



**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 WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE CLAIM FORM DB-300.**

**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 7-d, 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 .....

Mo.	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/C-48 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		

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 and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Health Care Provider's Signature ..... Date .....  
Health Care Provider's Name (Please Print) ..... Tel. No. ....  
Office Address .....  
Number Street City or Town State Zip Code

**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.

**Employer's Statement**

Employer's Name: ..... Policy Number: .....

Employer's Address: ..... Telephone number: .....

Employee's Name and Address: .....

Was the employee provided with the Statement of Rights (Form DB271S)  Yes  No If "Yes", date .....

Is Employee a  Member  Owner  Partner  Spouse Employee's Occupation .....

Date of Employment: .....  Full time worker  Part time worker Social Security Number .....

Normal work week: (check boxes to show usual days worked)  Sun.  Mon.  Tue.  Wed.  Thur.  Fri.  Sat.

Date Employee Last Worked: ..... Date Employee Wages Ceased: .....

Has Employee returned to work?  Yes  No If "Yes," date: .....

Has employment terminated?  Yes  No If "Yes," why? .....

Are wages being continued during disability? .....  Yes  No

If "yes," does employer request reimbursement? .....  Yes  No

Was employee on job when disability occurred? .....  Yes  No

Has claim been filed for Workers' Compensation? .....  Yes  No

Name of Workers' Compensation carrier: .....

Is Employee member of a union that provides for payment of weekly cash benefits?  Yes  No

If "yes," give name, address and telephone number of union: .....

Does employee contribute to cost of this insurance? .....  Yes  No

If "yes," is employee contribution the maximum permitted by law?  Yes  No

Other: \$ ..... per .....

Earnings 8 weeks prior to disability; include weekly value of board, lodging and tips.

	WEEK ENDING	NO. DAYS	GROSS
	Mo. Day Year	WORKED	AMOUNT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
			TOTAL \$

Employer tax ID: ..... Signed: ..... Title: ..... Date: .....