EQUITABLE

Equitable Financial Life Insurance Company of America *

For Assistance
Call (866) 274-9887

Important Information to Assist with Completion of the New Jersey Claim Form - Part C

Valued Customer:

There is a section of the New Jersey Claim Form (Employer Section Part C) where clarification may be helpful. We hope this document will aid in completion of the claim form.

Base Weeks and Base Gross Wages:

To qualify for benefits, during the first four of the last five completed calendar quarters immediately before the period of disability ("Base Year"), an employee must have (1) earned a certain gross amount in New Jersey covered employment, or (2) earned a certain weekly amount in New Jersey covered employment for at least 20 weeks ("Base Weeks"). Base Year and Base Week qualifying earnings amounts are updated annually on January 1st.

For current qualifying earnings amounts, please visit the New Jersey Department of Labor and Workforce Development at https://www.nj.gov/labor/ea/rates/rateindex.html

Taxability of Benefits:

Please see the below excerpt from IRS Publication 15A to assist you in calculating the taxable percent of benefits. Taxability is expected to be less than 100 percent when the employee is contributing to the cost of the coverage.

Excerpt from IRS Publication 15A, Page 17 and 18: ***Group policy.*** If both the employer and the employee contributed to the sick pay plan under a group insurance policy, figure the taxable sick pay by multiplying total sick pay by the percentage of the policy's cost that was contributed by the employer for the 3 policy years before the calendar year in which the sick pay is paid. If the policy has been in effect fewer than 3 years, use the cost for the policy years in effect or, if in effect less than 1 year, a reasonable estimate of the cost for the first policy year.

Example. Alan is employed by Edgewood Corporation. Because of an illness, he was absent from work for 3 months during 2015. Key Insurance Company paid Alan $2,000 sick pay for each month of his absence under a policy paid for by contributions from both Edgewood and its employees. All of the employees' contributions were paid with after-tax dollars. For the 3 policy years before 2015, Edgewood paid 70% of the policy's cost and its employees paid 30%.

Because 70% of the sick pay paid under the policy is due to Edgewood's contributions, $1,400 ($2,000 × 70%) of each payment made to Alan is taxable sick pay. The remaining $600 of each payment that is due to employee contributions is not taxable sick pay and is not subject to employment taxes. Also, see *Example of Figuring and Reporting Sick Pay*, later in this section.

For more information please visit: https://www.irs.gov/pub/irs-pdf/p15a.pdf

Mail,Email or Fax the completed form to:
Group Claims Department P.O. Box 14294
Lexington, KY 40512-4294
Fax 1-855-864-0530
Phone Number: (866) 274-9887
claimsubmission@groupclaims.com

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NOTICE OF NEW JERSEY TEMPORARY DISABILITY BENEFITS CLAIM

PART A CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE

1. Name: (Last, First, Middle) as shown on your Social Security card.	2. Social Security Number:	3. Birth Date:
4. Sex: ☐ Male ☐ Female	5. Home Telephone Number: ( )	6. Marital Status: ☐ Single ☐ Married

7. E-Mail Address: (E-Mail is used to provide important status updates.)

8. Mailing address : (Street, City or Town, State, Zip Code)

9. Employer Name:	10. Employer Telephone Number: ( )
11. Employer Address: (Street, City, State & Zip Code)	12. Occupation:

13. Are you a citizen of the United States? ☐ Yes ☐ No **If "No," complete block number's 14 & 15, and give country of origin.**

14. Alien Registration Number:	15. Work Authorization: *From:* _____ *To:* _____

16. Country of origin:

17. The last day you worked before your disability began: **(Include Saturday, Sunday, or Holiday)**	18. The first day you were unable to work due to present disability?
19. If now recovered, date of your recovery or return to work:	20. If due to accident, give date:
21. Date(s) of emergency room care: _____ _____ _____	22. Date of hospitalization: From: _____ To: _____

23. Describe your disability:

24. Was this disability caused by your job? ☐ Yes ☐ No If "Yes," describe:

25. Name of physician or hospital treating you for this disability:

26. Address of physician or hospital treating you for this disability:	27. Telephone Number: ( )

PART A (Continued)

Employment information - Other employers you have worked for during *the past 18 months.* Include full-time and part-time employment. If you had more than 3 employers, list on a separate sheet and attach to this form.

28. Name:	29. Telephone Number: ( )	30. Period of Employment: From: _____ To: _____
31. Address: (Street, City, State & Zip Code)	32. Work Location:	

33. Occupation:	34. Union Name:	35. Division:

36. Name:	37. Telephone Number: ( )	38. Period of Employment: From: _____ To _____
39. Address (Street, City, State & Zip Code)	40. Work Location	

41. Occupation:	42. Union Name:	43. Division:

44. **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

45. Since your last day of work have you received, claimed or applied for

a. Social Security 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

46. I request voluntary Federal Tax Withholding ☐ Yes ☐ No If "Yes," indicate the amount to be withheld from weekly benefits.

($20.00 minimum withholding per week) _____

47. 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.

If your employer has agreed to continue your regular pay while you are unable to work, do you agree to have the benefits available to you under this policy routed through your employer? ☐ Yes ☐ No. Please sign: _____

Note: A "No" answer could impact you continuing to receive your regular pay from your employer in exchange for the benefits available to you from this policy.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

SIGN HERE _____ _____

(Claimant's Signature) (Date)

NOTICE OF NEW JERSEY TEMPORARY DISABILITY BENEFITS CLAIM

PART B MEDICAL CERTIFICATE (To be completed by your doctor)

1. Patient was first treated by me on:

2. Patient was last treated by me on:

3. Is the patient unable to perform his/her regular work? ☐ Yes ☐ No

   If "Yes," please enter the date the disability began: _____

4. Estimate recovery: (give the approximate date claimant will be able to return to work) _____

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

6. Diagnosis (nature and cause of this disability which prevents claimant from working): ICD Code: _____

7. Clinical data and test to support diagnosis:

8. (a) If pregnant, provide estimated date of delivery: _____ (Month/ Day/ Year)

   Complications, if any: _____

   (b) If pregnancy has terminated, enter the date: _____ (Month/ Day/ Year)

   and the reason: ☐ Vaginal ☐ C-Section ☐ Miscarriage ☐ Others _____

9. Date(s) of emergency room care or hospitalization: From: _____ To: _____

10. Type of Surgery: _____ CPT Code: _____

    Date of Surgery: _____ Date Surgery Contemplated: _____

11. 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?

Print Doctor's Name and Degree:	**Doctor's Signature:**	
Address: (Street, City, State and Zip Code)		**Telephone Number:** ( )
Specialty:	**Certificate, License Number and State:**	**Date Signed:**

PART C TO BE COMPLETED BY YOUR EMPLOYER

1. Employee's Name: | 2. Social Security Number: | 3. Policy / Plan Number:

4. Employee Status: ☐ Full Time ☐ Part Time ☐ Intermittent ☐ Seasonal ☐ Other If other, please explain:

5. Employment Date: | 6. Effective Date of Insurance:

7. Date Regarding Last Day Worked:
   (a) Claimant's last day worked before this disability: _____
   (b) Exact reason for separation from work on the date listed: _____
   (c) Is lack of work: ☐ Temporary? ☐ Permanent?
   (d) Has claimant returned to work? ☐ Yes ☐ No If "Yes," give date: _____
   If the work was intermittent, list dates: _____

8. Continued Pay
   (a) Have you paid the claimant since the last day of work? ☐ Yes ☐ No
   (b) These monies represent pay: From: _____ To: _____
   (c) Total gross paid for the above period: $ _____ Amount per week $ _____
   (d) Check or Circle 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
   - ☐ 6. Payments required to be made under the State mandated temporary disability benefit plan pursuant to the New Jersey Disability law

   (e) Do you wish to have benefit payments (made payable to claimant) routed to you during wage continuation period?
   ☐ Yes ☐ No (Please note: employee must agree and provide signature in claimant section in order to process this request.) **Note: Items (d) 1, 2, and 3 may reduce benefits to the claimant.**

9. Workers' Compensation Liability:
   (a) Did the claimant's disability happen in connection with his / her work or while on 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
   (c) If "Yes," give Workers' Compensation carrier Name _____
   Address _____ Telephone number ( ) _____

10. Base Year And Base Gross Wages:

Please provide the total Gross Earnings for Base Year. (*Be sure to only include earnings for Base Weeks)*

Please provide the total number of Base Weeks included in the calculation for the same period:

Quarter	Gross Earnings	Number of Base Weeks
1		
2		
3		
4		

Base Week
Any calendar week (Sunday through Saturday) in which the employee earned a qualifying amount. For current qualifying earnings https://www.nj.gov/labor/ea/rates/rateindex.html

Base Year
The timeframe used to meet the minimum gross earnings requirement and to calculate the average weekly wage. The standard base year refers to the first four of the last five completed calendar quarters before the worker files a claim.

11. **Is employee enrolled in an LTD Plan?** ☐ **Yes** ☐ **No** **If "Yes," effective date:** _____

12. Based on the employer/employee premium contributions made over the last 3 years, what percentage of the Weekly Disability Benefit is considered taxable? _____% LTD _____% (If blank, we will code the benefit as 100% taxable until you submit written notice of the correct taxable %.)

I certify that the above information is correct.

Firm Name: | Signed:

Address: | Official Title:

Telephone Number: ( ) Date Signed:

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 Equitable _____ 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: