

**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-**"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 - "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. Name (first/middle/last)	2. Social Security Number
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3. Address (no./street/apt./city/state/zip code)

4. Telephone No.	5. Age	6. Married (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No
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7. My disability is (if injury, also state **how, when** and **where** it occurred) \_\_\_\_\_

8. Date Disabled (month/day/year)	a. I worked on that day <input type="checkbox"/> Yes <input type="checkbox"/> No	b. I have since worked for wages or profit <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give dates: _____
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9. 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 (mo/day/yr)	Through (mo/day/yr)	

10. Occupation (describe job)	a. Name of Union and Local No., if Member
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11. For the period of disability covered by this claim

	<b>Yes</b>	<b>No</b>
a. Are you <b>receiving</b> wages, salary or separation pay: .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you <b>receiving</b> or <b>claiming</b> :		
(1) Workers' Compensation for work-connected disability .....	<input type="checkbox"/>	<input type="checkbox"/>
(2) Unemployment Insurance Benefits .....	<input type="checkbox"/>	<input type="checkbox"/>
(3) Damages for personal injury .....	<input type="checkbox"/>	<input type="checkbox"/>
(4) Benefits under the Federal Social Security Act for long term disability .....	<input type="checkbox"/>	<input type="checkbox"/>
c. IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 11a or 11b, COMPLETE THE FOLLOWING:		
If have <input type="checkbox"/> received <input type="checkbox"/> claimed from _____ for the period _____ to _____		
	Date	Date

12. I have received disability benefits for another period or periods of disability within the 52 weeks immediately **before** my present disability began .....

If "Yes", fill in the following: I have been paid by \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Date Date

13. 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 Here** \_\_\_\_\_  
Date Signed 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 NYS Workers' Compensation Board, or write to: Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-Menands, Albany, NY 12241	Si Se le ocurren algunas preguntas respecto a reclamar beneficios por incapacidad, comuníquese 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, NY 12241
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**Health Care Provider must complete part B on reverse**

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.

