GUARDIAN®
State Disability Claims
P.O. Box 14332
Lexington, KY 40512
Telephone#1-800-268-2525
Fax# 610-807-2953

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING 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 and B 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.

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

1. Name: (Last, First, MI)

2. Address: | Line 2:

City: | State: | Zip: | Country:

3. Daytime Phone #: | 4. Email Address:

5. Social Security #: | 6. Date of Birth: | 7. Gender: ☐ Male ☐ Female

8. My disability is (if injury, also state how, when and where it occurred):

9. I became disabled or became ineligible for Unemployment Insurance because of this disability on: _____/_____/_____
I worked on that day: ☐ Yes ☐ No
Have you recovered from this disability? ☐ Yes ☐ No If Yes, what was the date you were able to work: _____/_____/_____
Have you since worked for wages or profit? ☐ Yes ☐ No If Yes, list dates: _____

10. Give the name of last employer. If more than one employer during last eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in the last eight (8) weeks worked.

LAST EMPLOYER			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.	

11. My job is or was (Occupation):

12: Union Member: ☐ Yes ☐ No
If "Yes", name of union or local number:

13. 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:

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14. 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) Paid Family Leave: ☐ Yes ☐ No
      (3) No-Fault motor vehicle accident or personal injury involving third party: ☐ Yes ☐ No
      (4) 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 14, COMPLETE THE FOLLOWING:
   I have ☐ Received ☐ Claimed from _____ for the period _____ to _____

15. In the year (52 weeks) **before** your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
   If Yes, fill in the following: I have been paid by _____ from _____ to _____

16. In the year (52 weeks) **before** your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
   If Yes, fill in the following: I have been paid by _____ from _____ to _____

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.

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. If my disability began while I was unemployed, I certify that I had been unemployed for more than four (4) weeks. I have read the instructions on page 2 of this form and that 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**

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.

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.

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PART B – HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

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. Name: (Last, First, MI)

2. Gender: ☐ Male ☐ Female

3. Date of Birth:

3. Diagnosis/Analysis: _____ Diagnosis Code: _____

a. Claimant's symptoms: _____

_____

b. Objective findings: _____

_____

5. Claimant Hospitalized? ☐ Yes ☐ No Date 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 estimated delivery date OR actual delivery date			

8. In your opinion, is this Disability the result of injury arising out of the course of employment or occupational disease? ☐ Yes ☐ No

If yes, has Form C-4 been filed with the Workers Compensation Board? ☐ Yes ☐ No

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.

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.

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 #**

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PART C – EMPLOYER'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

1. Employee's Name:			2. Social Security #:
3. Employee's Address:	Apt. #:	City:	State: Zip:
4. Employee's occupation:	5. Date of Hire:	6. Status: ☐ Full Time ☐ Part Time	

7. Is the Claimant an: ☐ Owner ☐ Officer ☐ Partner ☐ Employee ☐ High School Student

8. Indicate the Employee's normal work schedule: ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9. If the employee is no longer employed, explain why: ☐ Quit? ☐ Discharged? ☐ Labor Dispute? ☐ Lack of Work
If Quit or Discharged, explain why: _____. Do you expect to rehire him/her? ☐ Yes ☐

10. Date Employee last worked: _____
11. Date Employee's Wages Ceased: _____
12. Date Employee Returned to Work: _____
13. Are Wages being Continued during Disability? ☐ Yes ☐ No
14. If YES, are you requesting reimbursement? ☐ Yes ☐ No
15. Is Employee receiving or claiming Unemployment Ins.? ☐ Yes ☐ No
16. Is Employee receiving or claiming Workers' Comp. Ins.? ☐ Yes ☐ No
17. Did this Disability occur as a result of employment? ☐ Yes ☐ No
18. Is employee in a Union providing Disability Benefits? ☐ Yes ☐ No
19. Are you aware of other employment claimant may have? ☐ Yes ☐ No
20. Did employee receive PAID SICK TIME during disability? ☐ Yes ☐ No
If YES, provide dates of paid sick time: From: _____ To: _____

Weekly Wages 8 Weeks prior to Disability
(include value of Board, Lodging and Trips, 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	Policy #:	Tax ID #:	Date:
Employer Name:	Division #:	Phone #:	Fax #:
Address:		E-mail:	
Signature:	Print Name:	Title:	

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