

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

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SOCIAL SECURITY NUMBER

1. My name is _____
First Middle Last
2. My address is _____
Number Street City or Town State Zip Code Apt. No.
3. 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 _____
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 _____
8. Give name of last employer. If more than one employer during the 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.	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 _____ Date to _____ 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 _____ Date To _____ 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 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 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

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

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

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 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. male female
 4. Diagnosis/Analysis _____ Diagnosis Code _____
 a. Claimant's Symptoms _____

b. Objective Findings _____

5. Claimant hospitalized? Yes No From _____ To _____ CPT Code _____
 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..... <small>(Even if considerable question exists, estimate date. Avoid use of terms, such as unknown or undetermined.)</small>			

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 Workers' Compensation Board? Yes No

Remarks: **(attach additional sheet, if necessary)** _____
(If disability is pregnancy related, please enter estimated delivery date.)

I affirm that <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Licensed in the State of _____	License Number _____
I am a <input type="checkbox"/> Dentist <input type="checkbox"/> Podiatrist <input type="checkbox"/> Nurse-Midwife		

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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

Employer's Statement

Employee's Full Name (as shown on Social Security card): _____ Policy Number: _____
 S.S. Number: _____

Employee's Address: _____ Date of Birth: _____

Employee's Occupation: _____ Date employed: _____ Full Time Part Time
 Check days normally worked:

Is employee a Union member? Yes No

If "Yes," is employee eligible for Union benefits? Yes No

If Part Time, give particulars: _____

Date employee last worked: _____

Date employee returned to work: _____

Were wages continued during disability? Yes No

Were wages **Sick** pay? Yes No From: _____ To: _____

Were wages **Vacation** pay? Yes No From: _____ To: _____

Is reimbursement requested? Yes No

Is disability due to job? Yes No

If "Yes," has a compensation claim been filed? Yes No

Indicate Weekly Value of Board, Lodging and Tips: _____

Employer's Name: _____

Employer's Identification No.: _____

Is employee enrolled in a Hartford Long Term Disability Plan?

Yes No If "Yes," effective date: _____

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the Weekly Disability _____ %

LTD _____ % benefit is considered taxable? (See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.) If blank, we will assume the benefit is 100% taxable.

Is this employee currently covered by Social Security? Yes No If "No," state grounds for exemption: _____

Address: _____ Telephone No.: _____

Signed by: _____ Title: _____ Date: _____

DB-450 (3-97) Reverse **THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION**
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