



NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

GUARDIAN®

State Disability Claims
P.O. Box 26150
Lehigh Valley, PA 18002-6150
Telephone#1-800-268-2525
Fax# 610-807-2953
Email: State_Disability_Claims@glic.com

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 can not sign this form, your representative may sign it on 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 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. Name: (First, Middle, Last)		Policy #:	Social Security #:	
2. Address:		Apt. #	City	State Zip Code
3. Telephone #:		4. Date of Birth:		5. Married (Check one): <input type="checkbox"/> Yes <input type="checkbox"/> No 5a. <input type="checkbox"/> Male <input type="checkbox"/> Female

6. My disability is (if injury, also state **how**, **when** and **where** it occurred)

7. I became disabled on / /
Mo. Day Year

7a. I worked on that day Yes No

7b. 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 last eight (8) weeks, name **ALL** employers.

EMPLOYERS			Dates of Employment		Average Weekly Wages
Business Name	Business Address	Telephone No.	From	Through	(Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, Etc.)
			Mo. Day Yr.	Mo. Day Yr.	

9. My job is or was (**Occupation**) Name of Union and Local No., 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 To .

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 To

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 ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

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 does 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 form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NEW YORK STATE WORKERS COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, N.Y. 12241-0005.	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, N.Y. 12241-0005.
---	--

NOTICE OF 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 the 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 the approximate date. Make some estimate. If the Disability was caused by or arose in connection with pregnancy, enter the estimated delivery date under “Remarks.”

1. Claimant’s Name: (First, Middle, Last)	2. Date of Birth	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
---	------------------	---

4. Diagnosis/Analysis: a. Claimant’s Symptoms: b. Objective Findings/Treatment Plan: c. If Disability is pregnancy related, enter DELIVERY DATE	ICD <input type="checkbox"/> Estimated <input type="checkbox"/> Actual <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
--	---

5. Claimant Hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date From:	To	
--	------------	----	--

6. Operation Indicated? <input type="checkbox"/> YES <input type="checkbox"/> NO	a. Type :	b. Date	c. CPT
--	-----------	---------	--------

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 **	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Mo.</th> <th style="width:33%;">Day</th> <th style="width:33%;">Year</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Mo.	Day	Year												
Mo.	Day	Year														

** 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 the course of employment or occupational disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. If yes, has Form C-4 been filed with the Workers Compensation Board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Remarks:

I affirm that <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist I am a <input type="checkbox"/> Dentist <input type="checkbox"/> Podiatrist <input type="checkbox"/> Nurse-Midwife	Licensed in the State of:	Licensed #:
--	---------------------------	-------------

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)	Phone #:
--	----------

Office Address (Number, street, Apt./Suite, City/Town, State, Zip Code)

HIPAA NOTICE - In order to adjudicate a worker’s compensation claim, WCL 13-8 (4) (a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports or treatment with the Board and the carrier or employer. Pursuant to 45 CFR 184.512 these legally required medical reports are exempt from HIPAA’S restrictions on disclosure of health information.

Part C – EMPLOYER’S STATEMENT

1. Employee’s Name	2. Social Security #:
--------------------	-----------------------

3. Employee’s Address	Apt. #.	City	State	Zip
-----------------------	---------	------	-------	-----

4. Employee’s occupation	5. Date of Hire	6. Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
--------------------------	-----------------	---

7. Is the Claimant an: Owner Officer Partner Employee High School Student

8. Indicate the Employee’s normal work schedule: Mon Tue Wed Thur Fri Sat Sun

9. If the employee is no longer employed, explain why: Quit? Discharged? Labor Dispute? Lack of Work
If Quit or Discharged, explain why: _____ Do you expect to rehire him/her? Yes No

10. Date Employee last worked:	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)</th> </tr> <tr> <th style="width:33%;">Week Ending Month Day Year</th> <th style="width:33%;">No. of Days Worked</th> <th style="width:33%;">GROSS WEEKLY WAGES</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td colspan="2" style="text-align: right;">TOTAL</td> <td> </td> </tr> </tbody> </table>	Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)			Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES																			TOTAL		
Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)																												
Week Ending Month Day Year		No. of Days Worked	GROSS WEEKLY WAGES																									
TOTAL																												
11. Date Employee’s Wages Ceased:																												
12. Date Employee Returned to Work:																												
13. Are Wages being Continued during Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
14. If YES, are you requesting reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
15. Is Employee receiving or claiming Unemployment Ins.? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
16. Is Employee receiving or claiming Workers’ Comp. Ins.? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
17. Did this Disability occur as a result of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
18. Is employee in a Union providing Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
19. Are you aware of other employment claimant may have? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
20. Did employee receive PAID SICK TIME during disability? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
If YES, provide dates of paid sick time: From: _____ To: _____																												

EMPLOYER INFORMATION	Policy #:	Tax ID #:	Date:
-----------------------------	-----------	-----------	-------

Employer Name:	Division #:	Phone #	Fax #:
----------------	-------------	---------	--------

Address:	E-mail:
----------	---------

Signature:	Print Name:	Title:
------------	-------------	--------