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 **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 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 - 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. Name (first/ middle/ last)	2. Social Security Number
3. Address (no./ street/ apt./ city/ state/ zip code)	
4. Telephone No.	5. Age / 6. Married (Check one) ☐ Yes ☐ No

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 ☐ Yes ☐ No	b. I have since worked for wages or profit ☐ Yes ☐ No If Yes, give dates:

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

11. For the period of disability covered by this claim

	Yes	No
a. Are you **receiving** wages, salary or separation pay:	☐	☐
b. Are you **receiving** or **claiming:**		
(1) Workers compensation for work-connected disability	☐	☐
(2) Unemployment Insurance Benefits	☐	☐
(3) Damages for personal injury	☐	☐
(4) Benefits under the Federal Social Security Act for long term disability	☐	☐

c. IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 11a or 11b, COMPLETE THE FOLLOWING:
I have ☐ received ☐ claimed from _____ for the period _____ (Date) to _____ (Date)

12. 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 _____ (Date) To _____ (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, 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, NY 12241

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.

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 (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 _____ (First / Middle / Last) 2. Age _____ 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:

	Month	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 questions 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 date

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

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 Employer 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
4. Date Employed
5. Social Security No.
6. Policy No.
7. ☐ Full time ☐ Part time Check usual days worked: ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun
8. Is claimant an ☐ Employee ☐ Owner ☐ Partner ☐ High school student
9. Date employee last worked
10. Date employee's wages ceased
11. Date employee returned to work
12. Are wages being continued during disability? ☐ Yes ☐ No
13. If yes, is remburement requested? ☐ Yes ☐ No
14. Date you received the completed claim form
15. Did the disability occur as a result of employment? ☐ Yes ☐ No
16. Name and address of your Compensation carrier
17. Do you expect to rehire? ☐ Yes ☐ No
18. Is employee a member of a union which provides N.Y. State disability benefits? ☐ Yes ☐ No
19. If employee is no longer in your employ, check reason;
    ☐ Labor dispute ☐ Lack of work ☐ Fired ☐ Quit Explain:
20. Has the claimant received U.I. Benefits? If Yes, give dates.
    ☐ Yes ☐ No

EARNINGS FOR 8 WEEKS PRIOR TO DISABILITY
(Including the week in which the disability began)

MONTH	DAY	YEAR	NO. DAYS WORKED	AMOUNT
			TOTAL	

Indicate weekly value of board, lodging and tips
$_____

Name of Employer _____ Policy number _____

Address _____

Signature for employer _____ Title _____

Phone No.: _____ Dated _____ 19 ____

DB450 (8/94) Reverse