

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

1. My name is Social Security Number
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 a. I worked on that day Yes No
Month 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 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 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 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 Worker's 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 RECLAMACION 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

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 229 of the Disability Benefits Law. Your employer's disability benefits insurance is:

The First Rehabilitation Life Insurance Company of America
600 Northern Blvd.
Great Neck, NY, 11021-5202



Robert R. Snashall
Chairman

100 Broadway Menands ALBANY 12241 (518) 474-6674	State Office Building 44 Hawley Street BINGHAMTON 13901 (607) 721-8356	180 Livingston Street BROOKLYN 11248 (718) 802-6600	Statler Towers 107 Delaware Ave. BUFFALO 14202 (716) 842-2166	220 Rabro Drive Suite 100 HAUPPAUGE 11788 (631) 952-6000	175 Fulton Avenue HEMPSTEAD 11550 (516) 560-7700	41 North Division St. PEEKSKILL 10566 (914) 788-5775	130 Main Street W. ROCHESTER 14614 (716) 238-8300	935 James St. SYRACUSE 13203 (315) 423-2934
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DECLARACION DE DERECHOS LEY DE BENEFICIOS POR INCAPACIDAD


SI USTED NO PUEDE TRABAJAR A CAUSA DE ENFERMEDAD O LESION NO RELACIONADA CON EL TRABAJO PUEDE TENER DERECHO A BENEFICIOS POR INCAPACIDAD

1. Su patrono está obligado por ley a proveer pagos de Beneficios por Incapacidad a sus empleados.
2. Beneficios por Incapacidad establecidos por ley son pagados cualquier lesión o enfermedad no relacionada con el trabajo (incluyendo incapacidad debida a embarazo) comenzando a partir del octavo día consecutivo de incapacidad. Los beneficios son pagados por 26 semanas. Los pagos de beneficios por incapacidad se basan en el promedio de su sueldo semanal durante las ocho semanas inmediatamente anteriores a su incapacidad y estan limitados al maximo permitido por ley el día inicial de su incapacidad. Su patrono ó unión podran proveer en un plan o en un convenio beneficios diferentes que sean al menos tan favorables como los establecidos por ley
3. **PARA RECLAMAR BENEFICIOS usted** deberá radicar una notificación y prueba de incapacidad (Formulario DB450) con su patrono ó con la compañía de seguros nombrada abajo dentro del plazo de 30 días desde el primer día de incapacidad o toda o parte de su reclamación podra ser rechazada. Bajo ninguna circunstancia usted debe esperar mas de 26 semanas desde esa fecha para radicar su reclamación. El formulario DB-450 lo puede conseguir a traves de su patrono, la compañía de seguros, el proveedor de servicios médicos o cualquier oficina de la Junta de Compensación Obrera.(Direcciones y telefonos mas abajo). **No** asuma que su patrono ha radicado la reclamación por usted. **La radicación de la reclamación es su responsabilidad.**
4. Usted tiene el derecho de ser atendido por cualquier médico, quiropractico, dentista, enfermera-partera, podiatra, o psicologo que usted seleccione. Contrario a como ocurre en compensación obrera sus cuentas médicas no seran pagadas por su patrono o su compañía de seguros a menos que el patrono y o la unión lo hayan dispuesto mediante un plan de beneficios o convenio.
5. Los beneficios por incapacidad le seran pagados a usted **directamente** por la compañía de seguros, **no a traves de su patrono**, salvo en los casos en que su patrono sea aprobado como auto asegurado.
6. Si su patrono ó la compañía de seguros reclama que usted no tiene derecho al pago de Beneficios por Incapacidad ellos tienen la obligación de enviarle un Aviso de Rechazo, dentro de los 45 días siguientes a la radicación de su reclamación, explicandole las razones para no pagar los beneficios. Si usted no está de acuerdo con el rechazo, **tiene el derecho** de solicitar una revisión del mismo por la Junta de Compensación Obrera. **IMPORTANTE:** Si dentro del término de 45 días de haber radicado su reclamación no recibe los beneficios ni tampoco recibe un Aviso de Rechazo (Formulario DB-451), comuníquese inmediatamente con cualquier oficina de la Junta de Compensación Obrera.
7. **Si su incapacidad es el resultado de un accidente automovilistico** y usted ha radicado una reclamación para beneficios por 'no-fault' tambien deberá radicar una reclamación (Formulario DB-450) para beneficios por incapacidad. **Si no radica reclamación para beneficios por incapacidad, la compañía de seguro podría reducir los pagos 'no fault' que le correspondan. IMPORTANTE:** en estos casos, si no tiene derecho a beneficios por incapacidad, avise inmediatamente a la compañía de seguros.
8. Su patrono no puede pedirle que renuncie a su derecho de recibir beneficios por incapacidad ni tampoco puede descontar mas de 60 centavos semanales (a menos que la contribución adicional sea parte de un acuerdo) de su paga para contribuir al pago de las primas de seguro para los beneficios por incapacidad. **Usted no puede ser despedido ni discriminado por radicar una reclamación de beneficios incapacidad.**

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLMACION O NECESITA AYUDE PARA LLENARLO, O TIENE CUALQUIER OTRO PROBLEMA ACERCA DE UNA LESION O ENFERMEDAD NO RELACIONADA CON EL TRABAJO COMUNIQUESE CON CUALQUIER OFICINA DE LA JUNTA DE COMPENSACION OBRERA.

Este es un breve resumen de sus derechos como lo requiere la seccion 229 de la ley de Beneficios por Incapacidad. La compania de seguro de su patrono para beneficius por incapacidad es:

The First Rehabilitation Life Insurance Company of America
600 Northern Blvd.
Great Neck, NY, 11021-5202



Robert R. Snashall
Presidente

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