1199SEIU National Benefit Fund

330 West 42nd Street, New York, NY 10036-6977 • Tel (646) 473-9200 • www.1199SEIUBenefits.org

Notice and Proof of Claim for Disability Benefits

Healthcare Provider must Complete Part B on Reverse Side; Employer must Complete Part C (Attachment)

MEMBER: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. Use this form only 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 "Member'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 on your behalf. In that event, the representative's relationship to you and address should be noted under the signature.
4. Do not mail this claim unless your healthcare provider completes and signs Part B and you complete the Member's section at the top of Part C, and mail to your employer.
5. Your completed claim and Employer's Statement should be mailed within thirty (30) days after you become sick or disabled to the 1199SEIU National Benefit Fund.
6. Make a copy of this completed form for your records before you submit.

PART A MEMBER'S STATEMENT (Please Print in Black or Blue Ink) Answer All Questions

1. Member's Full Name: _____
2. Member's ID: _____ Telephone: (_____) _____
3. Address: _____
   City: _____ State: _____ Zip Code: _____ ☐ (Check Box if New Address)
4. Date of Birth: _____/_____/_____ (Month / Day / Year) 5. Married (check one): ☐ Yes ☐ No
6. My disability is (if injury, also state how, when and where it occurred) _____
   _____
   a. Are you taking legal action? ☐ Yes ☐ No If yes, Lawyer's Full Name: _____
   Lawyer's Address: _____
   _____
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 _____/_____/_____ (Month / Day / Year)
8. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers.

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

9. My job is or was: _____
   (Name of Union & Local #, 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 full sick pay from your employer? ☐ Yes ☐ No
    c. Are you receiving or claiming:
       1. Workers' Compensation for work-connected disability? ☐ Yes ☐ No
       2. Damages for personal injury? ☐ Yes ☐ No
       3. Unemployment Insurance benefits? ☐ Yes ☐ No
       4. Disability Benefits under the Federal Social Security Act? ☐ Yes ☐ No
       5. No Fault Automobile Insurance? ☐ Yes ☐ No

       If "Yes" is checked in any of the items a, b, c(1), c(2), c(3), c(4) or c(5), fill in 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 my accompanying statements, are to the best of my knowledge true and complete. I authorize the release to or by the Fund of any medical information necessary to process this claim.

    Member's Signature **X** _____ Date: _____
    If signed by other than member, print below: Full name, address, and relationship of representative.
    Full Name: _____ Relationship: _____
    Address: _____
    City: _____ State: _____ Zip Code: _____

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-Medands, Albany, NY 12241.

Si se le ocurren algunas preguentas respect a reclamar beneficios por incapacidad, comuniquese con su oficina mas cercana de la junta de compensacion obrera de Neuva York, o escriba a Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-Menands, Albany, NY 12241.

Healthcare Provider must complete Part B on the Reverse Side

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.

Please Print in Black or Blue Ink

IMPORTANT: Use this form only when the Member becomes sick while employed or becomes sick or disabled within (4) weeks after termination of employment. Otherwise use green Claim Form DB-300.

PART B HEALTHCARE PROVIDER'S STATEMENT (To be completed by provider and signed by Member).

The healthcare provider's statement must be filled in completely and mailed to the Fund or returned to the Member within seven (7) days of receipt of the form. For item 7(d), give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented if disability is caused by or arises in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Member's Full Name: _____
2. Age: _____ 3. Sex: ☐ Male ☐ Female
4. Diagnosis/analysis: (ICD9/CPT4 Code) _____
   a. Member's symptoms: _____
   _____
   b. Objective findings: _____
   _____
   c. Treatment Date: _____/_____/_____ (Month/Day/Year) ☐ Normal ☐ Caesarean Section
   d. If disability is a result of pregnancy, give approximate date of conception: _____ Date of Delivery: _____
5. Member hospitalized? ☐ Yes ☐ No From _____ To _____
   Name of Hospital: _____
6. Operations indicated? ☐ Yes ☐ No a. Type: _____ b. Date: _____/_____/_____ (Month/Day/Year)
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 member was unable to work because of this disability			
d. Date member will be able to perform usual work			

(Even if considerable questions exist, 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 equipment use or occupational disease? ☐ Yes ☐ No
   If "Yes," has Form C-4/48 been filed with the Workers' Compensation Board? ☐ Yes ☐ No
   Remarks (attach additional sheet, if necessary): _____
9. I affirm that I am a (Physician, Pordiatrist, Chiropractor, Dentist, Nurse-Midwife or Psychologist) _____
   Licensed in the State of _____ License #: _____
   Specialty: _____ WCB Rating #: _____
   Healthcare Provider's Signature **X** _____ Date: _____
   Healthcare Provider's Name (please print): _____
   Office Address: _____
   City: _____ State: _____ Zip Code: _____
   Telephone: (____) _____
   Must be furnished under authority of law – Individual Practitioner's Social Security #: _____ - _____ - _____
   All other T.I.N. _____

Report of Services

Date of Services	Place of Services	Description of Services Rendered	Procedure 1CD9/ CPT4	Charges
			Total	

Authorization to Pay Benefits to Healthcare Provider: I hereby authorize payment directly to the Healthcare Provider whose signature is above.

Member's Signature **X** _____ Date: _____

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PART C

Member: Please complete these 4 Lines (Please Print in Black or Blue Ink)

Date: _____

Member's Name: _____

Member ID or Social Security #: _____

Date Disability Began: _____

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 any 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 may download it from www.web.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.

HIPAA NOTICE: In order to adjudicate as a Workers' Compensation claim, WCL13a(4)(a) and 12 NYCRR 325-1.3 require healthcare 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.

ATTENTION: PAYROLL DEPARTMENT

The above member is the process of filing a claim for Disability Benefits with the 1199SEIU National Benefit Fund. Since you are the present employer, you are required by the Union Contract and the Trustees of the Fund to promptly complete the "Employer's Statement" below and return the completed form to the employee.

TO BE COMPLETED BY THE EMPLOYER

1. Date employed: _____/_____/_____ (Month / Day / Year) Regular weekly wage: $_____
2. Date last worked (before disability): _____/_____/_____ (Month / Day / Year)
   a. Full sick pay received, not the ⅓ sick pay provided in the Union Contract Period: From _____ To _____
   b. Vacation pay received: From _____ To _____ Number of days sick pay received: _____
3. Has employee returned to work? ☐ Yes ☐ No Date: _____/_____/_____ (Month / Day / Year)
4. Is this claim covered by Workers' Compensation? ☐ Yes ☐ No
5. Name of Employer (Please give correct Business Name): _____
6. Authorized Signature **X** _____ Date: _____
7. Title: _____ Telephone: (_____) _____
8. Weekly Wages: List Member's gross earnings during each of the last eight calendar weeks prior to week in which disability began.

Month	Week Ending Day	Year	Number of Days Worked	Amount
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
			Total	$

Please Use the Reverse Side If You Need Additional Space