Division of Temporary Disability Insurance / Private Plan
PO Box 957 / Trenton, NJ 08625

PRIVATE PLAN DISABILITY BENEFITS REQUEST FOR MEDICAL CERTIFICATE

Date Mailed:

SS#: XXX-XX-

Additional medical information is required in connection with your claim for temporary disability benefits under your employer's Private Plan**. Please have your Doctor immediately fill in the medical certificate at the bottom of this form. Mail this completed form immediately to the address shown above as we can take no action on your claim until we receive it.**

, Claims Examiner (609) FAX (609) 292-2537

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1. Patient has been under my care for this present period of disability from_____ to_____ and has been seen every *(Frequency)* _____. (Reverse side may be used for additional dates of care.)
2. Patient has been hospitalized from *(Dates)* _____ to _____.
3. **Patient has been unable to perform all the duties of his/her regular or usual job (or unable to work) from _____.** (THIS MONTH, DATE & YEAR MUST BE PROVIDED)
4. Prognosis: Approximate date claimant will be able to return to work. Please give estimated date_____.
5. Diagnosis: Nature and cause of this disability which prevents claimant from working _____ _____.
6. In your opinion, was the disability: ⬭ Due to an accident at work ⬭ Not related to his/her employment ⬭ Due to a condition which developed because of the nature of work?
7. Surgery performed:_____Type of surgery _____
8. If this disability is due to pregnancy, give expected date of delivery: _____
9. If pregnancy terminated, give date _____ ☐ Birth ☐ Miscarriage ☐ Abortion

I hereby certify that the above statements in my opinion, truly describe the claimant's disability and the estimated duration thereof.

PRINT Doctor's Name and Indicate Degree	**Doctor's Signature**	**Date Signed**
Address & Telephone Number		**Certificate License No.**