9887.
- For more help on your claim, call Customer Service at: (866) 274-9887

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

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New Jersey Temporary Disability Insurance (NJ TDB)
New Jersey Temporary Disability Benefits Application

PART A. ***YOUR INFORMATION*** **-to be completed by the Employee**

Social Security/Tax Identification #

Profile Information

1. Name: _____
first middle last

2. Home Address _____
Street city state zip

3. Mailing Address _____
Street city state zip

4. Date of Birth: _____ (mm/dd/yyyy)	5. Gender: _____
6. County:	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?		9. Check the highest level of schooling you have completed.	
☐ Caucasian ☐ African American ☐ Asian	☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native Latino/Hispanic ☐ Yes ☐ No	☐ Have not graduated high school ☐ High School Graduate/GED	☐ Associates/ Bachelor's Degree ☐ Graduate Degree

Disability Information

10. First date you were unable to work and under medical care for this disability (Include Saturday, Sunday or holiday)		_____ mm/dd/yyyy
11. Date you recovered or returned to work		_____ mm/dd/yyyy
12. Date(s) of emergency room care or hospitalization (If dates are provided attach proof· e.g. discharge papers)	from: _____ mm/dd/yyyy	to: _____ mm/dd/yyyy

NJ TDB – Continued in next page

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New Jersey Temporary Disability Benefits Application

Disability Information – continued

13. Describe your disability (for injuries, explain how and where it happened):

14. Physician's Name: _____
First middle last

_____ _____ Phone number:_____
City State

15. Was this injury or illness caused by your job? ☐ Yes ☐ No
If **yes**, have you or your employer (s) filed or intend to file a Workers' Compensation claim? ☐ Yes ☐ No

Additional Benefit Information

16. Do you want federal income tax withheld weekly from your benefits? ☐ Yes ☐ 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? ☐ Yes ☐ No If **Yes**, enter start/application date: _____

b. Pension benefits from your current employer? ☐ Yes ☐ No If **Yes**, enter start date: _____
Monthly amount $_____

c. Temporary Disability benefits from another state? ☐ Yes ☐ No

d. Unemployment Insurance benefits? ☐ Yes ☐ No

Certification and Signature

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.

18. Sign Here: _____ Date:_____

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: The NJ Temporary Disability Benefits program is not a "covered entity" under the Federal Health Information Portability and Accountability Act (H IPAA). All medical records of the Division, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law, are confidential and 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.

NJ TDB – Continued in next page

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ebclaims@equitable.com

New Jersey Temporary Disability Benefits Application

PART B ***EMPLOYMENT INFORMATION*** **- to be completed by the Employee**

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 _____

2. Federal Employer Identification Number (FEIN) (see instructions) _____-_____

Address: _____

street city state zip

3. Date of hire: _____ to _____ Last physical day of work before your disability: _____

4. ☐ Full time ☐ Part-time

5. Union: ☐ Yes ☐ No.

6. Occupation: _____

7. Work location City: _____ State: _____

8. Separation from this employer is: ☐ Temporary ☐ Permanent.

9. Which days do you normally work? ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

Regular Weekly Earnings $_____

11. Supervisor's name: _____

12. Phone: _____

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 leave benefits
☐ Other pay from your employer (explain) _____
☐ Severance pay ☐ With notice ☐ In lieu of notice
☐ Donated Leave

NJ TDB – Continued in next page

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New Jersey Temporary Disability Benefits Application

NJ TDB – Continued from prior page

1. Name of other employer (if applicable):

2. Federal Employer Identification Number (FEIN) (see instructions)
_____-_____

Company:_____

_____

street city state zip

3. Date of hire: _____ to _____ Last physical day of work before your leave: _____

4. ☐ Full time ☐ Part-time

5. Union: ☐ Yes ☐ No.

6. Occupation: _____

7. Work location city: _____ State: _____

8. Separation from this employer is:
☐ Temporary ☐ Permanent.

9. Which days do you normally work?
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

Regular Weekly Earnings
$_____

11. Supervisor's name:_____

12. Phone: (____)_____

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 leave benefits
☐ Other pay from your employer (explain)
_____
☐ Severance pay ☐ With notice ☐ In lieu of notice
☐ Donated Leave

NJ TDB – Continued in next page

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ebclaims@equitable.com

New Jessey Temporary Disability Benefits Application

NJ TDB – Continued from prior page

PART C ***MEDICAL CERTIFICATE***

Have your healthcare provider complete this page. 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 _____ Frequency _____

2. Date the patient was unable to perform regular work due to this disability _____ mm/dd/yyyy

3. Has your patient recovered from this disability? If so, provide recovery date _____ mm/dd/yyyy

4. Estimated recovery date
   (If patient has not recovered, provide approximate date patient will be able to return to work) _____ mm/dd/yyyy

