

**NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS**

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. Use this form 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 can not sign this 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 Complete's and Signs Part B - The "HEALTH CARE PROVIDER'S STATEMENT".
5. Your completed claim should be mailed WITHIN 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 \_\_\_\_\_ Social security number \_\_\_\_\_  
First Middle Last

2. ADDRESS \_\_\_\_\_  
Number Street City or Town State Zip Code Apartment Number

3. TEL. NO. ( ) \_\_\_\_\_ 4. Date of Birth \_\_\_\_\_ 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 \_\_\_\_\_ 7a. I worked that day (Check one)  Yes  No  
Month Day Year

7b. 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 the last eight (8) weeks, name **ALL** employers.

BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	Dates of Employment		Average Weekly Gross Wages <small>(Include Bonuses, Tips, Commissions, Reasonable value of Board, Rent, Etc)</small>
			FROM	THROUGH	
			Mo. Day Year	Mo. Day Year	

9. My job is or was (**Occupation**) \_\_\_\_\_ Name of Union and Local Number, 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. Unemployment Insurance Benefits  Yes  No

3. Damages for personal injury  Yes  No

4. Benefits under the Federal Social Security Act for long-term disability  Yes  No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:  
 I have  received  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 forgoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

**CLAIM SIGNED ON:** \_\_\_\_\_  
Date: Claimant Signature:

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

**Disclosure of Information:** The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

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 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA 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 12241-0005

**NOTICE OF PROOF OF CLAIM FOR DISABILITY BENEFITS -** IMPORTANT: Use this form only when the claimant becomes sick or disable while employed or becomes sick or disabled within four(4) weeks after termination of employment. Otherwise use the 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 7d, give the approximate date. Make some estimate. If the Disability is caused by or arising in connection with pregnancy, enter the estimated delivery date under "Remarks."

1. Claimant's Name: \_\_\_\_\_ 2. Age \_\_\_\_\_ 3. Sex  Male  Female  
First Middle Last

4. Diagnosis / Analysis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

a. Claimant's Symptom's: \_\_\_\_\_

b. Objective Findings: \_\_\_\_\_

c. If Disability is **pregnancy** related, enter **ESTIMATED DELIVERY DATE** . \_\_\_\_\_

5. Claimant Hospitalized?  Yes  No Date from: \_\_\_\_\_ to \_\_\_\_\_

6. Operation indicated?  Yes  No a. Type \_\_\_\_\_ b. Date \_\_\_\_\_

7. Enter **Dates** for the following:

	Month	Day	Year
a. Date of your <b>first treatment</b> for this Disability .....			
b. Date of your <b>most recent treatment</b> for this Disability .....			
c. Date claimant was <b>unable to work</b> because of this Disability .....			
d. Date claimant <b>will be able to perform usual work</b> ** .....			

\*\*Even if considerable question exists, ESTIMATE DATE . Avoid the use of terms such as **unknown or undetermined**.

8. In your opinion is this Disability the result of injury arising out of the course of employment or occupational disease?  Yes  No

a. If yes, has Form C-4 been filed with the Workers' Compensation Board?  Yes  No

Remarks: \_\_\_\_\_

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF INSURER ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

**Health Care Provider's Signature** \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider's Name (Please Print) \_\_\_\_\_ Phone No. \_\_\_\_\_

Office Address: \_\_\_\_\_  
Number Street Apt/Suite City/Town State Zip Code

HIPPA NOTICE - In order to adjudicate a workers' compensation claim, WCL 13-8(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 184.512 these legally required medical reports are exempt from HIPPA'S restrictions on disclosure of health information.

**Part C - EMPLOYER'S STATEMENT**

1. Employee's Name: \_\_\_\_\_ 2. Soc.Sec. No: \_\_\_\_\_

3. Employee's Address: \_\_\_\_\_  
Number Street Apartment Number City / Town State Zip Code

4. Employee's Occupation: \_\_\_\_\_ 5. Date of Hire: \_\_\_\_\_ 6. Status:  Full Time  Part Time

7. Is the Claimant an:  Owner  Officer  Partner  Employee  High School Student

8. Indicate the employee's normal work schedule:  Mon  Tues  Wed  Thur  Fri  Sat  Sun

9. If the employee is no longer in your employ, explain why:  Quit?  Discharged?  Labor Dispute?  Lack of Work?

If Quit or Discharged explain why \_\_\_\_\_ Do you expect to rehire him/her?  Yes  No

10. Date Employee last worked: \_\_\_\_\_

11. Date Employee's Wages Ceased: \_\_\_\_\_

12. Date Employee Returned to Work: \_\_\_\_\_

13. Are **Wages being Continued** during Disability?  Yes  No

14. If **YES**, are you requesting reimbursement?  Yes  No

15. Is Employee receiving or claiming Unemployment Ins?  Yes  No

16. Is Employee receiving or claiming Workers' Comp. Ins?  Yes  No

17. Did this Disability occur as a result of employment?  Yes  No

18. Is Employee in a Union providing Disability Benefits?  Yes  No

19. Are you aware of other employment claimant may have?  Yes  No

20. Did Employee receive **PAID SICK TIME** during disability?  Yes  No

Weekly Wages 8 Weeks prior to Disability		
<small>(include value of Board, Lodging, and Tips if any)</small>		
Week Ending	No. of Days	GROSS WEEKLY WAGES
Month Day Year	Worked	
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
TOTAL		

If YES, provide dates of paid sick time: From: \_\_\_\_\_ To: \_\_\_\_\_

**EMPLOYER INFORMATION:** \_\_\_\_\_ **NYSIF DISABILITY POLICY NUMBER:** \_\_\_\_\_ Date: \_\_\_\_\_

Employer NAME: \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

ADDRESS: \_\_\_\_\_ E-mail: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Print name: \_\_\_\_\_ Title: \_\_\_\_\_