

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

DB450 (1-91)

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 GREEN 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 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 HIS 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

2. My Social Security Number is:

1. My name is _____

First
Middle
Last

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

Business Name	Business Address	Telephone No.	Date of Employment				Average Weekly Wages (include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
			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) Worker's Compensation for work-connected disability _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
(2) Damages for personal injury _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
(3) Unemployment Insurance Benefits _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
(4) Disability Benefits under the Federal Social Security Act _____	<input type="checkbox"/> YES	<input type="checkbox"/> 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 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 _____

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.

SIGN
→ Claim signed on _____
HERE
Date
Claimant's Signature

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 WORKER'S COMPENSATION BOARD, OR WRITE TO: WORKERS COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, N.Y. 12241

SI SE LE OCURREN 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

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE SIDE

★ 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.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

DB450 (1-91) REVERSE

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE GREEN 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. Age _____

First Middle Last

4. Diagnosis/Analysis: _____

a. Claimant's Symptoms: _____

b. Objective Findings: _____

3.

Male

Female

5. Claimant Hospitalized? From _____ To _____

6. Operation Indicated? 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 questions exists, estimate date. Avoid use of terms such as unknown or undetermined.)

Mo.	Day	Year

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-4/48 been filed with the Board? YES NO

Remarks (Attach additional sheet, if necessary): _____

9. I affirm that I am a _____ Licensed or Certified in the State of _____ License No. _____
(Physician, Podiatrist, Chiropractor, Dentist, Nurse-Midwife or Psychologist)

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

PART C — EMPLOYER'S STATEMENT IMPORTANT – Indicate percentage employee contributes to premium _____ %
(If blank or not a %, we will tax at 100%)

1. Employee's Name _____

2. Employee's address _____

3. Employee's Occupation _____ Date Employed _____ 19__ S.S. Number _____

4. Full time Part time Check usual days worked

MON	TUE	WED	THUR	FRI	SAT	SUN
-----	-----	-----	------	-----	-----	-----

5. Is claimant an employee owner partner high school student

6. Date employee last worked _____ 19__

7. Date employee's wages ceased _____ 19__

8. Date employee returned to work _____ 19__

9. Are wages being continued during disability? _____

10. If yes, is reimbursement requested? _____

11. On what date did you receive the completed claim form? _____ 19__

12. Did the disability occur as a result of employment Yes No

13. Name and address of your Compensation carrier _____

14. Do you expect to rehire? _____

15. Is employee a member of a union which provides N.Y. State disability benefits? _____

16. If employee is no longer in your employ, check reason
 Labor dispute Lack of work Fired Quit
 Explain: _____

17. Has the claimant received U.I. Benefits? Yes No
 If yes, give dates: _____ 19__

Employer's Name _____
 Address _____
 Date _____ Telephone _____
 Signed by _____ Title _____

MONTH	DAY	YEAR	NO DAYS WORKED	AMOUNT
TOTAL				

Indicate weekly value of board, lodging and tips \$ _____

POLICY # _____

CLAIMS INQUIRY ONLY 1-888-202-5164
 American Medical and Life Insurance Co.
 500 Helendale Rd. #260, Rochester, N.Y. 14609