1199SEIU National Benefit Fund

498 Seventh Avenue, New York, NY 10018-0009 • Tel: (646) 473-9200 • Outside NYC Area Codes: (800) 575-7771
Email: DBLClaims@1199Funds.org • 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: PLEASE 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 the Member's Statement (Part A). Please be accurate. Please 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 full name, address and relationship to you should be noted under the signature.
4. Do not mail this claim unless your healthcare provider completes and signs Part B. You must complete the member's section at the top of Part C, and then mail it to your employer.
5. Your completed claim and Employer's Statement (Part C) should be mailed to the 1199SEIU National Benefit Fund within thirty (30) days after you become sick or disabled.
6. Make a copy of this completed form for your records before you submit it to the 1199SEIU National Benefit Fund.

PART A: MEMBER'S STATEMENT (PLEASE PRINT IN BLACK OR BLUE INK. PLEASE ANSWER ALL QUESTIONS.)

1. Member's full name: _____
2. Member's ID #: _____ Home phone: _____ Cell phone: _____
3. Address: _____
   City: _____ State: _____ Zip code: _____ ☐ (Check box if new address)
4. Date of birth: _____ 5. Married (check one): ☐ No ☐ Yes
6. My disability is (if it is an injury, please also state how, when and where it occurred): _____
   _____
   a. Are you taking legal action? ☐ No ☐ Yes If "yes," lawyer's full name: _____
   Lawyer's address: _____
7. Date I became disabled: _____ a. I worked on that day. ☐ No ☐ Yes b. I have since worked for wages or profit. ☐ No ☐ Yes
   If "yes," list dates: _____
8. Please list information about your last employer. If you had more than one employer in the last eight (8) weeks, list 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 title is or was: _____
   (Name of Union & Local #, if you are a member): _____
10. For the period of disability covered by this claim:
    a. Are you receiving wages, salary or separation pay? ☐ No ☐ Yes
    b. Are you receiving full sick pay from your employer? ☐ No ☐ Yes
    c. Are you receiving or claiming:
       1. Workers' Compensation for work-connected disability? ☐ No ☐ Yes
       2. Damages for personal injury? ☐ No ☐ Yes
       3. Unemployment insurance benefits? ☐ No ☐ Yes
       4. Disability benefits under the federal Social Security Act? ☐ No ☐ Yes
       5. No-fault automobile insurance? ☐ No ☐ Yes

    If "yes" is checked for 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 of _____ to _____.
11. I have received disability benefits for another period of disability within the 52 weeks immediately before my present disability began. ☐ No ☐ Yes
    If "yes," fill in the following: I have been paid by _____, for the period of _____ 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 1199SEIU National Benefit Fund of any medical information necessary to process this claim.

    Member's signature **X** _____ Date: _____
    If signed by someone other than the member, please print the representative's full name, address and relationship to the member:
    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-Menands, 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 Nueva 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.

1199SEIU National Benefit Fund

498 Seventh Avenue, New York, NY 10018-0009 • Tel: (646) 473-9200 • Outside NYC Area Codes: (800) 575-7771
Email: DBLClaims@1199Funds.org • www.1199SEIUBenefits.org

Please Print in Black or Blue Ink

IMPORTANT: Use this form only if the member becomes sick while employed or becomes sick or disabled within four (4) weeks after termination of employment. Use green Claim Form DB-300 if the member becomes sick or disabled after having been unemployed more than four (4) weeks.

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 1199SEIU National Benefit Fund or returned to the member within seven (7) days of receipt of the form. For item 7(d), estimate an approximate date. Delay in the payment of disability benefits may be prevented if disability is caused by or arises in connection with pregnancy. Enter an estimated delivery date under "Remarks" in item 8.

1. Member's full name: _____
2. Age:_____ 3. Sex: ☐ Male ☐ Female
4. Diagnosis/Analysis (ICD-10/CPT-4 code): _____
   a. Member's symptoms:_____
   _____
   b. Objective findings: _____
   _____
   c. Treatment date: _____ If pregnancy, indicate: ☐ Normal delivery ☐ Caesarean section
   d. If disability is a result of pregnancy, give approximate date of conception: _____ Date of delivery: _____
5. Was member hospitalized? ☐ No ☐ Yes If "yes," for the period of _____to _____.
   Name of hospital:_____
6. Was surgery performed? ☐ No ☐ Yes If "yes," a. Type of surgery:_____ b. Date of surgery:_____
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 (estimate an approximate date)			

(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? ☐ No ☐ Yes
   If "yes," has form C-4/48 been filed with the Workers' Compensation Board? ☐ No ☐ Yes
   Remarks (attach additional sheet, if necessary): _____
9. I affirm that I am a (for example: physician, podiatrist, chiropractor, dentist, nurse-midwife, psychologist, etc.): _____
   Licensed in the State of _____ License #: _____
   Specialty: _____ WCB rating #: _____
   Healthcare provider's signature **X** _____ Date: _____
   Healthcare provider's full name (please print): _____
   Office address: _____
   City:_____ State: _____ Zip code:_____
   Office phone:_____
   Must be furnished under authority of law — individual practitioner's Social Security #: _____
   All other T.I.N.: _____

