APPENDIX

WORKSHEET 1

CALCULATING AVERAGE WEEKLY WAGE WITH 2 CONCURRENT PRIVATE PLAN EMPLOYERS

Claimant's Name_____ SSN#_____

Last day of work_____ First day of Disability (FDD)_____

1st Employer Name _____

2nd Employer Name _____

Last 8 weeks of Wages prior to FDD

Week Ending Date	Wages 1st Employer		Wages 2nd Employer		Total Wages for the Week
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
	1st _____	+	2nd _____	=	Grand Total_____

Grand Total last 8 weeks _____ divided by number of base weeks ___ = _____ AWW (Average Weekly Wage)

AWW_____ x 66 2/3% (or percentage of more favorable plan if greater) = WBR (Weekly Benefit Rate) _____

Each Private Plan employer pays their percentage of the total weekly benefit rate for which they are responsible.

To arrive at percentages, take the total employer wages (either 1st or 2nd) and divide by the grand total. The combination of 1st and 2nd employers' percentages must equal 100% and match the AWW

WORKSHEET 2
CALCULATING AVERAGE WEEKLY WAGE WITH 2 CONCURRENT EMPLOYERS
(WHEN ONE EMPLOYER IS STATE PLAN AND ONE EMPLOYER IS PRIVATE PLAN)

Claimant's Name_____ SSN#_____

Last day of work_____ First day of Disability (FDD)_____

1st Employer Name _____

2nd Employer Name _____

Last 8 weeks of Wages prior to FDD

Week Ending Date	Wages 1st Employer		Wages 2nd Employer		Total Wages for the Week
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
	1st _____	+	2nd _____	= Grand Total	_____

Grand Total last 8 weeks _____ divided by number of base weeks ___ = _____ AWW (Average Weekly Wage)

AWW_____ x 66 2/3% (or percentage of more favorable plan if greater) = WBR (Weekly Benefit Rate) _____

BASE YEAR CHART FOR STATE PLAN DISABILITY CLAIMS - 2017

IF THE DISABILITY DATE OF CLAIM IS WITHIN THE CALENDAR WEEK			THE BASE YEAR	
BEGINNING	and ENDING		BEGINS	and ENDS
12/31/17	01/06/18		01/01/17	12/30/17
01/07/18	01/13/18		01/08/17	01/06/18
01/14/18	01/20/18		01/15/17	01/13/18
01/21/18	01/27/18		01/22/17	01/20/18
01/28/18	02/03/18		01/29/17	01/27/18
02/04/18	02/10/18		02/05/17	02/03/18
02/11/18	02/17/18		02/12/17	02/10/18
02/18/18	02/24/18		02/19/17	02/17/18
02/25/18	03/03/18		02/26/17	02/24/18
03/04/18	03/10/18		03/05/17	03/03/18
03/11/18	03/17/18		03/12/17	03/10/18
03/18/18	03/24/18		03/19/17	03/17/18
03/25/18	03/31/18		03/26/17	03/24/18
04/01/18	04/07/18		04/02/17	03/31/18
04/08/18	04/14/18		04/09/17	04/07/18
04/15/18	04/21/18		04/16/17	04/14/18
04/22/18	04/28/18		04/23/17	04/21/18
04/29/18	05/05/18		04/30/17	04/28/18
05/06/18	05/12/18		05/07/17	05/05/18
05/13/18	05/19/18		05/14/17	05/12/18
05/20/18	05/26/18		05/21/17	05/19/18
05/27/18	06/02/18		05/28/17	05/26/18
06/03/18	06/09/18		06/04/17	06/02/18
06/10/18	06/16/18		06/11/17	06/09/18
06/17/18	06/23/18		06/18/17	06/16/18
06/24/18	06/30/18		06/25/17	06/23/18
07/01/18	07/07/18		07/02/17	06/30/18
07/08/18	07/14/18		07/09/17	07/07/18
07/15/18	07/21/18		07/16/17	07/14/18

BASE YEAR CHART FOR STATE PLAN DISABILITY CLAIMS – 2018

IF THE DISABILITY DATE OF CLAIM IS WITHIN THE CALENDAR WEEK			THE BASE YEAR	
BEGINNING and	ENDING		BEGINS and	ENDS
07/22/18	07/28/18		07/23/17	07/21/18
07/29/18	08/04/18		07/30/17	07/28/18
08/05/18	08/11/18		08/06/17	08/04/18
08/12/18	08/18/18		08/13/17	08/11/18
08/19/18	08/25/18		08/20/17	08/18/18
08/26/18	09/01/18		08/27/17	08/25/18
09/02/18	09/08/18		09/03/17	09/01/18
09/09/18	09/15/18		09/10/17	09/08/18
09/16/18	09/22/18		09/17/17	09/15/18
09/23/18	09/29/18		09/24/17	09/22/18
09/30/18	10/06/18		10/01/17	09/29/18
10/07/18	10/13/18		10/08/17	10/06/18
10/14/18	10/20/18		10/15/17	10/13/18
10/21/18	10/27/18		10/22/17	10/20/18
10/28/18	11/03/18		10/29/17	10/27/18
11/04/18	11/10/18		11/05/17	11/03/18
11/11/18	11/17/18		11/12/17	11/10/18
11/18/18	11/24/18		11/19/17	11/17/18
11/25/18	12/01/18		11/26/17	11/24/18
12/02/18	12/08/18		12/03/17	12/01/18
12/09/18	12/15/18		12/10/17	12/08/18
12/16/18	12/22/18		12/17/17	12/15/18
12/23/18	12/29/18		12/24/17	12/22/18
12/30/18	01/05/19		12/31/17	12/29/18

NOTICE OF TEMPORARY DISABILITY CLAIM DECISION

Private Plan Carrier: _____

Claimant Name and Address:

Date of this notice: _____

Social Security #: _____

Last Date Worked: _____

First Date Disabled: _____

Employer_____

Address: _____

Benefits paid on this claim prior to the date of this notice:

NONE ☐

GROSS WEEKLY BENEFIT RATE PAID: $_____

FROM_____TO_____

YOU ARE HEREBY NOTIFIED THAT YOUR CLAIM FOR DISABILITY BENEFITS IS REJECTED FOR THE REASON(S) CHECKED BELOW:

[ ] 1. Returned to work after disability.
[ ] 2. Disability ended during waiting period.
[ ] 3. Maximum benefits exhausted.
[ ] 4. Employment not covered under Law.
[ ] 5. No medical documentation received.
[ ] 6. Disabled due to self-inflicted injury.
[ ] 7. Disability occurred during commission of crime of first, second or third degree.
[ ] 8. Working during disability.
[ ] 9. Receiving continued pay from employer during disability.
[ ] 10. Disability occurred during labor dispute.
[ ] 11. Disability began more than 14 days after last day worked.
[ ] 12. Disability is work related.
[ ] 13. Received U.I., S.S. Disability Benefits or Maintenance and Cure during disability.
[ ] 14. Worked less than 20 base weeks (either with earnings of $169 per week or a week (up to 13 weeks) in which the claimant is separated from employment due to a declared state of emergency during the base year) OR did not earn $8,500 in base year.
[ ] 15. Late filing of claim without good cause.
[ ] 16. Failure to appear for impartial medical examination.
[ ] 17. Impartial medical examination found claimant able to work.
[ ] 18. Not too disabled to perform duties of regular employment.
[ ] 19. Failed to provide other required information.
[ ] 20. Not in class covered by employer's Private Plan.
[ ] 21. Disability began before effective date of Private Plan.
[ ] 22. Disability began after termination date of Private Plan.
[ ] 23. Private Plan not insured by this insurer.
[ ] OTHER

Explanation: _____

_____

APPEALS

IF YOU DISAGREE WITH THIS DECISION, YOU HAVE THE RIGHT TO APPEAL OUR DECISION BY CONTACTING PRIVATE PLAN COMPLIANCE, PO BOX 957, TRENTON, NJ 08625-0957.

Signature: _____ Title: _____ Phone: _____