

FIDUCIARY NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Fiduciary
23-08 Jackson Avenue
Long Island City, NY 11101
Tel: (718) 706-7114
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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 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 - 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

2. My Social Security Number is:

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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.

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 | <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

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
HERE → Claim signed on
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 WORKERS' 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 CERCA 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.
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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

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 3. Male Female
First Middle Last

4. Diagnosis/Analysis:
 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:

	Mo.	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-4/48 been filed with the Workers' Compensation 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, Chiropractor, Dentist, Nurse-Midwife, Podiatrist 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 - TO BE COMPLETED BY EMPLOYER

1. Employee's Name 2. Date Employed 20... PT FT
 3. Actual last date employee worked prior to disability 20... 4. Date returned to work 20...
 5. Is this disability the result of an occupational disease or an occupational injury?
 5a. If employee is terminated give reason
Mon. Tues. Wed. Thur. Fri. Sat. Sun

Employee's wages for last eight weeks before disability: Employee's normal working days
 Be sure to include in the gross earning all remunerations such as declared tips, lodging, value of meals, etc.

Week No.	(Week Ending)			Number of Days Worked	Gross Wages	Week No.	(Week Ending)			Number of Days Worked	Gross Wages
	Mo.	Day	Yr.				Mo.	Day	Yr.		
1						5					
2						6					
3						7					
4						8					

6. Has claimant received salary during period of disability? YES NO If yes, show amount and period paid
 7. If yes, are you requesting reimbursement?
 8. Is this claimant an employee, owner, co-owner, partner, or proprietor?
 9. Has employee filed for Unemployment Insurance? Workers' Compensation?
 10. Do your employees contribute to Disability Premium YES NO

Employer Signature
(Business Name-Give name as it appears on the policy)
 Address Position
 Phone Policy No.
 Date