NYSIF

New York State Insurance Fund
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

1. Do not complete a disability claim form until after you become disabled. Read all instructions on this form carefully; please check all dates.
2. Use this form if you become sick or disabled while employed or if you become sick or disabled within four weeks after your last day worked. If you become sick or disabled after having been unemployed more than four weeks, please use the Board's form DB-450.
3. Please answer all questions in Part A and questions 1 through 3 in Part B. **Please be sure to sign your form.** Do not submit this claim unless your health care provider completes and signs Part B, and your employer completes and signs Part C.
4. Your completed claim form should be submitted **within 30 DAYS** after you become sick or disabled to your most recent employer or NYSIF.

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

1. Last Name:_____ First Name:_____ MI: ___

2. Mailing Address: _____ Address Line 2: _____

City: _____ State: _____ Zip: _____ Country: _____

3. Daytime phone #: _____ **4.** Email Address: _____

5. Social Security #: _____ **6.** Date of Birth: _____ **7.** Gender: ☐ Male ☐ Female ☐ Not Designated/Other

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

9. I became disabled on: _____ I worked on that day: ☐ Yes ☐ No

Have you since worked for wages or profit? ☐ Yes ☐ No If Yes, list dates: _____

Have you recovered from this disability? ☐ Yes ☐ No If Yes, what was the date you were able to work: _____

10. Provide the name of your most recent employer. If you had more than one employer during last eight (8) weeks, name all employers. (The Average Weekly Wage is based on all wages earned in last eight weeks worked.)

MOST RECENT EMPLOYER			PERIOD OF EMPLOYMENT		Average Weekly Wage (Include bonuses, tips, commissions, value of board, rent, etc.)
Firm or Trade Name	Address	Phone Number	Date of Hire	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

11. My job is or was: _____ (Occupation) **12.** Union Member: ☐ Yes ☐ No If Yes: _____ (Name of Union or Local Number)

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. Unemployment Insurance	☐ Yes	☐ No
3. Paid Family Leave	☐ Yes	☐ No
4. Damages for personal injury	☐ Yes	☐ No
5. Long-term disability benefits under the 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 year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No

If Yes: Paid by: _____ from: _____ to: _____

15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No

If Yes: Paid by: _____ from: _____ to: _____

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I certify 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; submit completed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ (On behalf of claimant) _____ (Address) _____ (Relationship to Claimant)

Submit completed form to: NYSIF Document Control Center, Disability Claims, 1 Watervliet Ave Ext, Albany, NY 12206 or fax to 518-437-5201.

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type) **NEW YORK STATE INSURANCE FUND**

The Health Care Provider's Statement must be completed fully. 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 the estimated date. If disability is caused by or arising from pregnancy, enter estimated delivery date in item 7. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Patient Last Name: _____ First Name: _____ MI: ___

2. Gender: ☐ Male ☐ Female ☐ Not designated/Other **3.** Date of Birth: _____

4. Diagnosis/Analysis: _____ Diagnosis Code: _____

a. Claimant's symptoms: _____

b. Objective findings: _____

5. Claimant hospitalized?: ☐ Yes ☐ No From: _____ to _____

6. Operation indicated?: ☐ Yes ☐ No Type: _____ 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 the date. Avoid use of terms such as unknown or undetermined.)*			
e. If pregnancy-related, check box & enter 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/Certified in State of** **License Number** **Date**

Health Care Provider's Printed Name **Health Care Provider's Signature**

Health Care Provider's Address **Email** **Phone #** **FAX**

HIPAA Notice: In order to adjudicate a 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.

Submit completed form to:
NYSIF Document Control Center, Disability Claims
1 Watervliet Ave Ext, Albany, NY 12206
or fax to 518-437-5201

PART C - EMPLOYER'S STATMENT (Please Print or Type) **NEW YORK STATE INSURANCE FUND**

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

3. Address: _____ Add2: _____ City: _____ State: _____ Zip: _____

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 employee's wages ceased: _____

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

_____

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

11. 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: _____

12. Requesting reimbursement for other type of continued pay? ☐ Yes ☐ No

Dates employee received continued pay: From: _____ To: _____

Type of continued pay received: _____

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

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

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

16. Did this disability occur as a result of employment? ☐ Yes ☐ No

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

18. Are you aware of any other employment claim the employee may have? ☐ Yes ☐ No

Weekly Wages 8 Weeks Prior to Disability
(include value of board, lodging, and tips if any)

	Week Ending MM DD YYYY	# of Days Worked	GROSS WEEKLY WAGES
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

TOTAL: $ $ 0.00

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

FEIN: _____ **Phone:** _____ **Fax:** _____ **Email:** _____

Address: _____

Person completing form (Print) _____ **Title:** _____

Signature: _____ **Date:** _____

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

Disclosure of Information: The WCB 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 WCB an original signed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may download Form OC-110A at: wcb.ny.gov. Mail the completed Form to: Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, NY 12305. You can also contact WCB at (800) 353-3092.

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.

Submit completed form to:
NYSIF Document Control Center, Disability Claims, 1 Watervliet Ave Ext, Albany, NY 12206 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:

New York State Insurance Fund
NYSIF Document Control Center, Disability Claims
1 Watervliet Ave Ext.
Albany, NY 12206

Prescribed by the Chair,
Workers' Compensation Board