Clear Form

THE HARTFORD **NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS** **DB-450 (3-97)**

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. My address is _____ (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. 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 (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			MO.	DAY	YR.	MO.	DAY	YR.	

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 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

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241

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 PROVIDER'S 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 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. ☐ male ☐ female

4. Diagnosis/Analysis _____ Diagnosis Code _____
   a. Claimant's Symptoms _____

   b. Objective Findings _____

5. Claimant hospitalized? ☐ Yes ☐ No From _____ To _____ CPT Code _____
6. Operation indicated? ☐ Yes ☐ No a. Type _____ b. Date _____
7. Enter dates for the following:
   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 unkown or undetermined.)

Month	Day	Year

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

Employer's Statement

Policy Number: _____

Employee's Full Name *(as shown on Social Security card)*: _____ S.S. Number: _____

Employee's Address: _____ Date of Birth: _____

Employee's Occupation: _____ Date employed: _____ ☐ Full Time ☐ Part Time

Is employee a Union member? ☐ Yes ☐ No

If "Yes," is employee eligible for Union benefits? ☐ Yes ☐ No

Check days normally worked:

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

If Part Time, give particulars: _____

Date employee last worked: _____

Date employee returned to work: _____

Were wages continued during disability? ☐ Yes ☐ No

Were wages **Sick** pay**?** ☐ Yes ☐ No From: _____ To: _____

Were wages **Vacation** pay**?** ☐ Yes ☐ No From: _____ To: _____

Is reimbursement requested? ☐ Yes ☐ No

Is disability due to job? ☐ Yes ☐ No

If "Yes," has a compensation claim been filed? ☐ Yes ☐ No

Indicate Weekly Value of Board, Lodging and Tips: _____

Employer's Name: _____

Employer's Identification No.: _____

Is employee enrolled in a Hartford Long Term Disability Plan?
☐ Yes ☐ No If "Yes," effective date: _____

EARNINGS 8 WEEKS PRIOR TO DISABILITY
(Including the week in which the disability began)

Month	Day	Year	No. Days Worked	Amount
			Total	

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the Weekly Disability _____ % LTD _____ % benefit is considered taxable? ***(See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.)*** **If blank, we will assume the benefit is 100% taxable.**

Is this employee currently covered by Social Security? ☐ Yes ☐ No If "No," state grounds for exemption: _____

Address: _____ Telephone No.: _____

Signed by: _____ Title: _____ Date: _____

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