Renaissance
DENTAL • VISION • LIFE • DISABILITY

New York State
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

How to request Disability Benefits

Do not submit this form prior to your first date of disability. You must submit your completed claim form within 30 calendar days of your first day of disability to avoid losing benefits. Keep a copy of all forms and documentations for your records.

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 submitted 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 after termination of employment**, 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.4., please complete and attach Form DB-450.1.

Note: This form has a section to be filled out by your healthcare provider, and a section to be completed by your employer. Before providing the form to your employer, fill out your section and make a copy to keep.

- The health care provider is required to return the form to you with Part B completed within seven days. If there is a delay, you must wait to submit the form to your insurance carrier. If Part B is not complete (or has incomplete answers) there may be delay in the payment of benefits.
- Your employer is required to return the form to you with Part C completed within three business days. If there is a delay, you do not have to wait to proceed – you should send the form to your insurance carrier. They cannot deny your request for disability benefits solely because your employer failed to fill out their section.

Important to know:

You will receive a response within 18 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later. If your claim is rejected, you will receive either a Notice of Denial of Claim for Disability Benefits (Form DB-DEN) or a Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451). If you receive a Form DB-DEN, you will receive a form DB-451 with additional information within 45 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later.

If you do not receive a response within 18 days (or the Form DB-451 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.

Notice and Proof of Claim for Disability Benefits (Form DB-450) Instructions

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

You must answer all questions in this part.

Question 9: Enter the best estimate of average gross weekly wage. Fill out the table using your gross wages from your last employer prior to disability. If you had more than one employer in the previous 8 weeks prior to your disability, include all wage information from those employer(s) as well.

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the first day of disability, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If you received bonuses and/or commissions during the 52 weeks preceding the first day of disability, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

PART B - HEALTH CARE PROVIDER'S STATEMENT (to be completed by the health care provider)

The health care provider must fill in this statement completely and return it within seven days of receipt of this form.

PART C - EMPLOYER INFORMATION (to be completed by the employer)

The employer must complete and return to the employee within three business days of receipt.

Question 6: If wages were continued during disability, specify how wages were paid – through salary continuation, use of paid time off, sick time, etc.

Question 8: Enter the wages earned by the employee during the last eight weeks preceding the first day of disability. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 9 in the Part A instructions). Calculate the gross average weekly wage by adding up the gross amounts paid, and then dividing the total by eight (or number of weeks worked if less than eight).

SEND COMPLETED FORM TO RENAISSANCE GROUP CLAIMS BY:

MAIL: PO Box 1596, Indianápolis, IN 46206
SECURE EMAIL: GroupClaims@RenaissanceFamily.com
SECURE FAX: 607-773-2276

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

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

1. Last Name: _____ First Name: _____ MI: ___

2. Mailing Address (Street & Apt. #): _____

City: _____ State: _____ Zip: _____

3. Daytime Phone #: _____ Email Address: _____

4. Social Security #: _____ - _____ - _____ 5. Date of Birth: ___ / ___ / _____ 6. Gender: ☐ M ☐ F ☐ X

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

_____

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

Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: ____ / ____ / _____

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

9. 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.

LAST EMPLOYER(S) PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		
Firm or Trade Name	**Address**	**Phone Number**	**First Day** (MM/DD/YYYY)	**Last Day Worked** (MM/DD/YYYY)	**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)

Enter total wages earned in the last 8 weeks prior to the first day of disability below (Include wages for all employers listed above)

Week No.	Last Day Worked (MM/DD/YYYY)	No. of Days Worked	Gross Amount Paid
1			
2			
3			
4			
5			
6			
7			
8			
		Calculated average gross weekly wage:	$0.00

10. My job is or was: _____ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)

12. 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: _____

_____

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

_____

DB-450 10-23

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

13. 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. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No

3. Workers' compensation for work-connected disability? ☐ Yes ☐ No

4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No

5. 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 13, COMPLETE THE FOLLOWING:

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

14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No

If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____

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

If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____

16. 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? ☐ Yes ☐ No

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I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions of this form and certify 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 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.

_____ _____ _____

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. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: _____ First Name: _____ MI: __

2. Gender: ☐ M ☐ F ☐ X 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 medical been filed with the Board? ☐ Yes ☐ No

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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 #**

PART C - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Business Name _____

Mailing Address _____

City, State _____

Zip Code _____

Country (if not U.S.A.) _____

2. Employer's FEIN: _____

3. Contact Information:

Employer's contact name for questions relating to disability: _____

Employer's contact telephone number: _____

Employer's contact email address: _____

4. Is the employee a member of a union that provides the statutory disability benefits? ☐ Yes ☐ No

*If yes, provide Union name, address, and contact information _____

_____

5. Employee Information:

Employee's role: ☐ Employee ☐ Proprietor ☐ Partner ☐ Spouse of Employer ☐ Owner ☐ Co-Owner

Employee's date of hire (MM/DD/YYYY): _____

Date employee last worked: _____

Date employee returned to work (if applicable): _____

6. Were wages continued during disability? ☐ Yes ☐ No

If yes, what type? (PTO, sick time, other): _____

If yes, is reimbursement requested by employer? ☐ Yes ☐ No

*Reimbursement is only available if employer continued salary during disability or employee used sick time

7. Is the employee's disability work-related? ☐ Yes ☐ No

8. Enter the last 8 weeks of gross wages for the employee immediately prior to the disability starting with the week the disability began, and calculate the average gross weekly wage (include bonuses, tips, commissions, reasonable value of board, rent, etc. and see instructions for more information)

Week No.	Week ending date (MM/DD/YYYY)	No. of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
		Calculated average gross weekly wage:	$0.00

9. In the preceding 52 weeks has the employee taken leave for:

☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

Disability: Please provide specific dates for disability _____

PFL: Please provide specific dates for PFL _____

10. Is employee still in your employment? ☐ Yes ☐ No

If no, date employment was terminated: _____

11. If employee received unemployment benefits, date the benefit was last received: _____

PART C - EMPLOYER INFORMATION (to be completed by the employer)

I have read and acknowledge the fraud information below and affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____

Employer Signature: _____

Employer Contact Phone Number: _____

Date: _____

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 party, 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. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

FRAUD ACKNOWLEDGEMENT - 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.

FILING YOUR FORM

SEND COMPLETED FORM TO RENAISSANCE GROUP CLAIMS BY:

- **MAIL:** PO Box 1596, Indianápolis, IN 46206
- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX:** 607-773-2276