

**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 GREEN 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. Age \_\_\_\_\_ 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 .....

Month	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 date )

I affirm that I am a  Chiropractor  Physician  Psychologist  Licensed in the State of \_\_\_\_\_ License Number \_\_\_\_\_  
 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 Code

**EMPLOYER'S NOTICE OF CLAIM**

EMPLOYER'S NAME \_\_\_\_\_ CONTROL NUMBER 88847 SUFFIX 13 ACCOUNT \_\_\_\_\_  
 EMPLOYER'S ADDRESS \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_

EMPLOYEE'S NAME AND ADDRESS \_\_\_\_\_  
 EMPLOYEE'S LEGAL ZIP CODE \_\_\_\_\_ PLEASE PROVIDE THE EMPLOYEE'S MAILING ADDRESS, INCLUDING ZIP CODE, USED WHILE RECEIVING DISABILITY BENEFITS. ALSO, ADVISE THE ZIP CODE OF THE EMPLOYEE'S LEGAL ADDRESS, IF DIFFERENT FROM THE MAILING ADDRESS THIS ADDRESS WILL BE USED TO DETERMINE STATE AND LOCAL TAX AUTHORITIES.

IF CLAIMANT SUBJECT TO FICA WITHHOLDING, ENTER FICA CODE  (SEE CODES BELOW)  
 PERCENTAGE OF EMPLOYEE CONTRIBUTION TOWARD DISABILITY PREMIUM \_\_\_\_\_ % (IF NONE SHOWN WE WILL ASSUME EMPLOYER PAYS ALL)  
 DATE OF EMPLOYMENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  FULL TIME WORKER  PART TIME WORKER

EMPLOYER'S FEDERAL IDENTIFICATION NO \_\_\_\_\_  
 IF NORMAL WORK WEEK OTHER THAN 5 DAYS CHECK APPROPRIATE BOXES TO SHOW DAYS WORKED S M T W Y F S

AVERAGE WEEKLY EARNINGS FOR THE 8 WEEKS IMMEDIATELY PRECEDING LAST DAY WORKED \$ \_\_\_\_\_  
 AVERAGE WEEKLY EARNINGS FOR 8 PAYROLL WEEKS IMMEDIATELY PRECEDING LAST DAY WORKED EXCLUDING THE PAYROLL WEEK IN WHICH DISABILITY BEGAN (i.e., 7 FULL PAYROLL WEEKS) \$ \_\_\_\_\_

TO COMPUTE THE AVERAGE WEEKLY WAGE divide the total remuneration (including, board, lodging, gratuities, etc.), paid by you to your employee during the eight (8) weeks immediately preceding and including his last day worked prior to the commencement of disability, by the number of weeks during which he/she worked on at least one day during such eight (8) week period.

DATE LAST WORKED \_\_\_\_\_ WAS MORE THAN A HALF DAY WORKED?  YES  NO  
 DATE & HOUR DISABILITY BEGAN \_\_\_\_\_  AM  PM DATE & HOUR RETURNED TO WORK \_\_\_\_\_  AM  PM  
 IF FULL WAGES OR OTHER BENEFITS ARE PAID DURING DISABILITY INDICATE AMOUNT PER WEEK \$ \_\_\_\_\_  WAGES  SICK PAY  VACATION  
 NUMBER WEEKS \_\_\_\_\_ AND WHETHER EMPLOYER REQUESTS REIMBURSEMENT (ALLOWED ONLY IF WAGES OR SICK PAY PROVIDED)?  YES  NO  
 ESTIMATED DATE SALARY CONTINUANCE WILL CEASE \_\_\_\_\_

IS ILLNESS OR INJURY DUE TO OCCUPATIONAL CAUSES?  YES  NO IF YES, PLEASE PROVIDE COPY OF C-7 NOTICE OF CONTROVERSY.

REMARKS \_\_\_\_\_  
 SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
 (EMPLOYER'S REPRESENTATIVE) (TITLE) (TELEPHONE NUMBER)

**FICA CODE**

- Enter a two digit numeric code to indicate whether or not the claimant is subject to FICA. The codes (with explanations) are:
- 01 - Yes, subject to FICA tax, but actual deduction, if any, based on employer's contribution to premium
  - 04 - No, FICA tax not withheld since the employee is not a participant in the FICA program (e.g., city, state, Federal).
  - 05 - No, FICA tax not withheld since the employee is on salary continuance and employer is withholding FICA.
  - 06 - No, FICA tax not withheld since the employee is owner/proprietor (i.e., self-employed).
  - 07 - No, FICA tax not withheld since the FICA maximum contribution/earnings base has been exceeded.
  - 08 - No, FICA tax not withheld. Due to special alien status, employee is not subject to FICA.

**AETNA LIFE INSURANCE CO.  
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 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 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**

1. My name is \_\_\_\_\_  
First Middle Last Social Security Number \_\_\_\_\_
2. Address \_\_\_\_\_  
Number Street City or Town State Zip Code Apt. No.
3. 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 \_\_\_\_\_  
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			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.

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 \_\_\_\_\_ 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 \_\_\_\_\_  
Date Date 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 \_\_\_\_\_

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 RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA 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, NY 12241-0005.
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**HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE**