

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED **WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT.** OTHERWISE USE CLAIM FORM DB-300.

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type) THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM **MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS** OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name 2. Date of Birth 3. Sex Male Female
 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:
 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 be able to perform usual work

Month	Day	Year

(Even if considerable question exists, 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 employment or occupational disease? Yes No
 If yes, has form C-4 been filed with the Workers' Compensation Board? Yes No
 Remarks (attach additional sheet, if necessary)

(If disability is pregnancy related, please enter estimated delivery

I affirm that <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Licensed in the State of	License Number
I am a <input type="checkbox"/> Dentist <input type="checkbox"/> Podiatrist <input type="checkbox"/> Nurse-Midwife		

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.

Health Care Provider's SignatureDate
 Health Care Provider's Name (Please Print)Tel.No.
 Office Address
 Number Street City or Town State Zip

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-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 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.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

PART C – EMPLOYER'S STATEMENT If employee contribution is withheld, indicate taxable% (employer portion) for FICA deductions=_____%

1. Employee's Name _____ SS# _____
2. Address _____ Occupation _____
3. Date Employed _____ F/T P/T **Check usual days worked:** MON TUES. WED. THURS. FRI. SAT. SUN.
4. Is Claimant employee member owner partner independent contractor high school student employer's spouse
5. Date employee last worked..... _____
6. Date employee returned to work..... _____
7. Date employee's wages ceased, or will cease..... _____
8. Are wages being continued during disability? Yes No
9. If yes, is reimbursement requested? Yes No
10. On what date did you receive the completed claim form? _____
11. Did the disability occur as a result of employment? Yes No
12. Name and address of your Compensation carriers

13. Is employee a member of a union that provides NY Disability? Yes No
14. Do you expect to rehire?..... Yes No
15. If employee is no longer in your employ, check reason:
 Labor dispute Lack of work Fired Quit
16. Has the claimant received UI benefits? Yes – dates _____ No

IMPORTANT: To determine weekly benefit payable, indicate earnings 8 weeks prior to disability; include weekly value of board, lodging, tips and allowances

MONTH	DAY	YEAR	# DAYS	GROSS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				\$

Employer's federal tax ID # _____

Policy # WDL – _____

Employer _____
Address _____

Signed by _____ Title _____ Date _____ Telephone _____

SEND COMPLETED FORM TO ► AmTrust North America, PO Box 980 at Bowling Green Station, New York, NY 10274 OR FAX 800.584.9303
For inquiries call 1.800.535.2710