## NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Read instructions on page 2 ca providers must complete Part I	refully to avoid a delay in processing. You	u must answer all question	ns in Part A and que	estions 1 through 3 in	Part B. Health care
•	INFORMATION (Please Print or Ty	/pe)			
1. Last Name:	MI:				
2. Mailing Address (Stree	et & Apt #):				
City:	et & Apt #): State: Zip:	Country:			
3. Daytime Phone #:	Email Address:				
	5. Date				Female
	y (if injury, also state <u>how, when</u> and				
8. Date you became disa	bled: / /	Did you work on that	day?:	′es □ No	
	om this disability?				1 1
Have you since worker	d for wages or profit? ☐ Yes ☐ No	o If Yes list date	s.		_''
9. Name of last employer	prior to disability. If more than or	ne employer in previou			oyers. Average
Weekly Wage is based o	n all wages earned in last eight (8	B) weeks worked.			Average Weekly Wege
LAS	LAST EMPLOYER PRIOR TO DISABILITY			EMPLOYMENT	Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	Value of Board, Rent, etc.)
			Mo. Day Yr.	Mo. Day Yr.	
OTHER	EMPLOYER (during last eight (8) we	oka)			Average Weekly Wage
			PERIOD OF EMPLOYMENT		(Include Bonuses, Tips, Commissions, Reasonable
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	Value of Board, Rent, etc.)
			Mo. Day Yr.	Mo. Day Yr.	
40 My ich ic cruscy	Occupation	44 Union Month			
reasons fully:	r if you claimed but did <b>not</b> receiv	. ,			
if you did receive une	mployment benefits, provide all p	eriods collected:			
13. For the period of disa	bility covered by this claim:				
A. Are you receiving	wages, salary or separation pay:	$\square$ Yes $\square$ No			
B. Are you receiving	•				
· · · · · · · · · · · · · · · · · · ·	ensation for work-connected disa	ıbılıty: ∐Yes ∐ No			
	ave: ☐ Yes ☐ No vehicle accident?: ☐ Ye	es ⊡No <b>or</b> personal i	nium involvina t	hird party?	☐ Yes ☐ No
	bility benefits under the Federal S				□ res □ No
	ED IN ANY OF THE ITEMS IN 1				
	aimed from:			to:	1 1
	) before your disability began, hav				
				to:/	
15. In the year (52 weeks	) before your disability began, have	ve you received Paid F	amily Leave? [	□Yes □No	
16. If you became disable	ed while employed or within four w	rom:/ weeks of vour last day	' / worked. did vo	ur emplover provid	de vou with vour rights
under Disability Law v	vithin 5 days of your notice or req	uest for disability form	ns? Yes N	No	ao you man your ngmo
I hereby claim Disability Benefits statements, including any according any according to the control of the cont	s and certify that for the period covered by the panying statements are, to the best of my	this claim I was disabled. I h knowledge, true and comple	ave read the instruct tte.	ions on page 2 of this f	orm and that the foregoing
An individual may sign on behalf	aimant's Signature of the claimant only if he or she is legally a ation below and complete and submit Form	Date authorized to do so and the o OC-110A, Claimant's Autho	claimant is a minor, n	nentally incompetent or	nt's email address incapacitated. If signed by Records.
On behalf of Claimant		Address			Relationship to Claimant

## PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.

1. Last Name:	First Name:			MI:				
2.Gender: Male Female 3. Date of Birth:	1 1							
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 again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)								
e.If pregnancy related, please check box and enter the date  estimated delivery date OR actual delivery date								
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 Board? Yes No								
I certify that I am a:								
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife)  Licensed or Certified in the State of  License Number								
Health Care Provider's Printed Name	Health Ca	re Provider's Signature		Date				
Health Care Provider's	Phor	Phone #						

## IMPORTANT NOTICE TO CLAIMANT- READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

- 1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days to your employer or your last employer's insurance carrier**. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.
- 2. If you are using this form because you became disabled after having been unemployed for more than four (4) weeks, your completed claim should be mailed to: Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029. If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-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 insurance 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.

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". This form is available on the WCB website (www.wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

## PART C- EMPLOYER'S STATEMENT Instructions: Complete this form in its entirety for your employee claiming disability benefits. Any missing or incomplete information could result in delays processing their claim. 1. Employee's full name: 2. Employee's Social Security Number:\_\_\_ \_\_ - \_\_\_ - \_\_\_ \_\_\_ \_\_\_ Age: Their occupation: 4. Their role: □ Employee □ Proprietor □ Partner □ Spouse of Employer □ Owner □ Co-owner Date they last worked: \_\_\_\_/\_\_\_\_ 5.1Date they returned to work: \_\_\_\_/\_\_ / Date employee's wages ceased: \_\_\_\_/\_\_\_/ 7. Were wages continued during disability? ☐ Yes ☐ No Date/Type: \_\_\_ Note: If wages continued were a result of the employee using accrued sick time, vacation time, or paid time off, please indicate the type and date used, and attach to this sheet. 8. If wages were continued, is reimbursement requested to the employer? □ Yes □ No Note: Employers may only be reimbursed if the employee used sick time, or if you continued their salary during leave. 9. Is the disability due to their job (work-related)? □ Yes □ No 10. Is the employee a member of a union that provides NYS disability benefits? □ Yes □ No if yes, please provide Union name and address: 11. Provide a breakdown of this employee's 8 weeks wages immediately **PRIOR** to their disability, starting with the week the disability began. 12. Employee's date of hire: / / Amount (gross wages) # of Days wages includes tips, value of Date 13. Status: □ Full-time □ Part-time Worked board/lodging, and 14. Is employee a full-time High School Student? commissions □ Yes □ No 15. Days usually worked: □ Mon □ Tue □ Wed □ Thu □ Fri □ Sat □ Sun 16. Does employee contribute to their disability premium? □ Yes: □ No if yes, please specify dollar amount or specific percentage. If you leave this question blank we will assume they do not contribute. 17. Does employee work for anyone else besides your company? Total: □ Yes □ No 18. Has employee made a claim for disability benefits or paid family leave within the past 52 weeks prior to the date this disability began? Yes No If yes, please provide details below: Disability Benefits: from \_\_\_\_/\_\_\_ to \_\_\_\_/\_\_\_\_ Paid Family Leave: from \_\_\_\_/\_\_\_ to \_\_\_\_/\_\_\_\_ 19. If this employee received unemployment benefits, date the benefit was last received? \_\_\_\_/\_\_\_/ 20. If this employee is no longer in your employment, select reason: □ labor dispute □ lack of work □ discharged □ resigned Please provide detail: Business name (including any DBA/trade name):

Business address:

Return completed claim form (including Parts A and B) to ShelterPoint Life one of 3 ways:

Fax: 516-504-6414 Email: claimforms@shelterpoint.com Mail: ShelterPoint, 1225 Franklin Ave-Ste. 475, Garden City, NY 11530