

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

DB450 (2-91)

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 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 HIS 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

2. My Social Security Number is:

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1. My name is _____

First
Middle
Last

3. Address _____

Number
Street
City or Town
State
Zip Code
Ap't. 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

Employer's			Date 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 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) Worker's Compensation for work-connected disability _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (2) Damages for personal injury _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (3) Unemployment Insurance Benefits _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (4) Disability Benefits under the Federal Social Security Act _____ | <input type="checkbox"/> YES | <input type="checkbox"/> 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
→ Claim signed on _____
HERE
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 WORKER'S 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

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE SIDE

★ ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

