GUARDIAN®

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

State Disability Claims
P.O. Box 14332
Lexington, KY 40512
Telephone#1-800-268-2525
Fax# 610-807-2953

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 can not 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 Completes 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

1. Name: (First, Middle, Last)		Policy #: 00532830		Social Security #:
2. Address:	Apt. #	City	State	Zip Code
3. Telephone #:	4. Date of Birth:	5. Married (Check one): ☐ Yes ☐ No 5a. ☐ Male ☐ Female		

6. My disability is (if injury, also state **how**, **when** and **where** it occurred)

7. I became disabled on ____ /____ /____ (Mo. Day Year) | 7a. I worked on that day ☐ Yes ☐ No

7b. 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 last eight (8) weeks, name **ALL** employers.

EMPLOYERS			Dates of Employment		Average Weekly Wages
			From	Through	(Include Bonuses, Tips, Commissions, Reasonable
Business Name	Business Address	Telephone No.	Mo. Day Yr.	Mo. Day Yr.	Value of Board, Rent, Etc.)

9. My job is or was (**Occupation**) | Name of Union and Local No., 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 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 ANY INSURANCE COMPANY FILES A 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.

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 does 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 form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NEW YORK STATE WORKERS COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, N.Y. 12241-0005.

SI TIENE DUDASRELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKERS COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, N.Y. 12241-0005.

After Parts A, B, & C are completed, Mail to: Guardian – State Disability Claims – P.O. Box 14332, Lexington, KY 40512 or Fax: 610-807-2953
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

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. If the Disability was caused by or arose in connection with pregnancy, enter the estimated delivery date under "Remarks."

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

4. Diagnosis/Analysis: _____ ICD _____
   a. Claimant's Symptoms: _____
   b. Objective Findings/Treatment Plan: _____
   c. If Disability is pregnancy related, enter DELIVERY DATE _____ ☐ Estimated ☐ Actual ☐ Vaginal ☐ C-Section

5. Claimant Hospitalized? ☐ YES ☐ NO Date From: _____ To _____

6. Operation Indicated? ☐ YES ☐ NO a. Type : _____ b. Date _____ c. CPT _____

7. Enter Dates for the Following:

	Mo.	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 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 ☐ Dentist ☐ Physician ☐ Podiatrist ☐ Psychologist ☐ Nurse-Midwife | Licensed in the State of: | Licensed #:

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 #:

Office Address (Number, street, Apt./Suite, City/Town, State, Zip Code)

HIPAA NOTICE - In order to adjudicate a worker's compensation claim, WCL 13-8 (4) (a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports or 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 disclosure of health information.

Part C – EMPLOYER'S STATEMENT

1. Employee's Name | 2. Social Security #:

3. Employee's Address | Apt. #. | City | State | Zip

4. Employee's occupation | 5. Date of Hire | 6. Status: ☐ Full Time ☐ Part Time

7. Is the Claimant an: ☐ Owner ☐ Officer ☐ Partner ☐ Employee ☐ High School Student

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

9. If the employee is no longer employed, explain why: ☐ Quit? ☐ Discharged? ☐ Labor Dispute? ☐ Lack of Work
   If Quit or Discharged, explain why: _____. Do you expect to rehire him/her? ☐ Yes ☐ No

10. Date Employee last worked: _____
11. Date Employee's Wages Ceased: _____
12. Date Employee Returned to Work: _____
13. Are Wages being Continued during Disability? ☐ Yes ☐ No
14. If YES, are you requesting reimbursement? ☐ Yes ☐ No
15. Is Employee receiving or claiming Unemployment Ins.? ☐ Yes ☐ No
16. Is Employee receiving or claiming Workers' Comp. Ins.? ☐ Yes ☐ No
17. Did this Disability occur as a result of employment? ☐ Yes ☐ No
18. Is employee in a Union providing Disability Benefits? ☐ Yes ☐ No
19. Are you aware of other employment claimant may have? ☐ Yes ☐ No
20. Did employee receive PAID SICK TIME during disability? ☐ Yes ☐ No
    If YES, provide dates of paid sick time: From: _____ To: _____

Weekly Wages 8 Weeks prior to Disability (include value of Board, Lodging and Trips, if any)

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

EMPLOYER INFORMATION	Policy #: 00532830	Tax ID #: 15-0545841	Date:
Employer Name: Le Moyne College	Division #:	Phone #: 315-445-4156	Fax #: 315-445-6023
Address: 1419 Salt Springs Road, Syracuse, NY 13214		E-mail: zubietak@lemoyne.edu	
Signature:	Print Name: Amy Zubieta	Title: Assistant Director for HR	

DB-450 (Rev. 10/14)

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Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

STATE OF NEW YORK
Andrew Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS – DISABILITY BENEFITS LAW

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. 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 provided or any office of the Workers' Compensation Board. (See addresses and telephone numbers 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 any office of the Workers' Compensation Board.

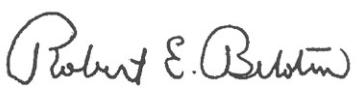
7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT:** In such 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 Benefits Law. Your employer's disability benefits insurance carrier is:

Guardian Life Insurance Company of America
7 Hanover Square, New York NY 10004
800-268-2525



ROBERT E. BELOTEN
CHAIR

100 Broadway	StafeOffice Building	111 Livingston St.		220 Rabro Drive		215 W. 125th Street		168-46 91st Ave.		
Menands	44 Hawley Street	22nd Floor	369 Franklin Street	Suite 100	175 Fulton Avenue	3rd Floor	41 North Division St.	3rd Floor	130 Main Street W.	935 James St.
ALBANY 12241	BINGHAMTON 13901	BROOKLYN 11201	BUFFALO 14202	HAUPPAUGE 11788	HEMPSTEAD 11550	NEW YORK 10027	PEEKSKILL 10566	QUEENS 11432	ROCHESTER 14614	SYRACUSE 13203
(866) 750-5157	(866) 802-3604	(800) 877-1373	(866) 211-0645	(866) 681-5354	(866) 805-3630	(800) 877-1373	(866) 746-0552	(800) 877-1373	(866) 211-0644	(866) 802-3730

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTA ESCRITO EN ESPANOL AL DORSO.

