Principal® Financial Group

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

State Disability Claim Form - NY

NOTICE AND PROOF OF CLAIM FOR DISABILTY 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 _____ (First / Middle / Last) Social security number ☐☐☐ ☐☐ ☐☐☐☐
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
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day Yr.	THROUGH Mo. Day Yr.	(Include bonuses, tips, commissions, reasonable value of board, rent, etc.)

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.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

DB-450 (2-04)

Principal Financial Group

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)

Print

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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 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 I am a	☐ chiropractor	☐ physician	☐ psychologist	Licensed in the state of	License number
	☐ 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 ☐ part time | If part-time, give particulars

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

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
Workers Comp. Carrier Name / Address / Phone #

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

GROSS EARINGS 8 WEEKS PRIOR TO DISABILITY
(include tips, commissions, lodging and allowances)

	WEEK ENDING MO.	DAY	YEAR	NO. DAYS WORKED	GROSS AMOUNT
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
				TOTAL $	

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