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 **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

Social Security Number

1. My name is _____
First Middle Last

2. Address _____
Number Street City or Town State Zip Code Apt. No.

3. Telephone Number: ( ) _____ 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
Month 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 the last eight (8) weeks, name all employers.

EMPLOYERS			DATES OF EMPLOYMENT		AVERAGE WEEKLYWAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day	THROUGH Mo. Day Yr.	

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 _____
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_____
Date Date

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.

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 ANY 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 SUBSTATIAL FINES AND IMPRISONMENT.

Claim signed on_____
Date Claimant's Signature

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

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 1241-0005

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 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 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. 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:
   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 been filed with the Worker's Compensation Board? ☐ Yes ☐ No
   Remarks (attach additional sheet, if necessary) _____
   (If disability is pregnancy related, please enter the estimated delivery)

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

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 ANY 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 SUBSTATIAL FINES AND IMPRISONMENT.

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (Please Print) _____ Telephone Number ( ) _____

Office Address _____
Number Street City or Town State Zip Code

HIPAA NOTICE – In order to adjudicate a workers' compensation claim, WCL13-a(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 164.512 these legally required medical reports are exempt fro HIPAA's restrictions on disclosure of health information.

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PART C - EMPLOYER'S STATEMENT Must be completed in full, by employer only immediately following claimant's last day worked. For inquiries, call Matrix at (877) 315-9838.

Employer's Name…The Research Foundation of State University of New York Policy Number: #DBL251315…Div #……..
Employee's Date of Birth ……..Effective Date of Coverage……

Is this claimant a N.Y. employee? ☐ Yes ☐ No ☐ Full Time ☐ Part Time …….. Contrib. % paid by Employee - pre or post tax
Date of Employment …… Contrib. % by Employer ……
Normal work week (check boxes to show usual days worked) ……..

S	M	T	W	TH	F	S
☐	☐	☐	☐	☐	☐	☐

Date Employee last worked …….. Number of Hours……..
Date Employee wages ceased……
Date Employee returned to work ……
Has Employment terminated?…… ☐ Yes ☐ No
If so, date of termination……
Was Employee laid off or was layoff contemplated prior to disability? …….
If so, give day of layoff……
Are wages being continued during disability? …… ☐ Yes ☐ No
If so, does your Employer request reimbursement … ☐ Yes ☐ No
Was Employee on the job when disability occurred? ☐ Yes ☐ No
Has claim been filed for Workmen's Compensation? ☐ Yes ☐ No
If yes, WC carrier name and address……..
Is Employee member of a union that provides
payment of weekly cash benefits?…… ☐ Yes ☐ No

Gross Earnings 8 weeks prior to disability					
	Week Ending			No. Days	
	Mo.	Day	Yr.	Worked	Gross Amount
1					
2					
3					
4					
5					
6					
7					
8					

If yes, give name and address of union……

Signed …… Employer……

Date……..Telephone Number……

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Mail To: 1st Reliance Standard Life Insurance Company
c/o Matrix Absence Management Inc.
Seven Skyline Drive - Suite 275
Hawthorne, NY 10532
Fax: 914-784-0024