

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

- | |
|---|
| <ol style="list-style-type: none"> USE THIS FORM IF YOU BECOME DISABLED WHILE EMPLOYED OR IF YOU BECOME DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. YOU MUST COMPLETE ALL ITEMS OF PART A — THE “CLAIMANT’S STATEMENT.” BE ACCURATE. CHECK ALL DATES. 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. DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B — “THE HEALTH CARE PROVIDER’S STATEMENT.” YOUR COMPLETED CLAIM SHOULD BE MAILED WITHIN THIRTY (30) DAYS AFTER YOU BECOME DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER’S INSURANCE COMPANY. 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

Social Security Number

1. My name is _____
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 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 receiving wages, salary or separation pay:..... Yes No
- b. Are you receiving or claiming:
- (1) Workers’ compensation for work-connected disability..... Yes No
- (2) Unemployment Insurance Benefits..... Yes No
- (3) Damages for personal injury..... Yes No
- (4) Disability 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

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 BELIEF 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.

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 INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKERS’ COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES DISABLED WHILE EMPLOYED OR BECOMES DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE CLAIM FORM DB-300.

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 7-d, 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: _____ Diagnosis Code _____

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	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Physician	<input type="checkbox"/> Psychologist	Licensed in the State of	License Number
	<input type="checkbox"/> Dentist	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Nurse-Midwife		

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF 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.

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 — EMPLOYER’S STATEMENT

1. Employee’s Name _____ DB Policy Number _____

2. Is this claimant now employed? Yes No Date Hired _____ Full Time Part Time

3. Total salary or wages paid (including vacation pay) for the eight week period immediately preceding disability _____

4. Did the employee work at least one day in each week of this eight week period? Yes No If answer is no, give number of weeks in which employee did NOT work at least one day. (Paid vacations count as time worked) _____

5. Indicate last day employee worked. Month _____ Day _____ Year _____ Reason for cessation of employment. Please explain _____

6. Are wages being paid to employee during disability? Yes No

7. If you are paying wages during disability, do you request reimbursement? Yes No If answer is yes, have you deducted the employee portion of Social Security Tax (FICA)? Yes No

8. Is this employee eligible to receive benefits under another policy or plan accepted by the Chairman of the Workers’ Compensation Board? Yes No

9. Is this claimant an employee owner co-owner partner or proprietor? (Check One)

10. When did, or do you expect, this employee to resume work? Month _____ Day _____ Year _____

11. Employee’s usual workdays Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

12. What is the name of your Workers’ Compensation Carrier? _____

13. Was the claim reported to your Workers’ Compensation Carrier? Yes No

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

Name of Employer _____ Telephone No. _____

Date _____ By _____ Title _____