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.)
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 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.state.ny.us. 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 COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

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.

EMPLOYER'S STATEMENT

Employer's Name ..... Policy # ..... Div. # .....
Employee's Date of Birth ..... Effective Date of Coverage .....
Is this claimant a N.Y. employee?....☐ Yes...☐ No...☐ Full Time...☐ Part Time ..... % paid by Employee
Date of Employment ..... % paid by Employer
Normal work week (check boxes to show usual days worked) .....

S	M	T	W	T	F	S
☐	☐	☐	☐	☐	☐	☐

Date Employee last worked.....Number of Hours .....
Date Employee wages ceased .....
Date Employee returned to work .....
Has Employment terminated? ..... ☐ Yes...☐ No .....
If so, date of termination .....
Was Employee laid off or was layoff contemplated prior to disability? ..... ☐ Yes...☐ No .....
If so, give day of layoff .....
Were wages continued during disability? ..... ☐ Yes...☐ No .....
If yes, does the Employer request reimbursement? ..... ☐ Yes...☐ No .....

Employer Reimbursement Request: If **Yes,** the Employer agrees to indemnify UnumProvident Corporation and hold the Company, its directors, officers, employees and agents harmless against any claim, loss, liability, suit or judgment (including attorneys' fees and cost of defenses or investigation related thereto) that arises as a result of the Employer's obligation to pay benefits under the Policy on behalf of the Company. In addition, the Employer shall indemnify UnumProvident Corporation against any claim by an insured for benefits that have been paid by the Employer and reimbursed by the Company.

Was Employee on the job when disability occurred? ..... ☐ Yes...☐ No .....
Has claim been filed for Workmen's Compensation? ..... ☐ Yes...☐ No .....
Is Employee member of a union that provides payment of weekly cash benefits? ..... ☐ Yes...☐ No .....
If yes, give name and address of union .....

Earnings 8 weeks prior to disability

	Week Ending Mo.	Day	Yr.	No. Days Worked	Amount
1					
2					
3					
4					
5					
6					
7					
8					

UNUMPROVIDENT

Signed ..... Employer ..... Date .....
Telephone Number .....

THE WORKER'S COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

DB-450 (2-04)

Mail To: First Unum Life Insurance Company, The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158
Pacific Time Zone Toll-free: 1.877.851.7637 Fax: 1.877.851.7624
All Other Time Zones Toll-free: 1.800.858.6843 Fax: 1.800.447.2498