Report of Services

Date of Service	Place of Service	Description of Service Rendered	Procedure ICD-10/ CPT-4	Charge
			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: _____

1199SEIU National Benefit Fund

498 Seventh Avenue, New York, NY 10018-0009 • Tel: (646) 473-9200 • Outside NYC Area Codes: (800) 575-7771
Email: DBLClaims@1199Funds.org • www.1199SEIUBenefits.org

PART C: EMPLOYER'S STATEMENT

Member: Please complete the following four (4) lines. **(Please print in black or blue ink.)**

Date: _____

Member's full name: _____

Member's ID #: _____

Date disability began: _____

DISCLOSURE OF INFORMATION: The Worker's Compensation Board (WCB) 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.wcb.ny.gov/content/main/forms/AllForms.jsp. Mail the completed authorization form or letter to the address given on Form OC-110A.

HIPAA NOTICE: In order to adjudicate as a Workers' Compensation claim, WCL 13-a(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 (your employee) is in the process of filing a claim for disability benefits with the 1199SEIU National Benefit Fund. Since you are the member's present employer, you are required by the Union contract and the Trustees of the 1199SEIU National Benefit Fund to promptly complete the "Employer's Statement" below and return the completed form to the employee.

EMPLOYER'S STATEMENT (TO BE COMPLETED BY THE EMPLOYER. PLEASE PRINT IN BLACK OR BLUE INK.)

1. Date employee was employed: _____ Employee's regular weekly wage: $_____
2. Date employee last worked (before disability): _____
   a. Full sick pay received (not the ⅓ sick pay provided in the Union contract), for the period of_____to _____.
   b. Vacation pay received, for the period of _____to _____. Number of days of sick pay received: _____
3. Has employee returned to work? ☐ No ☐ Yes If "yes," date of return: _____
4. Is this claim covered by Workers' Compensation? ☐ No ☐ Yes
5. Full name of employer (please give correct business name): _____
6. Authorized signature **X** _____ Date: _____
7. Job title: _____ Business phone: _____
8. Weekly Wages: List the employee's gross earnings during each of the last eight (8) calendar weeks prior to the 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

1199SEIU Benefit and Pension Funds

498 Seventh Avenue • New York, NY 10018-0009 • Tel: (646) 473-6710 • Fax: (646) 473-6768 • www.1199SEIUBenefits.org

Direct Electronic Deposit Authorization for Disability Benefits

(Please allow a minimum of two (2) weeks for this authorization to be processed.)

Please note that a new authorization is required for each new (unique) disability claim.

Please print clearly in black or blue ink, or complete online. **Remember to sign and date this form or it will not be valid.**

MEMBER'S FULL NAME _____ MEMBER ID # _____

MEMBER'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MEMBER'S PREFERRED PHONE _____ MEMBER'S SOCIAL SECURITY # _____

Election of Direct Deposit – you must sign and date this form to make <u>any</u> change *(choose one)*:

- ☐ New disability benefits direct deposit
- ☐ Change from my current financial institution to the financial institution listed below
- ☐ I am staying with my financial institution, but my account information has changed
- ☐ Cancel my direct deposit and send my checks to my home address listed above

For direct deposit into a checking account: Requires a voided check with the account holder's name pre-printed on the check; a stamp from the financial institution on this form; or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.

For direct deposit into a savings account: Requires a stamp from the financial institution on this form or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.

For banks in foreign countries or banks that do not accept direct deposit: Your check will be mailed directly to your home address.

Fill out this section to begin or change your direct deposit. If you are canceling your direct deposit, leave this section blank.

Type of account ***(choose one):*** ☐ Savings ☐ Checking _____ EFFECTIVE DATE (MM/DD/YYYY)

ROUTING # **(9 DIGITS)** _____ ACCOUNT # _____

NAME OF FINANCIAL INSTITUTION _____

ADDRESS OF FINANCIAL INSTITUTION _____ CITY _____ STATE _____ ZIP CODE _____

X _____
FINANCIAL INSTITUTION'S AUTHORIZING SIGNATURE **(REQUIRED)**

Financial Institution Stamp Below

Until further written notice from me, I hereby authorize the 1199SEIU Benefit and Pension Funds ("the Funds") to: (a) deposit my disability payment amount in my account, chosen above; and (b) make adjustments and have my account charged for any erroneous credits or other amounts to which I am not entitled. I further understand that should I close or change this account, I must give a new completed form to the Disability Department at least two (2) weeks before the disability direct deposit is to be terminated. I understand that direct deposit is a completely voluntary service provided by the Funds for my convenience, and that it can be terminated by the Funds or by me at any time. Because the wrong number can lead to my disability payment being sent to the wrong person's account, I understand that I must ensure my account type, account number and routing number are all correct.

X _____
MEMBER'S SIGNATURE **(REQUIRED)** DATE (MM/DD/YYYY) **(REQUIRED)**