



Temporary Disability Benefits CLAIM

POLICYHOLDER CERTIFICATION



EMPLOYER — *form completion information*

NOTICE OF CLAIM — Instructions

- A. Complete the **Employer's Statement** in full and transmit to:

Group Claims
Security Mutual Life Insurance Company of New York
P.O. Box 1625
Binghamton, NY 13902-1625

INCLUDE • Documentation of earnings if other than straight salary.
• If Workers' Compensation claim filed include copy of First Report of Accident and the decision.

- B. Give remaining **Employee's Statement** and **Attending Physician's Statement**** to claimant for completion.

REQUEST • Copy of awards from other source of benefits: Social Security, Workers' Compensation, retirement, state disability, others.

- C. All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

****If claimant has more than one treating physician, provide claimant with additional Attending Physician's Statement forms**

**STATEMENT OF CLAIM
TEMPORARY DISABILITY
BENEFITS**



SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlyn.com

EMPLOYER'S STATEMENT (To Be Completed By Your Employer or Company Representative)

1. Employee Name and Address:

2. Social Security No.
- -

3. Date hired:

4. Last Day Worked before this disability (do not use payroll week ending dates) → Month Day Year

(a) Exact reason for separation from work (include labor dispute) _____

(b) Is lack of work: Temporary Permanent

(c) Has claimant returned to work? Yes No

If "Yes," give date: → Month Day Year

(d) If the work was intermittent, list dates below.

8. Base Weeks and Base Year Gross Wages

A Base Week is a calendar week in which the claimant had New Jersey earnings of \$143.00 or more during the Base Year. The Base Year is the 52 calendar weeks preceding the week in which the disability occurred.

(a) Total number of Base Weeks _____

(b) Total Gross Wages in Base Year _____
(Include all wages earned by the claimant)

5. Continued Pay (do not enter wages earned prior to disability)

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

(b) If "Yes" From Month Day Year To Month Day Year

(c) Total gross paid or to be 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. Full salary advanced to effect #4 above
- 6. Supplemental benefits or gratuities

Note: Items (d) 1, 2 and 3 may reduce benefits to the claimant.

6. Is employee entitled to Workers' Compensation for this disability?

Yes No

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

(c) If "Yes," list Workers' Compensation insurance carrier below:

Name _____ Phone No. (____) _____

Address _____

Policy # _____ Claim # _____

9. Regular Weekly Wage \$ _____

10. Weekly Wages

Indicate below dates and claimant's GROSS earnings in NJ employment during the listed calendar weeks.

Description of Calendar Week	Calendar 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 → \$

Percentage of premium paid by employer _____% (If unanswered, we will assume 100% employer contribution)

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Firm Name _____

GROUP POLICY NO. _____
Please also write on Employee's Statement

Address _____

Signed _____

City, State and Zip Code _____

Print or Type Name _____

Mailing Address, if different _____

Official Title _____

Fax Number (____) _____

Phone Number (____) _____ Date _____

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607.723.3551 • www.smlny.com

**Complete Employee's Statement
and forward along with Attending
Physician's Statement to your
physician.**

EMPLOYEE'S STATEMENT		Group Policy No. _____
1. Name: (Last, First, Middle) _____		2. Date of Birth / /
3. Social Security No. - -		4. Home Address – required (Street, Apt. No., City, State, Zip Code) _____
5. County _____		6. Male <input type="checkbox"/> Female <input type="checkbox"/>
7. Mailing Address – if different (Street, Apt. No., City, State, Zip Code) _____		8. Occupation _____
9. Are you a citizen of the United States? Yes <input type="checkbox"/> No <input type="checkbox"/> If NO , answer #10 & #11 and give country of origin _____		10. Alien Reg. No. _____
11. Work Authorization From _____ To _____		12a. Reason for separation: <input type="checkbox"/> Illness/Accident <input type="checkbox"/> Terminated <input type="checkbox"/> Quit
12b. What was the last day that you actually worked before your disability began? →		Month _____ Day _____ Year _____
13. The first day you were unable to work due to present disability: (Include Saturday, Sunday, or Holiday) →		Month _____ Day _____ Year _____
14. Date you recovered or returned to work: (Do not use dates in the future) →		Month _____ Day _____ Year _____
15. Date(s) of emergency room care: _____ or hospitalization: From _____ To _____ Month/Day/Year Month/Day/Year Month/Day/Year		
16. Describe your disability (How, when, where it happened) _____		
17. Was this disability caused by your job? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," date of work related injury/illness: _____		
18. Identify the physician or hospital Name: _____ Telephone No. (____) _____ treating you for this disability: Address: _____		
Employment Information – Beginning with your most recent employer, list all employment (full and part-time) in the last 18 months. If you had more than 3 employers, list on separate sheet of paper and attach to this form.		
19a. Name and address of your most recent employer: _____ (Street) (City) (State) (Zip)		Period of employment From _____ To _____ Month/Day/Year Month/Day/Year
Occupation: _____ Union Name: _____ Division: _____		Telephone No. (____) _____ Work Location (City) (State)
19b. Name and address of your next most recent employer: _____ (Street) (City) (State) (Zip)		Period of employment From _____ To _____ Month/Day/Year Month/Day/Year
Occupation: _____ Union Name: _____ Division: _____		Telephone No. (____) _____ Work Location (City) (State)
19c. Name and address of your next most recent employer: _____ (Street) (City) (State) (Zip)		Period of employment From _____ To _____ Month/Day/Year Month/Day/Year
Occupation: _____ Union Name: _____ Division: _____		Telephone No. (____) _____ Work Location (City) (State)
20. Other Benefits – You Must Answer Each Question Listed Below For The Period of Disability Covered By This Claim:		
a. Have you worked since your disability began? (Including self-employment) Yes <input type="checkbox"/> No <input type="checkbox"/>		
b. Have you been receiving remuneration i.e., wages, salary or vacation pay? Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. Have you been involved in a labor dispute? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. Since your last day of work have you received, claimed or applied for:		
a. Social Security Disability benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>		
b. Pension benefits from your most recent employer? Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. Any other disability benefit provided by your employer or union? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. Workers' Compensation benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>		
e. Unemployment Insurance benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>		

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person who has attended me or has any records or knowledge of me or my health to furnish the Security Mutual Life Insurance Company of New York, or its representative, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Date _____ Signed _____



ATTENDING PHYSICIAN'S STATEMENT

Patient's name		Date of Birth
Nature of sickness (Describe complications if any)		
Is condition due to pregnancy? If "yes" what was approximate date of commencement of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date	
When did patient first consult you for this condition?	Date	
Nature of surgical or obstetrical procedure, if any. (Describe fully)	Date	
Give dates of treatment	Office Home Hospital	
How long was or will patient be continuously totally disabled? (Unable to work)	From	Through
Is condition due to injury or sickness arising out of patient's employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Remarks		
Date	Signed	*Social Security #
		*Tax ID #
Street Address	City or town	State
		Zip Code

Uniform Claim form (ID-1) *Under authority of law, individual practitioners must furnish SS#. All others must give employer ID#.