TOWN OF NISKAYUNA

Disability Claim Instructions

At the Time of Injury/Illness:
Complete Part A (page 1) of form DB-450 and have your physician complete Part B (page 2) on the reverse side of the form. Return the completed form to the Comptroller's Office or ensure that the completed form is mailed to; Sandy Busino c/o Town of Niskayuna, One Niskayuna Circle, Niskayuna, NY 12309. It is your responsibility to submit a completed form to the Comptroller's Office as soon as possible. To avoid denial of claim, the DB-450 must be submitted to our insurance carrier within thirty (30) days after you become sick or disabled.

Provide a copy of your job description to your treating physician at the onset of your injury/illness to allow them to gauge when you may be able to return to work based upon your work activities. You can request a copy of your job description from Sandra Busino if you or your Department Head do not have one available.

Retain page three (3), the "Statement of Rights-Disability Law", so you have NBL's (National Benefit Life Insurance Company-the Town's insurance carrier), information for further reference.

Prior to Returning to Work:
Submit the "Release to Work Statement", completed by your physician based upon your job description, to Sandra Busino in the Comptroller's office **before** returning to work. The information on the form must be reviewed before the Town can allow you to return to work.

Please direct any questions to Sandra Busino (386-4508).

Revised 9/14/2012

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 Mo. Day Yr.	THROUGH 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 ..... (Date) to..... (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 ..... (Date) To ..... (Date)
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, COMUNÍQUESE 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

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

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 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:

	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 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 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				Licensed in the State of	License Number
	☐ Chiropractor	☐ Physician	☐ Psychologist		
	☐ Dentist	☐ Podiatrist	☐ Nurse-Midwife		

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.

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.

Employer's Statement

Employer's Name: Town of Niskayuna Policy Number: 891002380 13
Employer's Address: One Niskayuna Circle Niskayuna NY 12309 Telephone number: (518) 386-4508
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: Self Insured
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 Mo.	Day	Year	NO. DAYS WORKED	GROSS AMOUNT
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
				TOTAL	$

Employer tax ID: 14-6002340 Signed: Title: Date:

STATE OF NEW YORK
David A. Paterson, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS - DISABILITY BENEFITS LAW

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of Disability Benefits to his/her employees.
2. Statutory Disability Benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.
3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or any office of the Workers' Compensation Board. (See addresses and telephone numbers below.) **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.
5. Disability Benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.
6. If your employer or the insurance carrier contends that you are not entitled to the payment of Disability Benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a **legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact any office of the Workers' Compensation Board.
7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT:** In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.
8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability Benefits Law. Your employer's disability benefits insurance carrier is:

NATIONAL BENEFIT LIFE INSURANCE COMPANY
ONE COURT SQUARE
LONG ISLAND CITY NY 11120

Robert E. Beloten
ROBERT E. BELOTEN
CHAIR

100 Broadway Menands ALBANY 12241 (866) 750-5157	State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	111 Livingston St. 22nd Floor BROOKLYN 11201 (800) 877-1373	369 Franklin Street BUFFALO 14202 (866) 211-0645	220 Rabro Drive Suite 100 HAUPPAUGE 11788 (866) 681-5354	175 Fulton Avenue HEMPSTEAD 11550 (866) 805-3630	215 W. 125th Street 3rd Floor NEW YORK 10027 (800) 877-1373	41 North Division St. PEEKSKILL 10566 (866) 746-0552	168-46 91st Ave. 3rd Floor QUEENS 11432 (800) 877-1373	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTA ESCRITO EN ESPANOL AL DORSO.

www.wcb.state.ny.us

DB-271S (8-09)

TOWN OF NISKAYUNA

RELEASE TO WORK STATEMENT

I have reviewed the attached job description for the title _____

and I agree that _____
Patient/Employee Name

can return to work on _____ with / without (CIRCLE ONE) restrictions.
Date

Please specify all restrictions below including, but not limited to, hours of work per day and week, lifting limits or specific restrictions of movement. Please print clearly.

_____
Medical Doctor's Name (Please print)

_____
Medical Doctor's signature

_____
Medical Doctor's phone number

_____
Date