



NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

State Disability Claims
P.O. Box 14332
Lexington KY 40512
Telephone#1-800-268-2525
Fax# 610-807-2953

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 can not sign this form, your representative 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 Completes 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

1. Name: (First, Middle, Last) Policy #: Social Security #:

2. Address: Apt. # City State Zip Code

3. Telephone #: 4. Date of Birth: 5. Married (Check one): Yes No
5a. Male Female

6. My disability is (if injury, also state how, when and where it occurred)

7. I became disabled on Mo. Day Year 7a. I worked on that day 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 last eight (8) weeks, name ALL employers.

Table with columns: EMPLOYERS (Business Name, Business Address, Telephone No.), Dates of Employment (From, Through), Average Weekly Wages (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, Etc.)

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) 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 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 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.

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 does 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 form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NEW YORK STATE WORKERS COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, N.Y. 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, N.Y. 12241-0005.

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. If the Disability was caused by or arose in connection with pregnancy, enter the estimated delivery date under "Remarks."

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

4. Diagnosis/Analysis: _____ ICD _____
 a. Claimant's Symptoms: _____
 b. Objective Findings/Treatment Plan: _____
 c. If Disability is pregnancy related, enter DELIVERY DATE _____ Estimated Actual Vaginal C-Section

5. Claimant Hospitalized? YES NO Date: From _____ To _____

6. Operation Indicated? YES NO a. Type _____ b. Date _____ c. CPT _____

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 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 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 Chiropractor Dentist Physician Podiatrist Psychologist Nurse-Midwife
 Licensed in the State of: _____ Licensed #: _____

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 #: _____

Office Address (Number, street, Apt./Suite, City/Town, State, Zip Code) _____

HIPAA NOTICE - In order to adjudicate a worker's compensation claim, WCL 13-8 (4) (a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports or treatment with the Board and the carrier or employer. Pursuant to 45 CFR 184.512 these legally required medical reports are exempt from HIPAA'S restrictions on disclosure of health information.

Part C – EMPLOYER'S STATEMENT

1. Employee's Name _____ 2. Social Security #: _____

3. Employee's Address _____ Apt. #. _____ City _____ State _____ Zip _____

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 Tue Wed Thur Fri Sat Sun

9. If the employee is no longer employed, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 14. If YES, are you requesting reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No 15. Is Employee receiving or claiming Unemployment Ins.? <input type="checkbox"/> Yes <input type="checkbox"/> No 16. Is Employee receiving or claiming Workers' Comp. Ins.? <input type="checkbox"/> Yes <input type="checkbox"/> No 17. Did this Disability occur as a result of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No 18. Is employee in a Union providing Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No 19. Are you aware of other employment claimant may have? <input type="checkbox"/> Yes <input type="checkbox"/> No 20. Did employee receive PAID SICK TIME during disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, provide dates of paid sick time: From: _____ To: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center;">Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)</th> </tr> <tr> <th style="text-align: center;">Week Ending Month Day Year</th> <th style="text-align: center;">No. of Days Worked</th> <th style="text-align: center;">GROSS WEEKLY WAGES</th> </tr> </thead> <tbody> <tr><td>1.</td><td></td><td></td></tr> <tr><td>2.</td><td></td><td></td></tr> <tr><td>3.</td><td></td><td></td></tr> <tr><td>4.</td><td></td><td></td></tr> <tr><td>5.</td><td></td><td></td></tr> <tr><td>6.</td><td></td><td></td></tr> <tr><td>7.</td><td></td><td></td></tr> <tr><td>8.</td><td></td><td></td></tr> <tr> <td colspan="2" style="text-align: right;">TOTAL</td> <td></td> </tr> </tbody> </table>	Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)			Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES	1.			2.			3.			4.			5.			6.			7.			8.			TOTAL		
Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)																																		
Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES																																
1.																																		
2.																																		
3.																																		
4.																																		
5.																																		
6.																																		
7.																																		
8.																																		
TOTAL																																		

EMPLOYER INFORMATION Policy #: _____ Tax ID #: _____ Date: _____

Employer Name: _____ Division #: _____ Phone #: _____ Fax #: _____

Address: _____ E-mail: _____

Signature: _____ Print Name: _____ Title: _____

After Parts A, B, & C are completed, Mail to: Guardian – State Disability Claims – P.O. Box 981578, El Paso, TX 79998-1578 or Fax: 610-807-2953
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.