# NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

DB450 (2-91)

## CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM ONLY 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 IN YOUR BEHALF. IN THAT EVENT, THE REPRESENTATIVE'S RELATIONSHIP TO YOU AND HIS ADDRESS SHOULD BE NOTED UNDER HIS 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 HIS 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

2. My Social Security Number Is: ☐☐☐ ☐☐ ☐☐☐☐

1. My name is ______________________
First Middle Last

3. Address ______________________
Number Street City or Town State Zip Code Apt. No

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 __________ a. I worked on that day ☐ YES ☐ NO
Mo 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 last eight (8) weeks, name all employers

| Employer's | | | Date of Employment | | Average Weekly Wages (include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc. |
|---|---|---|---|---|---|
| Business Name | Business Address | Telephone No. | From<br>Mo. Day Yr. | Through<br>Mo. Day Yr. | |
| | | | | | |
| | | | | | |
| | | | | | |

9. My job is or was __________ __________
Occupation Name of Union and Local No., 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) Worker's Compensation for work-connected disability __________ ☐ YES ☐ NO
(2) Damages for personal injury __________ ☐ YES ☐ NO
(3) Unemployment Insurance Benefits __________ ☐ YES ☐ NO
(4) Disability Benefits under the Federal Social Security Act __________ ☐ YES ☐ NO
If "Yes" is checked in any of the items a, b(1), b(2), b(3) or b(4), fill in the following:
I have ☐ Received or ☐ 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 __________

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.

SIGN → HERE Claim signed on __________ __________
Date Claimant's Signature

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

__________ __________
Name and Address Relationship

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NEW YORK STATE WORKER'S COMPENSATION BOARD, OR WRITE TO: WORKERS COMPENSATION BOARD DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, N.Y. 12241

SI SE LE OCURREN ALGUNAS PREGUNTAS RESPECTO A RECLAMAR BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON SU 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, N.Y. 12241

**HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE SIDE**

★ ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

# NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

DB450 (2-91) REVERSE

**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 7-d, 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 ______ (First / Middle / Last) 2. Age ______ 3. ☐ Male ☐ Female
4. Diagnosis/Analysis: ______
   a. Claimant's Symptoms: ______
   b. Objective Findings: ______
5. Claimant Hospitalized? From ______ To ______
6. Operation Indicated? a. Type ______ b. Date ______
7. Enter Dates for the Following:

| | Mo. | 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 questions 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-4/48 been filed with the Board? ☐ YES ☐ NO

   Remarks (Attach additional sheet, if necessary): ______

9. I affirm that I am a ______ (Physician, Podiatrist, Chiropractor, Dentist or Nurse-Midwife or Psychologist) Licensed or Certified in the State of ______ License No. ______

   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)

## PART C — EMPLOYER'S STATEMENT

**IMPORTANT** – TAXABLE PERCENTAGE ______%
**(If blank or not a %, we will tax at 100%)**

1. Employee's Name ______
2. Employee's address ______
3. Employee's Occupation ______ Date Employed ______ 19 ____ S.S. Number ______
4. Full time ☐ Part time ☐ Check usual days worked

| MON | TUE | WED | THUR | FRI | SAT | SUN |
|---|---|---|---|---|---|---|

5. Is claimant an employee ☐ owner ☐ partner ☐ high school student ☐
6. Date employee last worked ______ 19 ____
7. Date employee's wages ceased ______ 19 ____
8. Date employee returned to work ______ 19 ____
9. Are wages being continued during disability? ______
10. If yes, is reimbursement requested? ______
11. On what date did you receive the completed claim form? ______ 19 ____
12. Did the disability occur as a result of employment ☐ Yes ☐ No
13. Name and address of your Compensation carrier ______
14. Do you expect to rehire? ______
15. Is employee a member of a union which provides N.Y. State disability benefits? ______
16. If employee is no longer in your employ, check reason
    Labor dispute ☐ Lack of work ☐ Fired ☐ Quit ☐
    Explain: ______
17. Has the claimant received U.I. Benefits? ☐ Yes ☐ No
    If yes, give dates: ______ 19 ____

**Employer's Name** ______
**Address** ______
**Date** ______ **Telephone** ______
**Signed by** ______ **Title** ______

GROSS EARNINGS FOR 8 WEEKS PRIOR TO DISABILITY (Including the week in which the disability began)

| MONTH | DAY | YEAR | NO DAYS WORKED | AMOUNT |
|---|---|---|---|---|
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| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | TOTAL | |

Indicate weekly value of board, lodging and tips $ ______

POLICY # ______

**STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK**
**P.O. Box 25339**
**Farmington, N.Y. 14425-0339**