ESTADO DE NUEVAYORK
Andrew Cuomo, Gobernador

JUNTADE COMPENSACION OBRERA
Robert E. Beloten, Presidente

DECLARACION DE DERECHOS – LEY DE BENEFICIOS POR INCAPACIDAD

SI USTED NO PUEDE TRABAJAR A CAUSA DE ENFERMEDAD O LESION NO RELACIONADA CON EL TRABAJO PUEDE TENER DERECHO A BENEFICIOS POR INCAPACIDAD

1. Su patrono está obligado por ley a proveer pagos de Beneficios por Incapacidad a sus empleados.

2. Beneficios por Incapacidad establecidos por ley son pagados por cualquier lesión o enfermedad no relacionada con el trabajo (inclyendo incapacidad debida a embarazo) comenzando a partir del octavo dia consecutivo de incapacidad. Los beneficios son pagados por 26 semanas. Los pagos de beneficios por incapacidad se basan en el promedio de su sueldo semanal durante las ocho semanas inmediatamente anteriores a su incapacidad y estan limitados al maximo permitido por ley el inicial de su incapacidad. Su patrono ó unión podran proveer en un plan o en un covenio beneficios diferentes que sean al menos tan favorables como las establecidos por ley.

3. PARA RECLAMAR BENEFICIOS **usted** deberá radicar una notificación y prueba de incapacidad (Formulario DB450) con su patrono ó con la compañia de seguros nombrada abajo denro del plazo de 30 dias desde el primer dia de incapacidad o toda o parte de su reclamación podra ser rechazada. Bajo ninguna circunstancia usted debe esperar mas de 26 semanas desde esa fecha para fadicar su reclamación. El formulario DB-450 lo puede conseguir a traves de su patrono, la compañia de seguros, el proveedor de servicios médicos o cualquier oficina de la Junta de Compensación Obrera. (Direcciones y telefonos mas abajo). **No** asuma que su patrono ha radicado la reclamación por usted. **La radicación de la reclamación es su** responsabilidad.

4. Usted tiene el derecho de ser atendido por cualquier médico, quiropractico, dentista, enfermera-partera, podiatra o psicologo que usted seleccione. Contrario a como en compensación obrera sus cuentas médicas **no** seran pagadas por su patrono o su compañía de seguros a menos que el patrono y o la unión lo hayan dispuesto mediante un plan de beneficios o cenvenio.

5. Los beneficios por incapacidad le seran pagados a usted **directamente** por la compañía de seguros, **no a traves de su patrono,** salvo en los casos en que su patrono sea aprobado como auto asegurado.

6. Si su patrono ó la compañía de seguros reclama que usted no tiene derecho al pago de Beneficios por Incapacidad ellos tienen la obligación de enviarle un Aviso de Rechazo, dentro de los 45 dias siguientes ala radicación de su reclamoción, explicandole las razones para no pagar los beneficios. Si usted no está de acuerdo con el rechazo, **tiene el derecho** de solicitar una revisión del mismo por la Junta de Compensación Obrera. **IMPORTANTE:** Si dentro del término de 45 dias de haber radicado su reclamación no recibe los beneficios ni tampoco recibe un Aviso de Rechazo (Formulario DB-451) comuniquese inmediatamente con cualquier oficina de la Junta de Compensación Obrera.

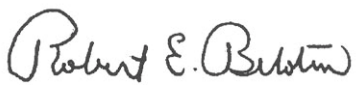
7. Si **su incapacidad es el resultado de un accidente automovilístico** y usted ha radicado una reclamación para beneficios por 'no-fault' tambien deberá radicar una reclamación (Formulario DB-450) para beneficios por incapacidad. **Si no radica reclamación para beneficios por incapacidad, la compañia de seguro podria reducir los pagos 'no fault' que le correspondan**. **IMPORTANTE:** en estos casos, si no tiene derecho a beneficios por incapacidad, avise inmediatamente a la compañia de suguros.

8. Su patrono no puede pedirle que renuncie a su derechode recibir beneficios por incapacidad ni tampoco puede descontar mas de 60 centavos semanales (a menos que la contribución adicional sea parte de un acuerdo) de su paga para contribuir al pago de las primas de seguro para los beneficios por incapacidad. **Usted no puede ser despedido ni discriminado por radicar una reclamación de beneficios por incapacidad.**

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO, O TIENE CUALQUIER OTRO PROBLEMA ACERCA DE UNA LESION O ENFERMEDAD NO RELACIONADA CON EL TRABAJO COMUNIQUESE CON CUALQUIER OFICINA DE LA JUNTA DE COMPENSACIÓN OBRERA.

Este es un breve resumen de sus derechos como lo requiere la Sección 229 de la Ley de Beneficios por Incapacidad. La compañia de seguro de su patrono para beneficios por incapacidad es :

Guardian Life Insurance Company of America
7 Hanover Square, New York NY 10004
800-268-2525



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CHAIR

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ESTA ENTIDAD EMPLEA Y SIRVE A PERSONAS CON INPEDIMENTOS SIN DISCRIMINAR EN SU CONTRA.
THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.