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 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 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 .... a. I worked on that day ☐ YES ☐ NO
mo. day year

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 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 .... For the Period .... To ....
Date Date

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 DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NEW YORK STATE WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY • MENANDS, ALBANY, N.Y. 12241.

SI SE LE OCURREN ALGUNAS PREGUNTAS RESPECTO A RECLAMAR BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON SU OFICINA 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 not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

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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 .... (First / Middle / Last) 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 .... (Physician, Podiatrist, Chiropractor, Dentist) Licensed in the State of .... License No ....

   Doctor's Signature .... Date ....

   Doctor's Name (Please Print) .... Tel. No. ....

   Office Address .... (Number / Street / City or Town / State / Zip Code)