STATEMENT OF RIGHTS
NEW YORK STATE DISABILITY BENEFITS

ANDREW M. CUOMO, Governor

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of disability benefits to his/her employees.

2. Statutory disability benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. The total amount of combined paid family and disability leave an employee may take in a 52 consecutive week period may not exceed 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.

3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or by contacting the Workers' Compensation Board. (See address and telephone number below.) **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**

4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.

5. Disability benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.

6. **If your employer or the insurance carrier contends that you are not entitled to the payment of disability benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact the Workers' Compensation Board at the telephone number below.

7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT**: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.

8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is:

STANDARD SECURITY LIFE INSURANCE
COMPANY OF NEW YORK
485 MADISON AVENUE
NEW YORK, NY 10022

Prescribed by the Chair,
Workers' Compensation Board

NYS Workers' Compensation Board PO Box 5205, Binghamton, NY 13902-5205
Customer Service: (877) 632-4996 www.wcb.ny.gov
THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

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 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 COMPLETE'S 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

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

1. NAME ______________________
First Middle Last

2. ADDRESS ______________________
Number Street City or Town State Zip Code Apartment Number

3. TEL# (______) ____________ **3a.** EMAIL ADDRESS ____________ **4.** Age ______ **5.** Married ☐ Yes ☐ No

6. My disability is (if injury, also state **HOW**, **WHEN**, and **WHERE** it occurred) ______________________

7. I became disabled on ______________________
Month Day Year

7a. I worked that day (Check one) ☐ Yes ☐ No

7b. I have since worked for wages or profit. ☐ Yes ☐ No If "Yes" give dates: ______________________

8. **GIVE NAME OF CURRENT/LAST EMPLOYER(S). IF YOU HAVE HAD MORE THAN ONE JOB IN THE LAST 8 WEEKS LIST ALL EMPLOYERS!**

EMPLOYERS

BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	Dates of Employment FROM Mo. Day Year	Dates of Employment THROUGH Mo. Day Year	Average Weekly Gross Wages (Include Bonuses, Tips, Commissions, Reasonable value of Board, Rent, Etc)

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 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 forgoing 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 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.ny.gov. 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 DUDASRELACIONADAS CON LA RECLA ACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUSE CON LA OFINCINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

Standard Security Life Insurance Company of New York P. O. Box 25339 Farmington, New York 14425

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.

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

4. Diagnosis / Analysis: ______ Diagnosis Code: ______

a. Claimant's Symptoms: ______

b. Objective Findings: ______

c. If Disability is **pregnancy** related, enter **ESTIMATED DELIVERY DATE** . ______

5. Claimant Hospitalized? ☐ Yes ☐ No Date 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 the 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 ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse-Midwife

Licensed in the State of: ______ **License Number:** ______

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 No. ______

Office Address: ______ (Number / Street / Apt/Suite / City/Town / State / Zip Code)

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL 13-8(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 184.512 these legally required medical reports are exempt from HIPAA's restrictions on discolsure of health information.

Part C - EMPLOYER'S STATEMENT

1. Employee's Name: ______ **2.** Soc.Sec. No: ☐☐☐ ☐☐ ☐☐☐☐

3. Employee's Address: ______ (Number / Street / Apartment Number / City / Town / State / Zip Code)

4. Employee's Occupation: ______ **5.** Date of Hire: ______ **6.** Status: ☐ Full Time ☐ Part Time

7. Is the Claimant an: ☐ Employee ☐ Owner ☐ High School Student **7a** Date of Birth: ______

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

9. If the employee is no longer in your employ, explain why: ☐ Quit ☐ Fired ☐ Laid Off ☐ Other (explain) ______

Do you expect to rehire him/her? ☐ Yes ☐ No

10. Date Employee last worked: ______

11. Date Employee Returned to Work: ______

12. Are you paying wages or sick time .... ☐ Yes ☐ No

a. If **YES**, time period paid ______

b. Are you requesting reimbursement for this time period?................ ☐ Yes ☐ No

13. Is Employee receiving or claiming Unemployment Ins? .... ☐ Yes ☐ No

14. Is Employee receiving or claiming Workers' Comp. Ins? .... ☐ Yes ☐ No

15. Did this Disability occur as a result of employment? .... ☐ Yes ☐ No

16. Is Employee in a Union providing **MONETARY DISABILITY BENEFITS?** ☐ Yes ☐ No

17. Are you aware of other employment claimant may have?............. ☐ Yes ☐ No

18. Has employee made a claim for Disability Benefits in the past 52 weeks? ☐ Yes ☐ No

19. TAXABLE PERCENTAGE__________%

Weekly Wages 8 Weeks prior to Last Day Worked Before Disability (include value of Board, Lodging, and Tips if any)

	Week Ending (Month / Day / Year)	No. of Days Worked	GROSS WEEKLY WAGES
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
TOTAL			

DISABILITY POLICY NUMBER: ______

EMPLOYER INFORMATION:

Employer Name: State Security Agency, LLC Employer Address: 70-21 Austin St., 3rd FL, Forrest Hills, NY 11375

Phone: 888-272-7630 Fax: 877-720-8701 E-mail: hr@statesecurityagency.net

Print Name: ______ Sign: ______ Title: ______ Date: ______

After Parts A, B, & C are COMPLETED, Do one of the following: SSLICNY Phone: 800-477-0087 or 585-398-2340

Mail to: SSLICNY DBL Claims, P.O. Box 25339 Farmington, NY 14425 or Fax to: 585-398-2854 or E-mail to: claims@sslicny.com

Authorization for Release of Personal Health-Related Information
This authorization complies with the HIPAA Privacy Rule

Name of proposed insured/patient (please print) ____________________ Date of birth ____________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other personal health information concerning me to Standard Security Life Insurance Company of New York and its affiliated insurance companies, its agents, employees, and representatives (collectively referred to as "The Companies"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco. This authorization also allows my current or former employer to release information needed to process and evaluate my claim. If applicable this also includes any part of my no fault insurance file if my disability is the result of a motor vehicle accident.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do no apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Standard Security Life Insurance Company of New York and its affiliated insurance companies at P.O. Box 25339 Farmington, New York 14425-0339. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative ____________ Date ____________

Print name of signature above ____________

Description of Personal Representative's Authority or Relationship to Patient ____________