

CLAIM FILED AND REQUEST FOR INFORMATION-(E15)

1. Return this form to: <p style="text-align: center;">New Jersey Department of Labor and Workforce Development Division of Temporary Disability Insurance PO Box 387 Trenton, New Jersey 08625-0387</p>	3. Claimant's S.S. No.	4. Seq. No.	
	5. Claimant's Name		6. Claim Rec'd
2. Employer's Name and Address	7. Claim Date	8. Mailing Date	9. Exam No.
	10. Employer ID No.		11. Last Day Worked
	12. Base Year		
	From:		To:
	13. Work Location		14. Minimum Base Week Reg. 5

SAMPLE

THE ABOVE NAMED CLAIMANT HAS FILED A CLAIM AND HAS STATED THAT HE/SHE WAS IN YOUR EMPLOY AT SOME TIME DURING THE BASE YEAR SPECIFIED IN ITEM 12 ABOVE. YOU MUST COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS SHOWN ABOVE OR FAX IT TO (609) 984-4138 WITHIN TEN DAYS FROM THE DAY OF MAILING SHOWN IN ITEM 8.

Please provide your EMPLOYER IDENTIFICATION NUMBER: _____

Do you have a private plan for disability insurance coverage which has been approved by the N.J. Division of Unemployment and Disability Insurance? Yes _____ No _____
 If YES, is the claimant covered under it? Yes _____ No _____

What was the claimant's last date worked immediately before this period of disability commenced?

 (Month Day Year)

What was the reason for separation from work on the above date? _____

Has the claimant returned to work? Yes _____ No _____ If YES, provide date:

 (Month Day Year)

If the claimant worked intermittently after the disability began, provide date(s): _____;
 _____;
 _____;

Have you paid the claimant since the last date worked? Yes _____ No _____
 If YES, please provide:

a. Amount paid per week: \$ _____

(CONTINUED ON REVERSE ->)

15. IF THE COMPANY NAME AND/OR ADDRESS SHOWN ABOVE IS/ARE INCORRECT, INDICATE CORRECTION(S) BELOW.
 NAME _____
 ADDRESS _____

I CERTIFY THAT THE INFORMATION SUBMITTED BY ME IN THIS REPORT IS TRUE AND CORRECT.
 PRINT NAME: _____ SIGNATURE: _____
 DATE: _____ TELEPHONE: () _____ OFFICIAL TITLE: _____



b. Continued pay is allocated for the period:
From _____ Through _____
(Month Day Year) (Month Day Year)

c. These payments represent:

- (1) ___ Regular weekly wages and/or sick pay
- (2) ___ Difference between regular weekly wage and disability benefits to be received
- (3) ___ Supplemental benefits or gratuities
- (4) ___ Regular vacation (if designated for a specific period)
- (5) ___ Pension

If the claimant is employed by a government entity, please provide:

a. Claimant's payroll number (if N.J. State employee): _____

b. Number of accumulated (unused) sick days as of the last date worked: _____

Workers' Compensation Liability:

Did the disability occur in connection with the claimant's work or while on your premises, or was the disability due in any way to his/her occupation? Yes ___
No ___ If YES, have you filed or do you intend to file a workers' compensation claim on behalf of the claimant? Yes ___ No ___ If YES, please provide the name, address and telephone number of the workers' compensation carrier:

Name _____
Street _____
City _____ State _____ ZIP _____
Telephone No. _____

In how many calendar weeks did the claimant earn at least the minimum base week requirement (indicated above in Item 14) in New Jersey covered employment during the base year (refer to Item 12 above), which is the 52 calendar week period preceding the week in which the leave began? _____ weeks

Provide the total wages that the claimant earned IN ALL WEEKS during the base year period indicated above in Item 12: \$ _____

Please provide the claimant's regular weekly wage (that is, earnings for a usual work week) immediately prior to the beginning of the disability: \$ _____

Please provide the calendar week-ending dates and the claimant's GROSS earnings in New Jersey covered employment during the ten calendar weeks immediately prior to the week in which the disability began:

CALENDAR WEEK-ENDING DATES

GROSS WAGES

(Calendar week in which disability began)

(Omit this week)

1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
7. _____	\$ _____
8. _____	\$ _____
9. _____	\$ _____
10. _____	\$ _____

TOTAL: \$ _____

Are you exempt from FICA tax? Yes ___ No ___