



PO Box 12430
 Albany, NY 12212-2430
 Phone: (877) RN BENEFITS
 Fax: (518) 869-2317
 disability@rnbenefits.org

Notice and Proof of Claim for Disability Benefits

1. Complete this form only if you become sick or disabled while employed, or if you become sick or disabled within four weeks after termination of employment. If you become sick or disabled after having been unemployed more than four weeks, use green claim form DB-300.
2. Complete all items in Part A, "Claimant's Statement." Be accurate. Check all dates.
3. Date and sign the bottom of this side of the form. If you cannot sign the claim form, a representative may sign on your behalf, but the representative must include his/her address and relationship to you.
4. Bring this form to your doctor and ask him/her to complete all items in Part B, "Doctor's Statement."
5. Bring this form to your employer and ask him/her to complete all items in Part C, "Employer's Statement."
6. When all parts of the form are filled in, **mail, fax, or e-mail the claim form** to the Benefits Fund within 30 days after you become sick or disabled.

Part A - Claimant's Statement

1. Full Name _____ 2. Social Security Number _____
3. Address _____ City _____ State _____ ZIP _____
- Home Telephone (____) _____ 4. Age _____ 5. Date of Birth _____ Married: Yes No
6. I became disabled on _____. My disability is (if injury, also state how, when, and where it occurred) _____
- _____ 7. I worked on that day: Yes No
- I have have not worked since becoming disabled. if you have worked, please list dates you worked: _____
8. Please list all employers you've worked for during the 8 weeks prior to your disability:

Employer Information			Dates of Employment		Regular Weekly Compensation <small>(include all differentials, but no overtime, bonuses, or special allowances)</small>
Name	Address	Phone No.	From Mo. Day Yr.	Through Mo. Day Yr.	

9. My position title was _____
10. For the disability period covered by this claim, a) Are you receiving any salary or separation pay? Yes No If yes, please complete:
 I have received claimed from _____ (employer name) for _____ to _____ (dates).
- b) Are you receiving or claiming (1) Workers' Compensation for work-connected disability? Yes No If yes, please complete:
 I have received claimed from _____ (employer name) for _____ to _____ (dates).
- (2) Are you receiving or claiming damages for personal injury (no-fault, etc.)? Yes No If yes, please complete:
 I have received claimed from _____ (company name) for _____ to _____ (dates).
- (3) Are you receiving or claiming Unemployment Insurance Benefits? Yes No If yes, please complete:
 I have received claimed from _____ (company name) for _____ to _____ (dates).
11. If you have received disability benefits for another period or periods of disability within the 52 weeks immediately before your present disability began, please complete: I have been paid by _____ (company name) for _____ to _____ (dates).

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, and any accompanying statements are, to the best of my knowledge, true and complete.

Sign here

 _____ (Signature) _____ (Date)
 Representative's Address _____
 Representative's Relationship _____

For Benefits Fund office use only

Pay _____ Weeks _____ Days _____

Reject _____

Certified by _____ Date _____

Part B - Doctor's Statement (please type)

1. Claimant's Name _____ 2. Age _____ 3. Female Male
4. Diagnosis/Analysis _____ Diagnosis Code _____
- a) Claimant's Symptoms _____ Objective Findings _____
5. Was claimant hospitalized? Yes No From _____ (date) to _____ (date)
6. Was an operation indicated? Yes No a) Type _____ Procedure Code _____ b) Date _____
7. 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 (please provide an estimated approximate date) _____.
8. If claimant's disability is caused by or has arisen in conjunction with pregnancy, please provide estimated delivery date _____.
9. In your opinion, is this disability the result of an injury arising out of and in the course of employment or occupational disease?
 Yes No If yes, has Form C-4, C-4C, or C-4P been filed with the Board? Yes No
- Remarks: (please attach additional sheet if necessary) _____
10. I am physician/podiatrist/chiropractor/dentist (please circle one) licensed in the state of _____
- Doctor's Signature _____ License Number _____ Date _____
- Doctor's Name (please type) _____ Phone Number _____
- Office Address _____ City _____ State _____ ZIP _____

Part C - Employer's Statement (please type)

1. Employee's Name _____ 2. Social Security Number _____
3. Date of Employment _____ Position Title _____
4. Actual last date employee worked prior to disability _____ a) Date full sick time paid to _____.
5. If employee has returned to work, give date of return _____ 6. If not yet returned to work, do you expect to rehire? Yes No
7. Did disability occur as a result of employment? Yes No If yes, please explain _____
8. Please list employee's compensation for last eight weeks prior to disability:

Week No.	Week Ending			No. of Days Worked	Regular Compensation	Week No.	Week Ending			No. of Days Worked	Regular Compensation
	Month	Day	Year				Month	Day	Year		
1						5					
2						6					
3						7					
4						8					

9. Employee's usual days worked: Monday Tuesday Wednesday Thursday Friday Saturday Sunday
10. Has employee made a claim for disability benefits in the past 52 weeks? Yes No If yes, please provide the date _____.
11. Is claimant an Employee? Other? If other, please explain _____.
12. If employee is no longer employed by you, check reason for separation:
 Fired (Please provide reason) _____
 Resigned (Please provide reason) _____
 Other (Please explain) _____
13. Name of Workers' Compensation carrier: _____
14. Did employee receive Unemployment Insurance Benefits within eight weeks prior to disability? Yes No If yes, date: _____
15. Does the employee work for anyone other than you? Yes No If yes, please explain _____

Your Name _____	Title _____	Signature _____
Employer Name _____	Employer Code Number _____	
Address _____	City _____	State _____ ZIP _____
Telephone Number _____		Date _____

When Parts A, B, and C are completed, mail to NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430, fax to (518) 869-2317, or scan and e-mail to disability@rnbenefits.org.