

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED WHILE EMPLOYED OR IF YOU BECOME SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. USE 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 OF PART A - THE "CLAIMANT'S 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 IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT."
5. YOUR COMPLETED CLAIM SHOULD BE MAILED WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

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

Social Security Number

1. My name is..... First Middle Last [][][] [][][] [][][][]
2. Address..... Number Street City or Town State Zip Code Apt. No.
3. Tel. No..... 4. Date of Birth 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 Month Day Year a. I worked on that day Yes No
 b. I have since worked for wages or profit. Yes No If "Yes", give dates
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was Occupation Name of Union and Local Number, 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) Unemployment Insurance Benefits..... Yes No
- (3) Damages for personal injury Yes No
- (4) Benefits under the Federal Social Security Act for long-term disability Yes No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:

I have received claimed from for the period 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.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on Date Claimant's Signature

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

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 web page, www.wcb.ny.gov. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

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

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name 2. Date of Birth 3. Sex Male Female

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:

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

Month	Day	Year

(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 been filed with the Workers' Compensation Board? Yes No

Remarks (attach additional sheet, if necessary)

(If disability is pregnancy related, please enter estimated delivery)

I affirm that I am a	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Physician	<input type="checkbox"/> Psychologist	Licensed in the State of	License Number
	<input type="checkbox"/> Dentist	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Nurse-Midwife		

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Health Care Provider's Signature Date

Health Care Provider's Name (Please Print) Tel.No.

Office Address

Number Street City or Town State Zip

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-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 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.

TO BE COMPLETED BY EMPLOYER OF CLAIMANT

1. Name of Employee _____

2. From what date was he/she continuously employed? _____

3. Last day of work prior to his/her disability? _____

4. when did he/her return to work? _____

5. Is the disability the result of a injury or occupational disease arising out of or in the course of employment? _____

6. Will wages be paid during disability? _____

If yes, amount per week \$ _____ for the period _____

List 8 weeks of wages prior to disability

\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

RETURN COMPLETED FORMS TO
Hollow Metal Trust Fund
395 Hudson Street 9th Flr
New York NY 10014

By _____

Name of Employer

Title _____

Date