5. Diagnosis (describe 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

7. If disability is due to pregnancy, provide the estimated date of delivery _____ mm/dd/yyyy
   a. Pre-term complications _____ Postpartum complications _____
   b. If patient has delivered, enter the delivery date _____ mm/dd/yyyy
   Identify the type of delivery ☐ Birth ☐ C-Section ☐ Miscarriage ☐ Abortion

8. Date(s) of emergency room care or hospitalization from _____ mm/dd/yyyy to _____ mm/dd/yyyy

9. Type of surgery: _____ Date of Surgery: _____ mm/dd/yyyy
   Anticipated Surgery Date: _____ mm/dd/yyyy
   Is surgery for cosmetic purposes only? ☐ Yes ☐ No

10. Was this patient referred to you? ☐ Yes ☐ No
    If yes, name of referring doctor: _____

NJ TDB – Continued in next page

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New Jersey Temporary Disability Benefits Application

NJ TDB – Continued from prior page

HEALTHCARE PROVIDER CERTIFICATION AND SIGNATURE

I certify the above statements describe the patient's disability period:

Name: _____
first middle last

Date: _____

Signature: _____

Certificate License No. _____ State: _____

Physician Specialty: _____

Address: _____ ☐ Check, if Resident
Street City State Zip Code

Phone: _____ Fax: _____

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NEW JERSEY TEMPORARY DISABILITY INSURANCE (NJ TDB) STATEMENT OF RIGHTS

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Equitable Financial Life Insurance Company of America
For Assistance Call (866) 274-9887

CASH BENEFITS
FOR HEALTH CONDITIONS AND PREGNANCY/CHILDBIRTH RECOVERY

NJ TEMPORARY DISABILITY INSURANCE
Temporary Disability benefits can partially replace your wages when you have to stop working due to a physical or mental health condition or other disability unrelated to your work, including pregnancy/childbirth and COVID-19.

Most New Jersey workers qualify
To be eligible you must:

- meet earnings requirements in the 18 months prior to the start of your claim; see the current year's requirements at **myleavebenefits.nj.gov;**
- stop working due to an illness/injury that is not caused by your job; and
- be under the care of a licensed medical provider.

For work-related disabilities, see: **myleavebenefits.nj.gov/workrelated**

Apply for benefits at www.equitable.com
It's your responsibility to ensure that a complete application – including the medical provider portion – is submitted to the Department's Division of Temporary Disability Insurance.

Send completed form to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

It can take two to six weeks to approve a claim and pay benefits, once we have a complete application.

Receive 85% of your average weekly wages, up to a maximum
See the current year's maximum weekly benefit level at myleavebenefits.nj.gov. Your medical provider certifies how long you need to recover from your medical condition, up to a maximum of 26 weeks. After you start receiving Temporary Disability benefits, we may ask you to provide us with proof of your continuing disability to keep receiving benefits.

NJ TDB Statement of Rights Continued on next page.

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NEW JERSEY TEMPORARY DISABILITY INSURANCE (NJ TDB)
STATEMENT OF RIGHTS

NJ TDB Statement of Rights continued from prior page



Temporary Disability Insurance for pregnancy/childbirth recovery

Temporary Disability provides cash benefits for pregnant parents when they need to stop working before giving birth and while recovering afterward. Parents can transition directly from Temporary Disability to bonding benefits, also known as Family Leave Insurance. Learn more at myleavebenefits.nj.gov/maternity.

Covered employers and employees

Most employers must participate in the State Temporary Disability Insurance plan and deduct your payroll taxes for it or provide a private plan. The federal government is exempt, and it is optional for local governments (for example counties, municipalities and school districts). Generally, employees who work a significant amount of time outside of New Jersey are not covered but are encouraged to apply to find out if they are eligible. Your employer's private plan is with Equitable. Contact us with any questions regarding your coverage.

You are covered under a private plan. Your insurance carrier, Equitable Financial Life Insurance Company of America, is responsible for processing and paying benefits on your disability claim. Reach out to Equitable to learn more about your coverage and obtain claim forms.

Job protection

Temporary Disability Insurance is a wage replacement program and does not provide job protection. However, your job may be protected under the federal Family & Medical Leave Act (FMLA), which is a separate law enforced by the U.S. Department of Labor. Generally, employers with at least 50 employees are covered under FMLA and must provide up to 12 weeks of job-protected, unpaid medical leave. You may need to provide notice to your employer if you're taking leave under this law.
In addition, if an employer retaliates against you for taking or seeking to take Temporary Disability benefits, you have the right to take private legal action.
For more information, visit **myleavebenefits.nj.gov/jobprotection.**

For further assistance contact Equitable



Phone Number: (866) 274-9887

MONDAY-FRIDAY
8:00 am – 8:00 pm eastern time



Send completed form to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262

Fax Number: (315) 477-2499

Email: ebclaims@equitable.com

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Electronic Funds Transfer (EFT) Request Form

Clear Form

Instructions

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: ( ) - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: ( ) - _____

Type of Account (select one):

Checking: ☐ **Saving:** ☐

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize _____ hereinafter called "The Insurance Company" and/or its Third Party Administrator, hereinafter called "TPA", to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Insurance Company and/or its TPA has received written notice from me (us) of its termination in such time and in such manner as to afford The Insurance Company and/or its TPA and Depository a reasonable opportunity to act on it.

