



Administered by
Principal Life Insurance Company
 Des Moines, Iowa 50392-0002

**State Disability
 Claim Form - NY**

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

1. My name is _____ Social security number _____
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 _____ a. I worked on that day yes no
Month 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 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		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

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.state.ny.us. 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, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER’S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005
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DB-450 (2-04)



Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Authorization for Release
of Personal Health and
Other Information to
Principal Life Insurance Company

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan and its administrator, disability plan and its administrator, insurer, or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me to disclose my entire medical record to the Principal Life Insurance Company (Principal Life), its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by Principal Life. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information.

I understand that unless prohibited by state or federal law the protected health information is to be disclosed under this authorization so that Principal Life may administer claims and determine or fulfill responsibility for coverage and provision of benefits, coordinate the provision of benefits under my medical and disability coverages, and conduct other legally permissible activities that relate to any coverage I have or have applied for with Principal Life.

Also, I authorize the Internal Revenue Service, Social Security Administration, any state taxing authority and any employer, former employer, business associate or partners, insurance company, insurance support organization, Worker's Compensation or vocational or rehabilitation counselor or provider to give any information or record it has about me, my employment, employment history or income to Principal Life.

The following groups of persons employed or working for Principal Life may use my personal health and other information which is described above: employees of the claim or legal departments and any other personnel of Principal Life, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have or have applied for with Principal Life. This includes, reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, employer or former employer as needed to perform fiduciary responsibility under any benefit plan and, when required by law, to any other public or private entity or person.

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Disability Claims, Life and Health Segment, Principal Life Insurance Company, Des Moines, IA 50392. I understand that a revocation is not effective if Principal Life has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that if I refuse to sign this authorization to release my complete medical record, Principal Life may not be able to process my application for life or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon your request, a copy of this completed authorization will be provided to you. Any alteration of this form will not be accepted.

Claimant's signature: _____ Date: _____ Incident # _____

Claimant's full name: _____ Date of birth: _____

Claimant's address: _____

Telephone number: (_____) _____ Can confidential messages be left at this number? **yes** **no**

OPTIONAL: I give you permission to speak with _____ (full name) My spouse, Domestic Partner, or _____, concerning my claim during my disability.

If you are the representative of the member or the member's dependent (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the member's or dependent's behalf. Please include the proper documentation that attests to your ability to sign.

I certify that I am a citizen of the following country:

(Country) (Signature) (Date)

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Part B. – Health Care Provider’s Statement (Please print or type)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

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	<input type="checkbox"/> chiropractor	<input type="checkbox"/> physician	<input type="checkbox"/> psychologist	Licensed in the state of	License number
I am a	<input type="checkbox"/> dentist	<input type="checkbox"/> podiatrist	<input type="checkbox"/> nurse-midwife		

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Health care provider’s signature _____ Date _____
 Health care provider’s name (please print) _____ Tel. No. _____
 Office address _____
Number Street City or Town State ZIP

Part C. – Employer Statement

Must be completed in full, by employer only immediately following claimant’s last day worked. For inquires, call 1-800-245-1522.

Employee’s name	Social security number	Age	Policy #
Employee’s occupation	Date of hire	<input type="checkbox"/> full time <input type="checkbox"/> part time <small>If part-time, give particulars</small>	
Check one: <input type="checkbox"/> owner <input type="checkbox"/> employee <input type="checkbox"/> proprietor <input type="checkbox"/> partner	Check days normally worked	Actual last day worked	Actual date paid through
	<input type="checkbox"/> Mon <input type="checkbox"/> Tu <input type="checkbox"/> Wed <input type="checkbox"/> Th <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		

Wages continued during disability? yes no
 If yes, were wages Sick Pay? yes no from: _____ to: _____
 Were wages Vacation Pay? yes no from: _____ to: _____
 If employee received Sick Pay, are you requesting reimbursement? yes no
 Has employee returned to work? yes no Date returned _____
 Did disability occur on the job? yes no
 If yes, was a Workers Comp. Claim filed? yes no

GROSS EARNINGS 8 WEEKS PRIOR TO DISABILITY (include tips, commissions, lodging and allowances)					
	WEEK ENDING			NO. DAYS WORKED	GROSS AMOUNT
	MO.	DAY	YEAR		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
TOTAL \$					

Workers Comp. Carrier Name / Address / Phone # _____

% of employer contribution to premium for FICA Deductions = _____ %
(If left blank, 100% will be deducted.)

Is employee a member of a union? yes no Does union provide disability benefits? yes no
 If “yes”, provide name, address & phone # of union below.

Union’s name / address	Phone number
Employer’s name / address	Phone number
Signed by _____	Date _____ Title _____