



# Notice & Proof of Claim Disability Benefits

GE Financial Assurance  
Employer Services Group

GE Group Life Assurance Company  
PO Box 1955  
100 Bright Meadow Boulevard  
Enfield, CT 06083 - 1955

Claimant: Read the following instructions carefully

1. USE THIS FORM ONLY IF YOU BECOME SICK OR DISABLED WHILE EMPLOYED OR IF YOU BECOME SICK OR DISABLED WITHIN (4) FOUR 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 SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE 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.
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

DB 450 05/01

### Part A - Claimant's Statement. Answer All Questions. ( please print or type )

1. My Name is \_\_\_\_\_ 2. \_\_\_\_\_ • \_\_\_\_\_ • \_\_\_\_\_  
( FIRST ) ( MIDDLE ) ( LAST ) SOCIAL SECURITY NUMBER

3. Address \_\_\_\_\_  
( NUMBER ) ( STREET ) ( CITY ) ( STATE ) ( ZIP ) ( APT # )  
Telephone ( ) \_\_\_\_\_ 4. My age is \_\_\_\_\_ yrs. 5. Married? (check one)  Yes  No

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

7. I became disabled on \_\_\_\_\_ 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:

E m p l o y e r ' s			Dates of Employment		AVG Weekly Wages
Business Name	Business Address	Telephone No.	From Through		(including Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
			Mo. Day Yr.	Mo. Day Yr.	

9. My job is or was \_\_\_\_\_  
O C C U P A T I O N NAME OF UNION AND LOCAL #, 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) Worker's Compensation for work-connected disability?  Yes  No
- (2) Damages or personal injury?  Yes  No
- (3) Unemployment Insurance Benefits?  Yes  No
- (4) Disability Benefits under the Federal Social Security Act?  Yes  No

If yes, checked in any of the items a, b(1), b(2), b(3) or b(4)? Fill in the following:

I have  received or  claimed from \_\_\_\_\_ to \_\_\_\_\_  
DATE DATE

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 \_\_\_\_\_  
DATE DATE

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. Claim signed on \_\_\_\_\_ / \_\_\_\_\_  
DATE CLAIMANT'S SIGNATURE

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

NAME AND ADDRESS

RELATIONSHIP

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD 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.

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

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, NY 12241.

SI SE LE OCCURREN ALGUNAS PREGUNTAS REPECTO A RECLAMAR BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON SU 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, NY 12241.

# 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 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 this form mailed to the Insurance Carrier or Self-Insured Employer or returned to the claimant within seven (7) days of the receipt of the form. For item 7-d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated date of delivery under “remarks”.

1. Claimant’s Name \_\_\_\_\_ 2. Age \_\_\_\_\_ yrs.

3.  Male  
 Female

4. Diagnosis/Analysis \_\_\_\_\_  
 a.) 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 .....

Month	Day	Year

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 Remarks ( attach additional sheet if necessary )

9. I affirm that I am a \_\_\_\_\_

Licensed or Certified in the State of \_\_\_\_\_ License No. \_\_\_\_\_

Health Care Provider’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider’s Name ( please print ) \_\_\_\_\_ Tel. No. \_\_\_\_\_

Office Address \_\_\_\_\_  
( NUMBER ) ( STREET ) ( CITY ) ( STATE ) ( ZIP ) ( APT # )

**Employer’s Statement**

Employee’s Full Name: \_\_\_\_\_ License No. \_\_\_\_\_

Employee’s Address \_\_\_\_\_ S.S. Number: \_\_\_\_\_

Employee’s Occupation: \_\_\_\_\_ Date Employed \_\_\_\_\_  Full Time  Part Time

Is He/She a Union Member?  Yes  No Check Days Normally Worked:  Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.  Sun.

Date He/She last worked: \_\_\_\_\_  
 Date Wages Ceased: \_\_\_\_\_  
 Date He/She Returned to Work: \_\_\_\_\_  
 Wages Continue During Disability? \_\_\_\_\_  
 Is Reimbursement Requested? \_\_\_\_\_  
 Is Disability Due to Job? \_\_\_\_\_  
 If so, has a Compensation Claim been filed? \_\_\_\_\_  
 Indicate Weekly Value of Board, Rent, --- \_\_\_\_\_

Is He/She currently covered by Social Security?  Yes  No If no, state grounds for exemption.

Tips, etc. \$ \_\_\_\_\_

Employer’s Name \_\_\_\_\_

Employer’s ID # \_\_\_\_\_

Percentage of Wkly Disability Premium paid by Employer \_\_\_\_\_ %.

If blank, we will assume Employer pays 100% of the Premium.

Earnings 8 Weeks prior to Disability <small>( including the week in which the disability began ).</small>				
Month	Day	Year	# of Days Worked	Amount
<b>Total</b>				

Address \_\_\_\_\_ Date \_\_\_\_\_ Telephone No. \_\_\_\_\_

Signed \_\_\_\_\_ Title \_\_\_\_\_