

**NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS**

**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-30 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**

1. My name is ..... Social Security Number  
First Middle Last [ ][ ][ ] [ ][ ] [ ][ ][ ][ ][ ]
2. Address.....  
Number Street City or Town State Zip Code Apt. No.
3. Tel. No..... 4. Date of Birth..... 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 ..... a. I worked on that day  Yes  No  
Month Day Year
- 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 ..... to .....  
Date 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 ..... To .....  
Date 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 know edge true and comp etc

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELEIF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMAT ON CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATER AL FACT SHALL BE GU LTY OF A CR ME AND SUBJECT TO SUBSTANT AL F NES AND MPR SONMENT.

Claim signed on .....  
Date Claimant's Signature Claimant's Email Address

If signed by other than claimant, print below: name, address, and relationship of representative.

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 an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Worker's 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 authorization form or letter to the address given below.

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 12241-0005	SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPICIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A : WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005
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