Instructions

The **Notice of Proof of Claim for Disability Benefits** form is used only if you become sick or disabled while employed or if you become sick or disabled within four (4) weeks after termination of employment. You will need to print this form, complete all items of Part A-Claimant's Statement, sign and date the form, and give the form to your doctor. Your doctor will need to complete and sign Part B-Doctor's Statement.

(Form Below)

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM ONLY IF YOU BECOME SICK OR DISABLED WHILE EMPLOYED OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT.** USE GREEN 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 OR PART A – THE **"CLAIMANTS 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 IN YOUR BEHALF. IN THAT EVENT, THE REPRESENTATIVE'S RELATIONSHIP TO YOU AND HIS ADDRESS SHOULD BE NOTED UNDER HIS SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR DOCTOR COMPLETES AND SIGNS PART B – THE "DOCTOR'S STATEMENT."**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN TWENTY (20) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR HIS INSURANCE COMPANY.**

PART A – CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

2. My Social Security Number is: ☐☐☐ ☐☐ ☐☐☐☐

1. My name is _____ (First / Middle / Last)

3. Address _____ (Number / Street / City or Town / State / Zip Code / Apt. No.)

Tel. No. _____ 4. My age is _____ 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 _____ (mo. / day / year)

a. I worked on that day ☐ YES ☐ NO

b. I have since worked for wages or profit If "Yes," give dates _____

_____

8. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers.

Employers			Dates of Employment		Average Weekly Wages
Business Name	Business Address	Telephone No.	From Mo. Day Yr.	Through Mo. Day Yr.	(Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)

9. My job is or was _____ (Occupation / Name of Union and Local No., 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) Damages for personal injury _____ ☐ YES ☐ NO

(3) Unemployment Insurance Benefits _____ ☐ YES ☐ NO

(4) Disability Benefits under the Federal Social Security Act _____ ☐ YES ☐ NO

If "Yes" is checked in any of the items a, b(1), b(2), b(3) or b(4), fill in the following:

I have ☐ Received or ☐ Claimed from _____ (Date) For the Period _____ (Date) 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.

SIGN HERE → Claim signed on _____ (Date / Claimant's Signature)

If signed by other than claimant, print below: name address, and relationship of representative.

_____ (Name and Address / Relationship)

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABLIITY BENEFITS, CONTACT THE NEARNEST OFFICE OF THE NEW YORK STATE WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATIONS BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY • MENANDS, ALBANY, N.Y. 11241.

SI SE LE OCURREN ALGUNAS PREGUNTAS RESPECTO A RECLAMAR BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON SU OFICIANA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY • MENANDS, ALBANY, N.Y. 12241.

DOCTOR MUST COMPLETE PART B ON REVERSE SIDE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty no to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WHITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE GREEN CLIAM FORM DB-300.

PART B – DOCTORS STATEMENT (Please Print or Type)

The doctor's statement must be filled in completely. For item 7-d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks,"

1. Claimant's Name _____ 2. Age _____ 3. ☐ Male ☐ Female
4. Diagnosis/Analysis: _____
   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:

	Mo.	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 be able to perform usual work _____ (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			

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, C4C, or C-4P been filed with the Board? ☐ YES ☐ NO
   Remarks (Attach additional sheet, if necessary) _____

9. I affirm that I am a _____ Licensed in the State of _____ License No. _____
   (Physician, Podiatrist, Chiropractor, Dentist)
   Doctor's Signature _____ Date _____
   Doctor's Name (Please Print) _____ Tel. No. _____
   Office Address _____
   Number Street City or Town State Zip Code