NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Zurich American Insurance Company P.O. Box 9102, Plainview, New York 11803-9002

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.**

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

1. My name is _____ (First / Middle / Last)
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. 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 (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day Yr.	THROUGH Mo. Day Yr.	

9. My job is or was _____ (Occupation) _____ (Name of Union or 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 _____

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 INCAPACIDID, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

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 PROVIDERS 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 (7) 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:

	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 date.)

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

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Employer's Statement

Employer's Name _____ Policy Number _____

Employer's Address _____ Telephone Number _____

Employee's Name and Address _____

Was the employee provided with the Statement of Rights (Form DB271S) ☐ Yes ☐ No If "Yes", date _____

Is Employee a ☐ Member ☐ Owner ☐ Partner ☐ Spouse Employee's Occupation _____

Date of Employment _____ ☐ Full-time Worker ☐ Part-time Worker Social Security Number _____

Normal Work Week (Check boxes to show usual days worked) ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

Date Employee Last Worked _____ Date Employee Wages Ceased _____

Has Employee returned to work ☐ Yes ☐ No If "Yes", date _____

Has employment terminated ☐ Yes ☐ No If "Yes", why _____

Are wages being continued during disability ..... ☐ Yes ☐ No

If "Yes", does Employer request reimbursement ..... ☐ Yes ☐ No

Was Employee on job when disability occurred ..... ☐ Yes ☐ No

Has claim been filed for Workers' Compensation ..... ☐ Yes ☐ No

Name of Workers' Compensation carrier _____

Is Employee member of a union that provides for payment of weekly cash benefits ☐ Yes ☐ No

If "Yes", give name, address and telephone number of union _____

Does Employee contribute to cost of this insurance ..... ☐ Yes ☐ No

If "Yes", is employee contribution the maximum permitted by law ☐ Yes ☐ No Other $ _____ per _____

Earnings 8 weeks prior to disability; include weekly value of board, lodging and tips.

	WEEK ENDING Mo. Day Year	NO. DAYS WORKED	GROSS AMOUNT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		TOTAL	$

Employer tax ID _____ Signed _____ Title _____ Date _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION