SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
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New York State
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Use this form if you became disabled **while employed** or if you became disabled **within four (4) weeks after termination of employment** OR if you became **disabled after having been unemployed for more than four (4) weeks.** Please answer all questions in Part A and questions 1 through 3 in Part B. Read all instructions on this form carefully. Health care providers must complete Part B on page 2.

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: _____ First Name: _____ MI: _____
2. Mailing Address: _____ Line 2: _____
   City: _____ State: _____ Zip: _____ Country: _____
3. Daytime Phone #: _____ 4. Email Address: _____
5. Social Security #: _____ 6. Date of Birth: _____ 7. Gender: ☐ Male ☐ Female
8. My disability is (if injury, also state how, when and where it occurred): _____
   _____
9. I became disabled or became ineligible for Unemployment Insurance because of this disability on: _____
   I worked on that day: ☐ Yes ☐ No
   Have you recovered from this disability? ☐ Yes ☐ No If Yes, what was the date you were able to work: _____
   Have you since worked for wages or profit? ☐ Yes ☐ No If Yes, list dates: _____
10. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Compensation, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo Day Yr	Mo Day Yr	
OTHER EMPLOYER (during last eight (8) weeks			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Compensation, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo Day Yr	Mo Day Yr	
			Mo Day Yr	Mo Day Yr	

11. My job is or was: _____ (Occupation). 12. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)
13. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No
    If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits after LAST DAY WORKED, explain reasons fully:
    _____
    _____
14. For the period of disability covered by this claim:
    A. Are you **receiving** wages, salary or separation pay: ☐ Yes ☐ No
    B. Are **receiving** or **claiming**:
       1. Workers' Compensation for work-connected disability: ☐ Yes ☐ No
       2. Paid Family Leave: ☐ Yes ☐ No
       3. No-Fault motor vehicle accident (check box): ☐ Yes ☐ No or personal injury involving third party (check box): ☐ Yes ☐ No
       4. Long-term disability benefits under the Federal Social Security Act for this disability: ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 14, COMPLETE THE FOLLOWING:

I have: ☐ received ☐ claimed from: _____ for the period _____ to: _____

15. In the year (52 weeks) **before** your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If "Yes", fill in the following: Paid by: _____ from: _____ to: _____
16. In the year (52 weeks) **before** your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If "Yes", filling in the following: Paid by: _____ from: _____ to: _____

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. If my disability began while I was unemployed, I certify that I had been unemployed for more than four (4) weeks. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's Signature **Date**

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of Claimant **Address** **Relationship to Claimant**

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 9. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name: _____ First Name:_____ MI:_____
2. Gender: ☐ Male ☐ Female 3. Date of Birth: _____
4. Diagnosis/Analysis:_____ Diagnosis Code: _____
   a. Claimant's symptoms: _____
   _____
   b. Objective findings:_____
   _____
5. Claimant hospitalized? ☐ Yes ☐ No From: _____ To:_____
6. Operation indicated? ☐ Yes ☐ No a. Type _____ b. Date _____

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 Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
   ☐ Yes ☐ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

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.

I certify that I am a:

_____ (Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife)
_____ Licensed or Certified in the State of
_____ License Number

_____ Health Care Provider's Printed Name
_____ Health Care Provider's Signature
_____ Date

_____ Health Care Provider's Address
_____ Phone #

HIPAA NOTICE – In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a (4) (a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance 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.

PART C - EMPLOYER STATEMENT

1. Employee's Name _____ DB Policy Number _____
2. Is this claimant now employed? ☐ Yes ☐ No Date Hired_____ ☐ Full Time ☐ Part Time
3. Total salary or wages paid (including vacation pay) for the eight week period immediately preceding disability_____
   _____
4. Did the employee work at least one day in each week of this eight week period? ☐ Yes ☐ No If answer is no, give number of weeks in which employee did NOT work at least one day. (Paid vacations count as time worked)_____
5. Indicate last day employee worked. Month _____ Day_____ Year_____ Reason for cessation of employment. Please explain _____
6. Are wages being paid to employee during disability? ☐ Yes ☐ No
7. If you are paying wages during disability, do you request reimbursement? ☐ Yes ☐ No If answer is yes, have you deducted the employee portion of Social Security Tax (FICA)? ☐ Yes ☐ No
8. Is this employee eligible to receive benefits under another policy or plan accepted by the Chairman of the Workers' Compensation Board? ☐ Yes ☐ No
9. Is this claimant an ☐ employee ☐ owner ☐ co-owner ☐ partner or ☐ proprietor? (Check One)
10. When did, or do you expect, this employee to resume work? Month_____ Day_____ Year_____
11. Employee's usual workdays ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.
12. What is the name of your Workers' Compensation Carrier? _____
13. Was the claim reported to your Workers' Compensation Carrier? ☐ Yes ☐ No
14. Percentage of premium paid by employer _____%. (If unanswered, we will assume 100% employer contribution.)

Name of Employer _____ Telephone No._____

Date _____ By _____ Title _____