_____ _____

Signature(s): **Date:**

_____ _____

TERMS AND CONDITIONS

The Insurance Company and/or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer.

I understand that this agreement may be terminated by me upon written notice to The Insurance Company and/or its TPA.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Insurance Company and/or its TPA of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Insurance Company and/or its TPA. I agree that the financial institution shall hathe right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Insurance Company and/or its TPA with my home address and the names of any joint account holders for the account specified here in.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Insurance Company and/or its TPA of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Insurance Company and/or its TPA. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Insurance Company an/or its TPA with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Insurance Company and/or its TPA or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Insurance Company and/or its TPA if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Insurance Company and/or its TPA.

_____ _____

Signature: Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

_____ _____

Signature(s) of Other Persons on Account: Date

_____ _____

Date:

Send completed form to:
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Fax Number: (315) 477-2499
ebclaims@equitable.com

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NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS (NJ TDB)

Employer Information Addendum for NJ TDB - To Be Completed by the Employer

1. Business's full legal name and mailing address
Business Name _____
Mailing Address _____
City, State _____
Zip Code _____
Country (if not U.S.A.) _____

2. Employer's FEIN: _____

3. Contact Information:
Employer's contact name for questions relating to disability: _____
Employer's contact telephone number: _____
Employer's contact email address: _____

4. Employee Information:
Employee's date of hire: _____
Date employee last worked: _____
Date employee returned to work (if applicable): _____

5. Were wages continued during disability? ☐Yes ☐No
If yes, what type? (PTO, sick time, other): _____
If yes, is reimbursement requested by employer? ☐ Yes ☐No
*Reimbursement is only available if employer continued salary during disability or employee used sick time

6. Is the employee's disability work-related? ☐Yes ☐No

Continued on next page.

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7. Enter the last 8 weeks of gross wages for the employee immediately prior to the disability starting with the week the disability began, and calculate the average gross weekly wage (include bonuses, tips, commissions, reasonable value of board, rent, etc. and see instructions for more information)

Week No.	Week Ending Date (MM/DD/YYYY)	No. of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
		Calculated average gross weekly wage:	

8. **In the preceding 52 weeks has the employee taken leave for:**
   ☐ NJ Disability If yes, Please provide specific dates for disability: _____
9. **Is employee still in your employment? ☐Yes ☐No**
   If no, date employment was terminated:_____
10. **If employee received unemployment benefits, date the benefit was last received:** _____

Information Needed for Withholding and Reporting Taxes.

What percent of this employee's NJ TDB benefit is taxable?___%

What percentage, if any, do you contribute towards the cost of the NJ TDB premium?_%

Does the employee contribute towards the cost of the NJ TDB premium? ☐ Yes ☐ No If yes, at what percent?_____%

If yes, is it on a ☐ Pre-Tax basis or ☐ Post-Tax basis

Lack of response will result in the benefit being treated as 100% taxable.

Please refer to IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for information on calculating the taxable percent.

I have read and acknowledge the fraud information below and affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____
Employer Signature: _____
Employer Contact Phone Number: _____
Date: _____

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For Assistance Call (866) 274-9887

Employer Short-Term Disability Addendum – To Be Completed by the Employer

If the employee is also covered by an Equitable Short-Term Disability policy, please complete the information below information.

Please complete the following for STD benefits

Is this employee a Union member? ☐ Yes ☐ No

Is the employee Hourly _____ or Salaried ___?

What is this employee's weekly or hourly rate of pay? $_____

Scheduled number of hours worked per week: _____

Is this employee receiving salary continuation or sick leave? Yes ____ No _____

If "**Yes**," please provide dates and payment amount. From _____ through_____
month/day/year month/day/year

What percentage, if any, do you contribute towards the cost of the STD premium?_____%

Is the Employer-paid premium added to the Employee's taxable wages? "Gross-Up" ☐ Yes ☐ No

Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No

If **Yes**, at what percent? ____% If **Yes**, is ☐ Pre-Tax basis or ☐ Post-Tax basis

What percent of this employee's STD benefit is taxable? _____ %

Note: Lack of response will result in the benefit being treated as 100% taxable.
Please refer to IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for information on calculating the taxable percent

Completed by: _____ Date: _____

Phone Number: _____ Email: _____

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