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 form, your repr esentative may sign it on 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

Social security number

1. NAME _____ (First / Middle / Last) | ___ | ___ | ____

2. ADDRESS _____ (Number / Street / City or Town / State / Zip Code / Apartment Number)

3. TEL# (_____) _____ **3a.** EMAIL ADDRESS _____ **4.** Age _____ **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) **7a.** I worked that day (Check one) ☐ Yes ☐ No

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.**

EMPLOYERS

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

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 representtive.

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 DUDASRELACIONADAS CON LA RECLA ACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUSE CON LA OFINCINA 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

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

Standard Security Life Insurance Company of New York P. O. Box 25339 Farmington, New York 14425

NOTICE OF 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 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.

1. Claimant's Name: _____ (First Middle Last) **2.** Date of Birth _____ **3.** Sex ☐ Male ☐ Female

4. Diagnosis / Analysis: _____ Diagnosis Code: _____

a. Claimant's Symptoms: _____

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 **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 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 I am a:				Licensed in the State of:	**License Number:**
	☐ Chiropractor	☐ Physician	☐ Psychologist		
	☐ 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 monetary 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	

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

21. Has employee made a claim for Disability Benefits in the past 52 weeks? ☐ Yes ☐ No

22. TAXABLE PERCENTAGE_____%

Weekly Wages 8 Weeks prior to Disability
(include value of Board, Lodging, and Tips if any)

	Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		TOTAL	

SSLICNY Phone:
800-477-0087 or 585-398-2340

EMPLOYER INFORMATION: **DISABILITY POLICY NUMBER:** _____ Date: _____

Employer NAME: _____ Phone No. _____ Fax No. _____

ADDRESS: _____ E-mail: _____

SIGNATURE: _____ Print name: _____ Title: _____

After Parts A, B, & C are **COMPLETED**, Do one of the following:

Mail to: SSLICNY DBL Claims, P.O. Box 25339 Farmington, NY 14425 or
Fax to: 585-398-2854 or E-mail to: dblclaims@sslicny.com