



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

- 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.
- YOU MUST COMPLETE ALL ITEMS OF PART A – THE “CLAIMANT’S STATEMENT”. BE ACCURATE. CHECK ALL DATES.
- 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.
- DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B – THE “HEALTH CARE PROVIDER’S STATEMENT.”**
- 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.
- 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

- My name is _____ Social security number _____
First Middle Last
- Address _____
Number Street City or town State ZIP Code Apt. No.
- Tel. No. _____ 4. Date of birth _____ 5. Married (check one) yes no
- My disability is (if injury, also state how, when and where it occurred) _____
- 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 _____
- 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.

- My job is or was _____
Occupation Name of Union and Local Number, if Member
- For the period of disability covered by this claim
 - Are you receiving wages, salary or separation pay: yes no
 - Are you receiving or claiming:
 - Workers’ compensation for work-connected disability yes no
 - Unemployment Insurance Benefits yes no
 - Damages for personal injury yes no
 - 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

- 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)

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

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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 chiropractor physician psychologist Licensed in the state of _____ License number _____
 I am a dentist podiatrist 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 _____ full time If part-time, give particulars
 part time

Check one: owner employee proprietor partner Check days normally worked _____ Actual last day worked _____ Actual date paid through _____
 Mon Tu Wed Th Fri Sat 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 _____