1199SEIU Benefit and Pension Funds

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

NEW YORK STATE NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Read instructions on page 3 and 4 carefully to avoid a delay in processing. You must answer all questions in Part A and provide your full name, date of birth and gender in Part B. Healthcare providers must complete Part B on page 3.

PART A: CLAIMANT'S STATEMENT (PLEASE PRINT OR TYPE)

SERVICE PROVIDER INFORMATION

MEMBER'S FULL NAME

DAYTIME PHONE | EMAIL ADDRESS

ADDRESS | APT./SUITE # | CITY | STATE | ZIP CODE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

Gender: ☐ M ☐ F ☐ X

1. Describe your disability (if injury, also state how, when and where it occurred): _____

2. Date you became disabled: _____ Did you work on that day? ☐ No ☐ Yes

   a. Have you recovered from this disability? ☐ No ☐ Yes If "yes," date you were able to return to work: _____

   b. Have you since worked for wages or profit? ☐ No ☐ Yes If "yes," list dates: _____

3. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

Employer			Dates of Employment		Average Weekly Wages (include business, tips, commissions, reasonable value of board, rent, etc.)
Firm or Trade Name	Address	Telephone No.	From Mo./Day/Yr.	Through Mo./Day/Yr.	

4. My job title is or was: _____

5. Union member: ☐ No ☐ Yes If "yes," name of union or local number: _____

6. Were you claiming or receiving unemployment prior to this disability? ☐ No ☐ Yes

   If you did not claim or if you claimed but did not receive unemployment insurance benefits after last day worked, explain reasons fully: _____

   If you did receive unemployment benefits, provide all periods collected: _____

7. For the period of disability covered by this claim: a. Are you receiving wages, salary or separation pay? ☐ No ☐ Yes

   b. Are you receiving or claiming:

   1. Unemployment benefits? ☐ No ☐ Yes
   2. Paid Family Leave? ☐ No ☐ Yes
   3. Worker's compensation for work-connected disability? ☐ No ☐ Yes
   4. No-fault motor vehicle accident? ☐ No ☐ Yes or personal injury involving third party? ☐ No ☐ Yes
   5. Long-term disability benefits under the Federal Social Security Act for this disability? ☐ No ☐ Yes

   If "yes," is checked in any of the items in 7, complete the following:
   I have ☐ received ☐ claimed from _____ , for the period of _____ to _____

8. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ No ☐ Yes
   If "yes," fill in the following: I have been paid by _____, for the period of _____ to _____.

9. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ No ☐ Yes

If “yes,” fill in the following: I have been paid by _____, for the period of _____ to _____.

10. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ No ☐ Yes

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 3 and 4 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

X _____

CLAIMANT'S SIGNATURE DATE (MM/DD/YYYY)

An individual may sign on behalf of the claimant only if they are 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.

_____

FULL NAME RELATIONSHIP

_____

ADDRESS APT./SUITE # CITY STATE ZIP CODE

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PART B: HEALTHCARE PROVIDER'S STATEMENT

THE HEALTHCARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTHCARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 4(d), you must give an estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 4(e). **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

_____ Gender: ☐ M ☐ F ☐ X

MEMBER'S FULL NAME DATE OF BIRTH

1. Diagnosis/Analysis: _____ Diagnosis Code: _____

   a. Claimant's symptoms: _____

   _____

   b. Objective findings: _____

   _____

2. Claimant hospitalized? ☐ No ☐ Yes If "yes," for the period of _____ to _____ .

3. Operation indicated? ☐ No ☐ Yes a. Type of surgery: _____ b. Date of surgery: _____

4. 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 member was unable to work because of this disability			
d. Date member 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			

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

   I certify that I am a (physician, podiatrist, chiropractor, dentist, podiatrist, nurse-midwife): _____

_____

LICENSED IN THE STATE OF LICENSE #

_____

HEALTHCARE PROVIDER'S FULL NAME (PLEASE PRINT)

X _____

HEALTHCARE PROVIDER'S SIGNATURE DATE (MM/DD/YYYY)

_____

HEALTHCARE PROVIDER'S ADDRESS CITY STATE ZIP CODE

_____

PHONE

IMPORTANT NOTICE TO CLAIMANT - READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment,** your completed claim should be mailed **within thirty (30) days of your first date of disability to your employer or your last employer's insurance carrier.** You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029.** If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your Social Security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

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.

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 part, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (www.wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the Internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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PART C: EMPLOYER'S STATEMENT

Member: Please complete the following two (2) lines. **(Please print in black or blue ink.)**

DATE MEMBER'S FULL NAME MEMBER'S ID#

DATE DISABILITY BEGAN

ATTENTION: PAYROLL DEPARTMENT

The above member (your employee) is in the process of filing a claim for disability benefits with the 1199SEIU National Benefit Fund. Since you are the member's present employer, you are required by the Union contract and the Trustees of the 1199SEIU National Benefit Fund to promptly complete the "Employer's Statement" below and return the completed form to the employee.

EMPLOYER'S STATEMENT (TO BE COMPLETED BY THE EMPLOYER. PLEASE PRINT IN BLACK OR BLUE INK.)

1. Date employee was employed: _____ Employee's regular weekly wage: $_____
2. Date employee last worked (before disability): _____
   a. Full sick pay received (not the ⅓ sick pay provided in the Union contract), for the period of_____to _____.
   b. Vacation pay received, for the period of _____to _____. Number of days of sick pay received: _____
3. Has employee returned to work? ☐ No ☐ Yes If "yes," date of return: _____
4. Is this claim covered by Workers' Compensation? ☐ No ☐ Yes
5. Full name of employer (please give correct business name): _____
6. Authorized signature **X** _____ Date: _____
7. Job title: _____ Business phone: _____
8. Weekly Wages: List the employee's gross earnings during each of the last eight (8) calendar weeks prior to the week in which disability began.

Month	Week Ending Day	Year	Number of Days Worked	Amount
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
			Total	$

Please use the reverse side if you need additional space

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Direct Electronic Deposit Authorization for Disability Benefits

(Please allow a minimum of two (2) weeks for this authorization to be processed.)

Please note that a new authorization is required for each new (unique) disability claim.

Please print clearly in black or blue ink, or complete online. **Remember to sign and date this form or it will not be valid.**

MEMBER'S FULL NAME _____ MEMBER ID # _____

MEMBER'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MEMBER'S PREFERRED PHONE _____ MEMBER'S SOCIAL SECURITY # _____

Election of Direct Deposit – you must sign and date this form to make <u>any</u> change *(choose one)*:

- ☐ New disability benefits direct deposit
- ☐ Change from my current financial institution to the financial institution listed below
- ☐ I am staying with my financial institution, but my account information has changed
- ☐ Cancel my direct deposit and send my checks to my home address listed above

For direct deposit into a checking account: Requires a voided check with the account holder's name pre-printed on the check; a stamp from the financial institution on this form; or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.

For direct deposit into a savings account: Requires a stamp from the financial institution on this form or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.

For banks in foreign countries or banks that do not accept direct deposit: Your check will be mailed directly to your home address.

Fill out this section to begin or change your direct deposit. If you are canceling your direct deposit, leave this section blank.

Type of account ***(choose one):*** ☐ Savings ☐ Checking _____ EFFECTIVE DATE (MM/DD/YYYY)

ROUTING # **(9 DIGITS)** _____ ACCOUNT # _____

NAME OF FINANCIAL INSTITUTION _____

ADDRESS OF FINANCIAL INSTITUTION _____ CITY _____ STATE _____ ZIP CODE _____

X _____

FINANCIAL INSTITUTION'S AUTHORIZING SIGNATURE **(REQUIRED)**

Financial Institution Stamp Below

Until further written notice from me, I hereby authorize the 1199SEIU Benefit and Pension Funds ("the Funds") to: (a) deposit my disability payment amount in my account, chosen above; and (b) make adjustments and have my account charged for any erroneous credits or other amounts to which I am not entitled. I further understand that should I close or change this account, I must give a new completed form to the Disability Department at least two (2) weeks before the disability direct deposit is to be terminated. I understand that direct deposit is a completely voluntary service provided by the Funds for my convenience, and that it can be terminated by the Funds or by me at any time. Because the wrong number can lead to my disability payment being sent to the wrong person's account, I understand that I must ensure my account type, account number and routing number are all correct.

X _____

MEMBER'S SIGNATURE **(REQUIRED)** DATE (MM/DD/YYYY) **(REQUIRED)**