TheStandard®

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

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 customer service line at 800.426.4332.

How To Apply For Benefits

- The New York State Disability Benefits application consists of the DB-450 form. This is the only form that is required as part of your application for New York State Disability Benefits. The two mandatory sections of this form are PART A – CLAIMANT'S STATEMENT and PART B – HEALTH CARE PROVIDER'S STATEMENT.
  1. You must complete and sign the section of the form called, PART A – CLAIMANT'S STATEMENT.
  2. Your treating physician must complete the section of the form called, PART B – HEALTH CARE PROVIDER'S STATEMENT.
- We would appreciate it if you would also have your employer complete PART C – EMPLOYER'S STATEMENT. This information will assist us in confirming your eligibility for the benefit and in determining the appropriate benefit level to which you may be eligible.
- Please sign and date the AUTHORIZATION TO OBTAIN INFORMATION form. This authorization allows us to request further information about your claim, if necessary.

Please send this information to The Standard Life Insurance Company of New York (The Standard) at the above address. Once we receive your completed claim application, it will take approximately one week to make a claim decision. If we have not reached a decision within one week, you will be notified with the details.

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.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

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 CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN 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 THIRTY (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

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

1. My name is ..... (First / Middle / Last)
2. Address ..... (Number / Street / City or Town / State / Zip Code / Apt. No.)
3. Tel. No ..... 4. Date of Birth ..... 5. Married (Check one) ❑ Yes ❑ No
6. My disability is (if injury, also state <u>how</u>, <u>when</u> and <u>where</u> it occurred) .....
   .....
7. I became disabled on ..... (Month / Day / Year) a. I worked on that day ❑ Yes ❑ No
   b. 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 the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was ..... (Occupation) ..... (Name of Union and Local Number, if Member)
10. For the period of disability covered by this claim
    a. Are you <u>receiving</u> wages, salary or separation pay: ..... ❑ Yes ❑ No
    b. Are you <u>receiving</u> or <u>claiming</u>:
       (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 ..... (Date) to ..... (Date)
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 ..... (Date) To ..... (Date)
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 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.

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 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, 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.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

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:

	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 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 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.)

					Licensed in the State of	License Number
I affirm that I am a	❑ Chiropractor	❑ Dentist	❑ Physician	❑ Podiatrist	❑ Psychologist	❑ 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 Signature ..... Date .....
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.

The Standard Life Insurance Company of New York

800.426.4332 Tel 800.378.8361 Fax
PO Box 5031 White Plains NY 10602-5031

New York State Disability Claim
Employer's Statement

Part C – Employer's Statement *Please print or type*

Employee's Full Name	Social Security No.	Job Title *Please attach a copy of the job description.*	1. Date Employed

2. Is employee insured for Statutory Disability benefits? ☐ Yes ☐ No
Effective Date _____

Is employee insured for Short Term Disability benefits? ☐ Yes ☐ No
Effective Date _____

Is employee insured for Long Term Disability benefits? ☐ Yes ☐ No
Effective Date _____

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined
Work Location
Address _____
State _____ ZIP _____

4. Has the employee filed for: Workers' Compensation ☐ Yes ☐ No
Other _____ ☐ Yes ☐ No
Weekly Amount _____

5. Has the employee had a claim for New York DBL benefits in the past 52 weeks? ☐ Yes ☐ No ☐ Unknown
If yes, please indicate the dates these benefits were paid _____

6. Employee's earnings 8 weeks prior to disability

Week Ending Month	Week Ending Day	Week Ending Year	No. Days Worked	Amount

Check days normally worked
☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

7. Last active day at work

8. Job status when disability began: ☐ Full-time (____ hours/week)
☐ Part-time (____ hours/week)

9. Date employee returned to work

10. Are wages being continued during disability? ☐ Yes ☐ No
If "Yes", does the employer request reimbursement? ☐ Yes ☐ No

11. Through what date are wages being continued? _____ Through what date is the employer requesting reimbursement? _____
Type of wages continued: ☐ Sick Pay ☐ Vacation Pay ☐ Salary Continuation ☐ Other _____

12. Is employee subject to:
Social security taxes? ☐ Yes ☐ No
Medicare taxes? ☐ Yes ☐ No

14. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)?
☐ Yes ☐ No

13. What percentage of the Statutory Disability premium does the employer pay? _____%
What percentage of the Short Term Disability premium does the employer pay? _____%
What percentage of the Long Term Disability premium does the employer pay? _____%
Has the percentage changed within the last three years for any of these coverages? ☐ Yes ☐ No
If Yes, please identify the affected coverages and the effective date(s) of changes.

Employer Name	Phone No.	Policy No.	
Mailing Address	**City**	**State**	**ZIP**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature _____ Date _____

Authorization to Obtain and Release Information

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 6. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ 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.

Authorization to Obtain and Release Information

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. The Standard Benefit Administrators performs claims administration services for Standard Insurance Company. 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.