





**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 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		

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

**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 If part-time, give particulars <input type="checkbox"/> part time	
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 _____