



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 B and C 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 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, 328 State Street, Schenectady, NY 12305**. If you answered "Yes" to question 14.B.3, please complete and attach Form DB-450.1.

If you have any questions about claiming disability benefits, you may contact the Board's Disability Benefits Bureau at (800) 353-3092. Additional information may be obtained at the Board's website: www.wcb.ny.gov, or you may write to the Disability Benefits Bureau at the address listed above.

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, 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 website, www.wcb.ny.gov. It can be found under Forms on the 'List of All Common Workers' Compensation Board Forms' web page. Mail the completed authorization form to the address listed above.

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.

You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 2. Employer must complete part C.

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

1. First Name: _____ Last Name: _____ MI: _____
2. Mailing Address (Street & Apt. #): _____
3. City: _____ State: _____ Zip: _____
4. Daytime Phone #: _____ Email Address: _____
5. Social Security #: _____ / _____ / _____ 6. 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.	Mo.	Day	Yr.

10. My job is or was: _____ 11. Union Member: Yes No If "Yes": _____
Occupation _____ 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. Unemployment Benefits Yes No
 2. Paid Family Leave? Yes No
 3. Workers' compensation for work-connected disability? Yes No
 4. No-Fault motor vehicle accident? Yes No **or** personal injury involving third party? Yes No
 5. 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 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: _____ / _____ / _____

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. The foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

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)

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 9. INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.

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

2. Gender: Male Female 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 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 <input type="checkbox"/> estimated delivery date OR <input type="checkbox"/> 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 Care Provider's Signature

Date

Health Care Provider's Address

Phone #

Part C - EMPLOYER'S STATEMENT1. Employee's Name: _____ 2. Soc. Sec. #:

3. Employee's Address: _____ Number Street Apartment Number City / Town State Zip Code

4. Employee's Occupation: _____ 5. Date of Hire: _____ 6. Status: Full Time Part Time7. Is the Claimant an: Employee Owner High School Student 7a. Date of Birth _____8. Indicate the employee's normal work schedule: Mon Tues Wed Thur Fri Sat Sun9. If the employee is no longer in your employ, explain why: Quit Fired Laid Off Other (explain) _____10. Date Employee last worked: _____ 10a. Do you expect to rehire him/her? YES NO

11. Date Employee returned to work: _____

12. Are you paying wages or sick time: YES NO

a. If YES, time period paid: _____

b. Are you requesting reimbursement for this time period? YES NO13. Is Employee receiving or claiming Unemployment Ins? YES NO14. Is Employee receiving or claiming Workers' Comp. Ins? YES NO15. Did this Disability occur as a result of employment? YES NO16. Is Employee in a Union proving **MONETARY DISABILITY BENEFITS?** YES NO17. Are you aware of other employment claimant may have? YES NO18. Has the employee received DBL or PFL benefits within the past 52 weeks? YES NO

19. TAXABLE PERCENTAGE _____ %

POLICY NUMBER: _____**Weekly Wages 8 Weeks prior to Last Day Worked Before Disability**

(include value of Board, Lodging, and Tips if any)

Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

TOTAL

EMPLOYER INFORMATION:

Employer Name: _____ Employer Address: _____

Phone: _____ Fax: _____ E-mail: _____

Print Name: _____ Sign: _____ Title: _____ Date: _____

After Parts A, B, & C are COMPLETED, Do one of the following:

SSLICNY Phone: 800-477-0087 or 585-398-2340

Mail to: **SSLICNY, P.O. Box 25339 Farmington, NY 14425 or Fax to: 585-398-2854 or E-mail to: claims@sslincny.com**