TheStandard®

The Standard Life Insurance Company of New York
800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602

Local 282 Welfare Trust Fund
New York State Disability Claim

Your New York State Disability Benefit Claim

This packet contains the forms that will help us to process your claim for New York State Disability Benefits. **Please save a copy of this material for your future reference.** For specific information about your New York State Disability Benefits coverage, please contact your employer's benefits administrator or call The Standard Life Insurance Company of New York's (The Standard) customer service line at 800.426.4332.

Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive may reduce the amount of New York State Disability Benefits due you. These benefits may include, but are not limited to, unemployment compensation, Workers' Compensation, and Social Security Disability. To avoid a possible overpayment of your claim, please inform The Standard if you receive other benefits.

Tax Withholding

Generally, the portion of your benefits subject to federal taxes, state taxes and city taxes (if applicable), is the percentage of premium paid by your employer.

When You Return To Work

Your disability benefits usually stop when you return to work. **Be sure that you or your employer notify The Standard immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

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).

Reset

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:	

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: _____

_____

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

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

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:	

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.

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Authorization to Obtain and Release Information

Employer/Policyholder Name **Local 282 Welfare Trust Fund** Group Policy Number **756303**

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 8. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Claim Number _____

Social Security No. _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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Employer/Policyholder Name **Local 282 Welfare Trust Fund** Group Policy Number **756303**

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

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