Communications
Workers of America
Local 1183
Health & Welfare Fund

58-38 69th street, 2 Front
Maspeth, New York 11378

Theresa Ferzola
Administrator

Tel: (718) 268-6373
Fax: (718) 793-4220

Enclosed please find paperwork for Disability Benefits through The Hartford Insurance Company.

Please complete Part A and have your doctor complete Part B.

Make copy for your records and mail original to:

Board of Elections

32 Broadway

New York, New York 10004

Attn: Payroll

They will complete Part C and mail it on to The Hartford at P.O. Box 14306, Lexington, Ky. 40512.

Theresa Ferzola

Administrator

P.S. Please date my name on pg 3

# 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 GREEN 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 15). 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 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 The Hartford P. O. Box 14306 Lexington, KY 40512-4306 Fax 1-866-411-5613.**
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. My name is: (First, Middle & Last) | 2. Social Security Number: | 3. Date of Birth: | 4. Marital Status ☐ Married ☐ Single |
|---|---|---|---|
| | | | |

| 5. My Address: (Number, Street, City or Town, State & Zip Code) | 6. My disability is: (if injury, also state how, when and where it occurred) |
|---|---|
| | |

| 7. My Telephone Number: ( ) | 8. E-Mail Address: (E-Mail is used to provide The Hartford At Work registration instructions and important status updates.) |
|---|---|
| | |

9. 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: _____

10. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

| Employer's Business Name | Employer's Business Address | Employer's Phone Number | Dates of Employment From (Month/Day/Year) | Dates of Employment Through (Month/Day/Year) | Average Weekly Wages (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.) |
|---|---|---|---|---|---|
| | | ( ) | | | |
| | | ( ) | | | |
| | | ( ) | | | |

| 11. My job is or was: (Occupation) | 12. Name of Union and Local Number, if member |
|---|---|
| | CWA Local 1183 H + W. Fund |

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) 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 13a OR 13b, COMPLETE THE FOLLOWING
   I have ☐ received ☐ claimed From _____ For the period _____ To _____

14. 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 _____

15. 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 FINES AND IMPRISONMENT.

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

Claim signed on: _____ Claimant's Signature: _____

If signed by other than claimant, print below: name, address, and relationship of representative: _____

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: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

**HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE**

The Hartford
P. O. Box 14306
Lexington, KY 40512-4306
Fax 1-866-411-5613

# 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 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 approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks". (Even if considerable question exists, estimate date. Avoid using terms such as unknown or undetermined).

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:
   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: _____
   e. If disability is pregnancy related, please estimate 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 form C-4 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

Remarks: (attach additional sheet, if necessary)

I affirm that I am a: ☐ Chiropractor ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse-Midwife

License Number: _____ Licensed in the State of: _____

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 FINES AND IMPRISONMENT.

Health Care Provider's Signature: | Date:

Health Care Provider's Name: (Please Print) | Telephone Number: ( )

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 Hartford
P. O. Box 14306
Lexington, KY 40512-4306
Fax 1-866-411-5613

# NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

## PART C - EMPLOYER'S STATEMENT

Employee's full name: (As shown on Social Security Card) | Social Security Number:

Employee's Address: (Street, City, State & Zip Code) | Date of Birth:

Date of employment: ☐ Full Time ☐ Part Time | Check days normally worked: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

If Part Time, give particulars:

Is employeea Union member? ☐ Yes ☐ No | If "Yes," is employee entitled to Union Benefits ☐ Yes ☐ No | ~~Occupation:~~

Date employee last worked: | Date employee returned to work: | Were wages continued during disability? ☐ Yes ☐ No

Were wages **Sick** pay? ☐ Yes ☐ No From: To:

Were wages **Vacation** pay? ☐ Yes ☐ No From To

Is reimbursement requested? ☐ Yes ☒ No

Is disability due to job? ☐ Yes ☐ No

If "Yes," has a compensation claim been filed? ☐ Yes ☐ No

Indicate Weekly Value of Board, Lodging and Tips:

Is this employee currently covered by Social Security? ☐ Yes ☐ No

If "No," state grounds for exemption:

EARNINGS 8 WEEKS PRIOR TO AND INCLUDING THE DATE LAST WORKED PRIOR TO THE ONSET OF DISABILITY

| Month | Day | Year | No. Days Worked | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | Total | |

**Is employee enrolled in a Hartford Long Term Disability Plan?**
☐ Yes ☒ No **If "Yes," effective date.** **Hartford NY Disability Policy Number:** LNY 723719

**Based on the employer/employee premium contributions made over the last 3 years, what percentage of the Weekly Disability benefit it is considered taxable? % LTD % (See section 6 of IRS Publication 15-A for information on determining the taxable percentage.)** *(If blank, we will code the benefit as 100% taxable until you submit written notice of the correct taxable %.)*

Employer's Name: C.W.A. LOCAL 1183 HEALTH & WELFARE FUND | Employer's Identification Number: 23-7348449

Address: (Street, City, State & Zip Code) 58-38 69th street, 2 Front Maspeth, NEW YORK 11378 718-268-6373 | Telephone Number: ( )

Signed by: T. Feiza | Date: | Title: Admin.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

**Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.**

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefit s from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

**For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For Residents of California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

**For residents of Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

**For Residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For residents of New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

**For residents of New York:** 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.

**For residents of Oregon:** 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

**For residents of Pennsylvania:** 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For residents of Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH.

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

STATE OF NEW YORK
Andrew M. 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 provider 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:

The Hartford
P. O. Box 14306
Lexington, KY 40512-4306
Fax 1-866-411-5613

Robert E. Beloten

**ROBERT E. BELOTEN**
**CHAIR**

| 100 Broadway Menands | StateOffice Building 44 Hawley Street | 111 LivingstonSt. 22nd Floor | 295 Main Street Suite 400 | 220 Rabro Drive Suite 100 | 175 FultonAvenue | 215 W. 125th Street 3rd Floor | 41 North Division St. | 168-46 91st Ave. 3rd Floor | 130 Main Street W. | 935 James St. |
|---|---|---|---|---|---|---|---|---|---|---|
| ALBANY 12241 | BINGHAMTON13901 | BROOKLYN11201 | BUFFALO 14203 | HAUPPAUGE 11788 | HEMPSTEAD11550 | 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.

*www.wcb.state.ny.us*

**DB-271S (1-11)**