**NIAGARA COUNTY**
**HUMAN RESOURCES DEPARTMENT**
GOLDEN TRIANGLE OFFICE BLDG.
111 MAIN STREET, GROUND LEVEL
LOCKPORT, NEW YORK 14094

*Peter P. Lopes*
Director
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# Memorandum

To: CSEA Union covered employee or Non Union Hourly Employee

From: Peter P. Lopes PPL

Date: July 28, 2016

Subj: Disability Insurance Program for CSEA and Non Union Hourly Employees

As a CSEA Union covered employee or Non Union Hourly Employee, you may be entitled to Disability Benefits if you are unable to work because of a non-occupational illness or injury (including disability due to pregnancy). In order to claim benefits under this program you are required to complete the attached form and submit to the Risk Management Office within 30 days from the first day of your disability. Benefits are determined based on eligibility requirements being met and are available for up to a total of 26 weeks in any 52 week period. Under this program, eligible employees will receive 50% of their gross pay up to a maximum of $170 per week for **up to** 26 weeks.

If you have any questions regarding this program you may contact this office at 438-4072 or the Risk Management Office at 438-4081.

Guardian

# NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

**State Disability Claims**
**P.O. Box 14332**
**Lexington, KY 40512**
**Telephone#1-800-268-2525**
**Fax# 610-807-2953**

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-300 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 can not sign this form, your representative may sign it on 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 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. Name: (First, Middle, Last) | | Policy #: | | Social Security #: | |
|---|---|---|---|---|---|
| 2. Address: | Apt. # | City | | State | Zip Code |
| 3. Telephone #: | 4. Date of Birth: | | 5. Married (Check one): ☐ Yes ☐ No<br>5a. ☐ Male ☐ Female | | |

6. My disability is (if injury, also state **how**, **when** and **where** it occurred)

7. I became disabled on / / (Mo. Day Year) — 7a. I worked on that day ☐ Yes ☐ No

7b. 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 last eight (8) weeks, name **ALL** employers.

| EMPLOYERS | | | Dates of Employment | | Average Weekly Wages (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, Etc.) |
|---|---|---|---|---|---|
| | | | From | Through | |
| Business Name | Business Address | Telephone No. | Mo. Day Yr. | Mo. Day Yr. | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

9. My job is or was (**Occupation**) — Name of Union and Local No., 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 .

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

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 knowledge true and complete.

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.

| Claim signed on: Date | Claimant's Signature |
|---|---|

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

**Disclosure of Information:** The Board does 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 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 you may download it from our web page, www.wcb.ny.gov/ It can be found under the heading Common Forms Online. Mail the completed form or letter to the address given below.

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, N.Y. 12241-0005.

SI TIENE DUDASRELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA 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, N.Y. 12241-0005.



After Parts A, B, & C are completed, Mail to: Guardian – State Disability Claims – P.O. Box 14332 Lexington KY 40512 or Fax: 610-807-2953
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

**NOTICE OF 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 the green 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 the approximate date. Make some estimate. If the Disability was caused by or arose in connection with pregnancy, enter the estimated delivery date under "Remarks."

1. Claimant's Name: (First, Middle, Last) | 2. Date of Birth | 3. Sex ☐ Male ☐ Female

4. Diagnosis/Analysis: ICD
   a. Claimant's Symptoms:
   b. Objective Findings/Treatment Plan:
   c. If Disability is pregnancy related, enter DELIVERY DATE ☐ Estimated ☐ Actual ☐ Vaginal ☐ C-Section

5. Claimant Hospitalized? ☐ YES ☐ NO Date: From To

6. Operation Indicated? ☐ YES ☐ NO a. Type b. Date c. CPT

7. Enter Dates for the Following:

| | Mo. | 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 be able to perform usual work** ** | | | |

** 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 the course of employment or occupational disease? ☐ Yes ☐ No
   a. If yes, has Form C-4 been filed with the Workers Compensation Board? ☐ Yes ☐ No

Remarks:

I affirm that I am a ☐ Chiropractor ☐ Dentist ☐ Physician ☐ Podiatrist ☐ Psychologist ☐ Nurse-Midwife | Licensed in the State of: | Licensed #:

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 Signature: | Date:

Health Care Provider's Name (Please Print) | Phone #:

Office Address (Number, street, Apt./Suite, City/Town, State, Zip Code)

HIPAA NOTICE - In order to adjudicate a worker's compensation claim, WCL 13-8 (4) (a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports or treatment with the Board and the carrier or employer. Pursuant to 45 CFR 184.512 these legally required medical reports are exempt from HIPAA'S restrictions on disclosure of health information.

**Part C – EMPLOYER'S STATEMENT**

1. Employee's Name | 2. Social Security #:

3. Employee's Address | Apt. #. | City | State | Zip

4. Employee's occupation | 5. Date of Hire | 6. Status: ☐ Full Time ☐ Part Time

7. Is the Claimant an: ☐ Owner ☐ Officer ☐ Partner ☐ Employee ☐ High School Student

8. Indicate the Employee's normal work schedule: ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9. If the employee is no longer employed, explain why: ☐ Quit? ☐ Discharged? ☐ Labor Dispute? ☐ Lack of Work
   If Quit or Discharged, explain why: . Do you expect to rehire him/her? ☐ Yes ☐ No

10. Date Employee last worked:
11. Date Employee's Wages Ceased:
12. Date Employee Returned to Work:
13. Are Wages being Continued during Disability? ☐ Yes ☐ No
14. If YES, are you requesting reimbursement? ☐ Yes ☐ No
15. Is Employee receiving or claiming Unemployment Ins.? ☐ Yes ☐ No
16. Is Employee receiving or claiming Workers' Comp. Ins.? ☐ Yes ☐ No
17. Did this Disability occur as a result of employment? ☐ Yes ☐ No
18. Is employee in a Union providing Disability Benefits? ☐ Yes ☐ No
19. Are you aware of other employment claimant may have? ☐ Yes ☐ No
20. Did employee receive PAID SICK TIME during disability? ☐ Yes ☐ No
    If YES, provide dates of paid sick time: From: To:

**Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)**

| | Week Ending Month Day Year | No. of Days Worked | GROSS WEEKLY WAGES |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| | | **TOTAL** | |

**EMPLOYER INFORMATION** | Policy #: | Tax ID #: | Date:

Employer Name: | Division #: | Phone # | Fax #:

Address: | E-mail:

Signature: | Print Name: | Title:

DB-450 (Rev. 12/17)

After Parts A, B, & C are completed, Mail to: Guardian – State Disability Claims – P.O. Box 14332 Lexington, KY 40512 or Fax: 610-807-2953
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