1199SEIU Benefit Funds

498 SEVENTH AVENUE • NEW YORK, NY 10018-0009 • Tel: (646) 473-6710 • Fax: (646) 473-6768 • www.1199SEIUBenefits.org • 1199SEIUBenefitFunds

NOTICE OF TOTAL OR PARTIAL REJECTION OF CLAIM FOR DISABILITY BENEFITS

THIS FORM MUST BE USED BY SELF-INSURED EMPLOYERS, UNIONS OR ASSOCIATIONS AND INSURANCE CARRIERS TO REJECT ALL OR PART OF A CLAIM FOR DISABILITY BENEFITS. This notice is to be mailed to the claimant within 45 days of receipt of claim by employer or carrier (whichever is earlier), to give the claimant opportunity of filing the notice with the Chair, Workers' Compensation Board for the purpose of review. IMPORTANT: Check each item for which claim is being rejected. Box 4, 6 and 8 require Box 9 be completed. An incomplete rejection will be considered invalid by the Board and carrier will be liable for payment.

Claimant	Date of this Notice		Social Security No.
	First Date of Disability	Carrier Claim/File No.	Return to Work Date (if known)
	Date Claim Rec'd by Employer		Date Claim Rec'd by Carrier
Employer	Address		
Policy Holder or Union (if different than Employer)	Address		
Benefits paid on this claim prior to the date of this notice ☐ None ☐ From _____ To _____ Amount per Week ($) _____			

You are hereby notified that your claim for disability benefits is rejected for the reason(s) checked below:

☐ 1. Payment of benefits is rejected after _____ the date you could return to work according to medical evidence on file. If you were still disabled after that date, submit additional medical evidence immediately.

☐ 2. Notice and proof of disability was not furnished within 30 days (see dates above) after disability began. (See Item 4 on reverse).

- ☐ (A) No benefits payable.
- ☐ (B) Payments are being made beginning 2 weeks prior to the date your claim was received. Benefits are payable from _____

☐ 3. We are not your last employer's Disability Benefits Insurance carrier.

- ☐ (A) Your claim has been forwarded to: _____
- ☐ (B) Your claim is returned herewith. We suggest you contact your employer to obtain the proper carrier or forward it to the Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029, if no carrier can be located.

☐ 4. Your record of employment is not sufficient to establish your eligibility for disability benefits. COMPLETE ITEM 9

☐ 5. Your disability began more than 4 weeks after your employment terminated. Your claim, together with copies of this notice and our related records, is being forwarded to the Workers' Compensation Board, Special Fund for Disability Benefits, for consideration.

☐ 6. You have received either 26 weeks of benefits, the maximum payable during a period of 52 consecutive weeks or for any one disability; or you have received the maximum payable under a Disability Benefits plan filed with the Workers' Compensation Board. COMPLETE ITEM 9

☐ 7. Your disability arose out of and in the course of your employment. We suggest you notify your employer and obtain a claim for Workers' Compensation (Form C-3) from the nearest Workers' Compensation Board Office.

☐ 8. Other - COMPLETE ITEM 9

9.Explanation

X SIGNATURE TITLE TELEPHONE NUMBER AND EXTENSION

TO CLAIMANT: READ IMPORTANT INSTRUCTIONS FOR REQUESTING REVIEW ON REVERSE SIDE.

DB-451 • 11/23 • NYS NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT'S REQUEST FOR REVIEW

INSTRUCTIONS TO CLAIMANT:

1. If you do not agree with this rejection of your claim, complete the below statement and mail BOTH sides of this form PROMPTLY to the below address. You must file your Request for Review within 26 weeks of the date of this notice.
2. Give SPECIFIC reasons for requesting a review for each item of rejection checked on the face of this form.
3. Attach any medical, employment and/or other evidence which you feel will support your request for review.
4. You may request the late filing be excused by the Chair, Workers' Compensation Board, if it was not reasonably possible to file within 30 days after disability began and filing was done as soon as possible EXCEPT when the claim was not filed within the period of disability.

MAIL TO:

WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
PO BOX 9029
ENDICOTT, NY 13761-9029

I acknowledge receipt of Notice of Rejection of my claim for Disability Benefits. I hereby request a review of the rejection of such claim for the following reasons (give complete details).

_____

_____

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_____

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_____

_____

_____

TITLE TELEPHONE NUMBER AND EXTENSION

X _____
CLAIMANT'S SIGNATURE DATE

If you need help reading this important document please call the Workers' Compensation Board's toll-free number:**1-877-632-4996**.