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 SIGNE YOUR CLAIM (SEE ITEM 12). IF YU 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 PROIVDER 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 …… (First) (Middle) (Last) | | | | | | | | | |

2. Address …… (Number) (Street) (City or Town) (State) (Zip) (Apt. No.)

3. Tel No. …… 4. Date of Birth …….... Married (check one) ❑ Yes ❑ No

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

……...

7. I became disabled on ……..…… (Month) (Day) (Year) a. I worked on that day ❑ Yes ❑ No

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 Mo. Day Yr.	THROUGH 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) Worker's 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 of ……. (Date) to …… (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

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 KNOW LEDGE 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 CRIM 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 Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorized letter. You may telephone your 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 INCAPACIDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NEWVA YROK, 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_____ Diagnosis Code_____
   a. Claimant's Symptons_____
   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:
   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.)

Month	Day	Year

8. In your opinion, is this disability the result of injury arising out of an in the course of employment or occupational disease? ☐ Yes ☐ No
If yes, has form C-4 been filed with the Worker's Compensation Board? ☐ Yes ☐ No
Remarks (attach additional sheet, if necessary)_____

(If disability is pregnancy related, please enter estimated delivery)

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

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Health Care Provider's Signature_____ Date_____
Health Care Provider's Name (Please Print)_____ Tel. No. _____
Office Address_____
Number Street City/Town State Zip

HIPPA NOTICE- In order to adjudicate a worker's compensation claim, WCL-13a(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 legal required medical reports are exempt from HIPPA's restrictions on disclosure of health information.

PART C – EMPLOYER'S STATEMENT IMPORTANT – Indicate percentage employer contributes to premium_____ %

1. Employee's Name_____
2. Employee's Address_____ **Policy No. 8-910**_____
3. Employee's Occupation_____ Date Employed_____ S.S. Number_____
4. Full Time☐ Part Time☐ Check Usual Days Worked

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

5. Is Claimant: an employee ☐ owner ☐ partner ☐ high school student☐ employer's spouse ☐
6. Date employee last worked_____
7. Date employee returned to work_____
8. Date employee's wages ceased or will cease_____
9. Are wages being continued during disability? _____
10. If yes, is reimbursement requested?_____
11. On what date did you receive the completed claim form?_____
12. Did disability occur as a result of employment ☐ Yes ☐ No
13. Name and address of your Compensation Carrier: _____
14. Is employee a member of a union which provides N.Y. State disability benefits?_____
15. Do you expect to rehire_____
16. If employee is no longer in your employ, check reason
    Labor Dispute☐ Lack of work☐ Fired☐ Quit☐
17. Has the claimant received U.I Benefits? ☐ Yes ☐ No
    If yes, give dates_____

Employer's Name_____
Address_____

EARNINGS FOR 8 WEEKS PRIOR TO DISABILTY
{INCLUDING THE WEEK IN WHICH THE DISABILITY BEGAN}

MONTH	DAY	YEAR	NO. OF DAYS WORKED	AMOUNT
			TOTAL	

Indicate weekly value of board, lodging and tips$_____

Mail completed forms to:
DBL CLAIMS DEPARTMENT
NATIONAL BENEFIT LIFE INS. CO.
JAF BOX 2366
NEW YORK, NY 10116

Signed by_____ Date_____ Telephone_____