NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED WHILE EMPLOYED OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT.** USE CLAIM FORM **DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS.**
2. YOU MUST COMPLETE ALL ITEMS OF PART A - THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT."**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

1. My name is ..... **Social Security Number** ☐☐☐ ☐☐ ☐☐☐☐
First Middle Last

2. Address.....
Number Street City or Town State Zip Code Apt. No.

3. Tel. No..... 4. Date of Birth..... 5. Married (Check one) ☐ Yes ☐ No

6. My disability is (if injury, also state how, when and where it occurred) .....
.....

7. I became disabled on ..... a. I worked on that day ☐ Yes ☐ No
Month Day Year

b. I have since worked for wages or profit. ☐ Yes ☐ No If "Yes", give dates .....

8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was ....
Occupation Name of Union and Local Number, if Member

10. For the period of disability covered by this claim
a. Are you <u>receiving</u> wages, salary or separation pay:..... ☐ Yes ☐ No
b. Are you <u>receiving</u> or <u>claiming:</u>
(1) Workers' compensation for work-connected disability..... ☐ Yes ☐ No
(2) Unemployment Insurance Benefits..... ☐ Yes ☐ No
(3) Damages for personal injury..... ☐ Yes ☐ No
(4) Benefits under the Federal Social Security Act for long-term disability..... ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
I have ☐ received ☐ claimed from ..... for the period ..... to .....
Date Date

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began ..... ☐ Yes ☐ No
If "Yes", fill in the following: I have been paid by ..... From ..... To .....
Date Date Date

12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELEIF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on .....
Date Claimant's Signature

If signed by other than claimant, print below: name, address, and relationship of representative.
.....

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Worker's Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPICIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A : WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

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PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)
THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name ..... 2. Date of Birth ..... 3. Sex ☐ Male ☐ Female
4. Diagnosis/Analysis .....
   a. Claimant's Symptoms .....
   .....
   .....
   b. Objective Findings .....
   .....
5. Claimant Hospitalized? ☐ Yes ☐ No From ..... To .....
6. Operation Indicated? ☐ Yes ☐ No a. Type ..... b. Date .....
7. Enter Dates for the Following:

	Month	Day	Year
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date claimant was unable to work because of this disability			
d. Date claimant will be able to perform usual work			

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☐ No
   If yes, has form C-4 been filed with the Workers' Compensation Board? ☐ Yes ☐ No
   Remarks (attach additional sheet, if necessary) .....
   (if disability is pregnancy related, please enter estimated delivery)

I affirm that I am a				Licensed in the State of	License Number
☐ Chiropractor	☐ Physician	☐ Psychologist			
☐ Dentist	☐ Podiatrist	☐ Nurse-Midwife			

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Health Care Provider's Signature ..... Date .....
Health Care Provider's Name (Please Print) ..... Tel.No. .....
Office Address .....
Number Street City or Town State Zip

HIPAA NOTICE: In order to adjudicate a workers' compensation claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

PART C - EMPLOYERS STATEMENT

1. Employee's Name: _____ **POLICY NUMBER: DBL-** _____
2. Employee's Occupation: _____ S.S. No.: _____ Date of Birth: _____
3. Date Employee Last Worked: _____ # of hrs. worked on last day: _____ DATE EMPLOYED: / / FULL TIME ☐ PART TIME ☐
4. Date Employee's Wages Ceased: _____ CHECK DAYS NORMALLY WORKED

Mon	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun
☐	☐	☐	☐	☐	☐	☐

5. Date Employee Returned To Work: _____
6. Wages Continued During Disability? _____
7. Is Reimbursement Requested? ____ If "Yes," through what date? _____
8. Is Disability Due To Job? _____
   If "Yes," is a compensation claim filed? _____
9. Is Employee A Member of a Union Which Provides N.Y. State Disability Benefits? _____
10. If Employee is no longer in your employ, check reason
    Labor Dispute ☐ Lack of Work ☐ Discharged ☐ Quit ☐
    Explain _____
11. Has Employee made a claim for Disability Benefits in the past 52 weeks?
    ☐ Yes ☐ No. If Yes, Date _____

EARNINGS 8 WEEKS PRIOR TO DISABILITY
(Including the week in which the disability began)

MONTH	DAY	YEAR	NO. DAYS WORKED	AMOUNT
			TOTAL	$0.00

12. Percentage of Premium paid by employer: _____ (If blank we will assume 100%.)

EMPLOYER'S NAME: _____
ADDRESS: _____
DATE: _____ **TELEPHONE: ( )** _____
SIGNED BY: _____ **TITLE:** _____

MAIL COMPLETED FORMS TO:
Union Security Life Insurance Company of New York
ADMINISTRATIVE OFFICE
P.O. Box 972030, El Paso, TX 79997-2030

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION