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 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. 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 ..... (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.)
			FROM	THROUGH	
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	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 SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on ..... (Date) ..... (Claimant's 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.ny.gov. 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 RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

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 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. Date of Birth ..... 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 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 Workers' Compensation Board? ☐ Yes ☐ No
   Remarks (attach additional sheet, if necessary) .....
   (If disability is pregnancy related, please enter estimated delivery

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

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 from HIPAA's restrictions on disclosure of health information.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

PART C – EMPLOYER'S STATEMENT If employee contribution is withheld, indicate taxable% (**employer** portion) for **FICA** deductions=_____%

1. Employee's Name _____ SS# _____
2. Address _____ Occupation _____
3. Date Employed_____ ☐ F/T ☐ P/T **Check usual days worked:** ☐ MON ☐ TUES. ☐ WED. ☐ THURS. ☐ FRI. ☐ SAT. ☐ SUN.
4. Is Claimant ☐ employee ☐ member ☐ owner ☐ partner ☐ independent contractor ☐ high school student ☐ employer's spouse
5. Date employee last worked..... _____
6. Date employee returned to work..... _____
7. Date employee's wages ceased, or will cease..... _____
8. Are wages being continued during disability?. ..... ☐ Yes ☐ No
9. If yes, is reimbursement requested? ..... ☐ Yes ☐ No
10. On what date did you receive the completed claim form? _____
11. Did the disability occur as a result of employment? ..... ☐ Yes ☐ No
12. Name and address of your Compensation carriers

_____

13. Is employee a member of a union that provides NY Disability? ..... ☐ Yes ☐ No
14. Do you expect to rehire?..... ☐ Yes ☐ No

IMPORTANT: To determine weekly benefit payable, indicate earnings 8 weeks prior to disability; include weekly value of board, lodging, tips and allowances

MONTH	DAY	YEAR	# DAYS	GROSS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
			TOTAL	$

15. If employee is no loner in your employ, check reason:
☐ Labor dispute ☐ Lack of work ☐ Fired ☐ Quit

Employer's federal tax ID # _____

16. Has the claimant received UI benefits? ☐ Yes – dates _____ ☐ No

Employer_____ **Policy # WDL –**_____

Address _____

Signed by _____ **Title**_____ **Date** _____ **Telephone** _____

SEND COMPLETED FORM TO ► **Wesco Insurance Company An Am Trust Financial Company,** PO Box 980 at Bowling Green Station, New York, NY 10274; **OR** FAX (800) 584-9303 For inquiries call 1 800 535-2710

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS - DISABILITY BENEFITS LAW

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of Disability Benefits to his/her employees.

2. Statutory Disability Benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.

3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or any office of the Workers' Compensation Board. (See addresses and telephone numbers below.) Do not assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**

4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will not be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.

5. Disability Benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.

6. If your employer or the insurance carrier contends that you are not entitled to the payment of Disability Benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a **legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact any office of the Workers' Compensation Board.

7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT:** In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.

8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 228 of the Disability Benefits Law. Your employer's disability benefits insurance carrier is:

NATIONAL BENEFIT LIFE INSURANCE COMPANY
ONE COURT SQUARE
LONG ISLAND CITY, NY 11120
(800) 535-2710

Robert E. Beloten

ROBERT E. BELOTEN
CHAIR

100 Broadway Menands	State Office Building 44 Hawley Street	111 Livingston St. 22nd Floor	295 Main Street Suite 400	220 Rabro Drive Suite 100	175 Fulton Avenue	215 W. 125th Street 3rd Floor	41 North Division St.	168-46 91st Ave. 3rd Floor	130 Main Street W.	935 James St.
ALBANY 12241	BINGHAMTON 13901	BROOKLYN 11201	BUFFALO 14203	HAUPPAUGE 11788	HEMPSTEAD 11550	NEW YORK 10027	PEEKSKILL 10566	QUEENS 11432	ROCHESTER 14614	SYRACUSE 13203
(866) 750-5157	(866)802-3604	(800) 877-1373	(866) 211-0545	(866) 881-5354	(866) 805-3630	(800) 877-1373	(866) 746-0552	(800) 877-1373	(866) 211-0644	(866) 802-3730

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTA ESCRITO EN ESPANOL AL DORSO.

www.wcb.ny.gov

DB-271S (1-11)