

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM ONLY 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 IN YOUR BEHALF. IN THAT EVENT, THE REPRESENTATIVE'S RELATIONSHIP TO YOU AND HIS ADDRESS SHOULD BE NOTED UNDER HIS SIGNATURE.
4. DO NOT MAIL THIS CLAIM UNLESS YOUR DOCTOR COMPLETES AND SIGNS PART B—THE "DOCTOR'S STATEMENT."
5. YOUR COMPLETED CLAIM SHOULD BE MAILED WITHIN TWENTY (20) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR HIS INSURANCE COMPANY.

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

1. My name is _____
First Middle Last
2. My Social Security Number is: _____
□ □ □ □ □ □ □ □ □ □ □ □
3. Address _____
Number Street City or Town State Zip Code Apt No.
- Tel. No. _____ 4. My age is _____ 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
Mo. 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.

9. My job is or was _____
Occupation Name of Union and Local No., 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) Damages for personal injury YES NO
- (3) Unemployment Insurance Benefits YES NO
- (4) Disability Benefits under the Federal Social Security Act YES NO
- If "Yes" is checked in any of the items a., b.(1), b.(2), b.(3) or b.(4), fill in the following:
 I have Received or Claimed from _____ For 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 _____
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 FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, A COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION."

SIGN X Claim signed on _____ Date _____ Claimant's Signature _____

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

Name and Address	Relationship
IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NEW YORK STATE WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY - MENANDS, ALBANY, N.Y. 12241.	SI SE LE OCCUREN ALGUNAS PREGUNTAS RESPECTO A RECLAMAR BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON SU 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, N.Y. 12241.

DOCTOR MUST COMPLETE PART B ON PAGE 2

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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 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:
 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

Mo.	Day	Year

(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/C-48 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 Chiropractor Dentist Physician Podiatrist Psychologist Nurse-Midwife
 Licensed in the State of License Number

Any person who knowingly and with intent to defraud any insurance company files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

HIPAA NOTICE – In order to adjudicate a workers' compensation claim, WCL13-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.

Employer's Statement

Employer's Name: Policy Number:
 Employer's Address: Telephone number:

Employee's Name and Address:
 Was the employee provided with the Statement of Rights (Form DB271S) Yes No If "Yes", date
 Is Employee a Member Owner Partner Spouse Employee's Occupation
 Date of Employment: Full time worker Part time worker Social Security Number
 Normal work week: (check boxes to show usual days worked) Sun. Mon. Tue. Wed. Thur. Fri. Sat.
 Date Employee Last Worked: Date Employee Wages Ceased:

Has Employee returned to work? Yes No If "Yes," date:
 Has employment terminated? Yes No If "Yes," why?

Are wages being continued during disability? Yes No
 If "yes," does employer request reimbursement? Yes No

Was employee on job when disability occurred? Yes No
 Has claim been filed for Workers' Compensation? Yes No

Name of Workers' Compensation carrier:
 Is Employee member of a union that provides for payment of weekly cash benefits? Yes No
 If "yes," give name, address and telephone number of union:

Does employee contribute to cost of this insurance? Yes No
 If "yes," is employee contribution the maximum permitted by law? Yes No
 Other: \$ per

Earnings 8 weeks prior to disability; include weekly value of board, lodging and tips.

	WEEK ENDING			NO. DAYS WORKED	GROSS AMOUNT
	Mo.	Day	Year		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
	TOTAL				\$

Employer tax ID: Signed: Title: Date: