NYSIF
New York State Insurance Fund

NEW YORK STATE
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Read instructions on page 2 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 4 in Part B. Health care providers must complete Part B on page 2. Your employer should complete part C. However, do not delay submitting the form to NYSIF if you have difficulty getting part C completed.

PART A – CLAIMANT'S INFORMATION (Please Print or Type)

1. First Name:_____ MI:_____ Last Name:_____
2. Mailing Address:_____
   Number Street Apartment # City or Town State Zip Code
3. Daytime Phone #: _____ E-mail Address: _____
4. Social Security #: _____ 5. Date of Birth: _____ 6. Gender: ☐Male ☐Female
7. Describe your disability (if injury, also state how, when and where it occurred): _____
   _____
8. Date you became disabled: _____ Did you work on that day? ☐Yes ☐No
   Have you recovered from this disability? ☐Yes ☐No If Yes, date you were able to return to work: _____
   Have you since worked for wages or profit? ☐Yes ☐No If Yes, list dates: _____
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER during last eight (8) weeks			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

10. My job is or was: _____ (Occupation) 11. Union Member: ☐Yes ☐No If Yes, _____ (Name of Union or Local Number)
12. Were you claiming or receiving Unemployment prior to this disability? ..... ☐Yes ☐No
    If you did not claim or if you claimed but did not receive unemployment insurance benefits after LAST DAY WORKED, explain reasons fully: _____
    If you did receive unemployment benefits, provide all periods collected: _____
13. 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. Paid Family Leave ..... ☐Yes ☐No
       3. No-Fault motor vehicle accident..... ☐Yes ☐No
          or personal injury involving a third party?..... ☐Yes ☐No
       4. Long-term disability benefits under the Federal Social Security Act for *this* disability? ..... ☐Yes ☐No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:
    I have: ☐received ☐claimed from: _____ for the period _____ to _____
14. In the 52 weeks before your disability began, have you received disability benefits for other periods of disability? ... ☐Yes ☐No
15. In the 52 weeks before your disability began, have you received Paid Family Leave? ..... ☐Yes ☐No
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ..... ☐Yes ☐No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

X Sign here: _____ _____
Claimant's signature Date

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of claimant Address Relationship to Claimant

PART B – HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type) NYSIF

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. First Name: _____ MI: ____ Last Name: _____
2. Gender: ☐ Male ☐ Female 3. Date of Birth: _____ 4. Phone #: _____
5. Diagnosis/Analysis: _____ Diagnosis Code: _____
   a. Claimant's symptoms: _____
   _____
   b. Objective findings: _____
   _____
6. Claimant hospitalized? ☐ Yes ☐ No From: _____ To: _____
7. Operation indicated? ☐ Yes ☐ No a. Type: _____ b. Date: _____

8. 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 the 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			

9. 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 Care Provider's Signature Date

_____ _____ _____
Health Care Provider's Address Phone Number Fax Number

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 (Please Print or Type) NYSIF

1. Employee's First Name: _____ Last Name: _____ 2. SSN: _____

3. Mailing Address: _____
Number Street Apartment # City or Town State Zip Code

4. Employee's Occupation: _____ 5. Date of Hire: _____ 6. Status: ☐ Full-Time ☐ Part-Time

7. Is the employee a(n) ☐ Owner ☐ Officer ☐ Partner ☐ High School Student ☑ None of these

8. Date employee last worked: _____ Date wages ceased: _____ Date employee handed in this form: _____

9. If the employee is no longer in your employ, explain why: _____

10. Date employee returned to work (if applicable): _____

11. List the employee's **gross wages for the 8 weeks before disability**, including the week their disability leave began. (Include the value of board, lodging or tips, if any.) For biweekly or semimonthly pay, list only the last 4 pay periods.

Week Ending Month/Day/Year	Number of Days Worked	Gross Weekly Wages
Total:		$ 0.00

12. Did employee receive PAID SICK TIME during disability? ..... ☐ Yes ☐ No

If Yes, are you requesting reimbursement for paid sick time? ..... ☐ Yes ☐ No

Dates employee received paid sick time: ..... From: _____ to _____

13. Did the employee receive other types of continued pay? ..... ☐ Yes ☐ No

Dates employee received continued pay: ..... From: _____ to _____

Type of continued pay received: _____

14. Is the employee receiving/claiming Unemployment Insurance? ..... ☐ Yes ☐ No

15. Is the employee receiving/claiming Workers' Compensation? ..... ☐ Yes ☐ No

16. Is the employee receiving/claiming Paid Family Leave? ..... ☐ Yes ☐ No

If Yes, what dates is the employee receiving/claiming PFL?.. _____

17. Is the employee in a union providing disability benefits? ..... ☐ Yes ☐ No

18. Do you know of other employment the employee may have? ..... ☐ Yes ☐ No

---

EMPLOYER NAME:_____ **NYSIF DB POLICY #**: _____ **FEIN**: _____

Phone: _____ Ext: _____ Fax: _____ E-mail: _____

Address: _____

Person completing form (Print)_____ Title: _____

Signature: _____ Date: _____

Submit completed form to:
NYSIF • Attn: Disability Benefits • PO Box 66698 • Albany, NY 12206
Or E-mail DBClaims@nysif.com **Or** Fax to 518-437-5201

NEW YORK STATE | Workers' Compensation Board

STATEMENT OF RIGHTS
NEW YORK STATE DISABILITY BENEFITS

ANDREW M. CUOMO, Governor

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. The total amount of combined paid family and disability leave an employee may take in a 52 consecutive week period may not exceed 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 by contacting the Workers' Compensation Board. (See address and telephone number 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 the Workers' Compensation Board at the telephone number below.

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 and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is:

NYSIF
Attn: Disability Benefits
PO Box 66698
Albany, NY 12206

Prescribed by the Chair,
Workers' Compensation Board

Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029
Customer Service: (877) 632-4996 ● www.wcb.ny.gov

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION