New York State Nurses Association

N Y S N A
Benefits Fund

Completed forms should be submitted via
Mail: NYSNA Benefits Fund P.O. Box 12430
Albany, NY 12212
E-mail: disability@rnbenefits.org
Fax: (518) 869-2317

Notice and Proof of Claim for Disability Benefits

Please complete this form if you become disabled while employed or if you become disabled within four weeks after termination of employment. Please answer all questions in Part A and sign and date the form. Read all instructions on this form carefully. Health care providers must complete Part B on page two.

When all parts of the form are filled in, mail, fax, or e-mail (disability@rnbenefits.org) 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_____
Telephone Number (_____) _____ 4. Age _____ 5. Date of Birth _____
6. Married: ○ Yes ○ No
7. I became disabled on _____/My disability is (if injury, also state how, when, and where it occurred) *below*

_____

8. I worked on that day: ○ Yes ○ No. I ○ have ○ have not worked since becoming disabled.
If you have worked, please list dates you worked: _____.
9. If this is a maternity claim, does the claimant want to file for Paid Family Leave? ○ Yes ○ No.
10. Please list all employers you've worked for during the 8 weeks prior to your disability:

Employer Information			Dates of Employment		Regular Weekly Compensation *Include all differentials, but no overtime, bonuses, or special allowances*
			From	Through	
Name	**Address**	**Phone No.**	**M/D/Y**	**M/D/Y**	

11. My position title was _____
12. 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).
13. If you have received disability benefits for another period or periods of disability within the 52 weeks immediatelybefore 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. I acknowledge that I am sending this form to the NYSNA Benefits Fund who will review it for completeness and submit it to Metropolitan Life Insurance Company (MetLife). By sending this form, I authorize MetLife to provide the NYSNA Benefits Fund with access to the medical information MetLife obtains regarding my claim for the purpose of claim administration.

Sign here _____ (Date)_____
Representative's Address _____
_____
Representative's Relationship _____

For Benefits Fund office use only

Date of Disability: _____
Payment start date: _____
_____
Certified by: _____ Date: _____

Part B - Doctor's Statement

1. Claimant's Name _____ 2. Age _____ 3. ○ Female ○ Male (check one)
4. Diagnosis/Analysis _____ Diagnosis Code _____
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 occupationaldisease?
○ 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 print) _____ Phone Number _____
Office Address _____ City _____ State ___ ZIP _____

Part C - Employer's Statement

1. Employee's Name _____ 2. Social Security Number _____
3. Date of Employment _____ Position Title _____
4. Actual last date employee worked prior to disability _____ Date full sick time paid through _____
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 _____
Employer Name _____ Employer Code Number _____
Address _____ City _____
State _____ ZIP _____ Phone _____
Signature _____ Date _____

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