

**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 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 CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN 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**.
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**

Social Security Number

1. My name is..... First Middle Last [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ][ ]
2. Address..... Number Street City or Town State Zip Code Apt. No.
3. Tel. No..... 4. Date of Birth ..... 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 ..... a. I worked on that day  Yes  No  
 b. 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 the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT			AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM		THROUGH	
			Mo.	Day	Yr.	

9. My job is or was ..... Occupation Name of Union and Local Number, 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.....  
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 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.

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.

Claim signed on ..... Date Claimant's Signature

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

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**Disclosure of Information:** The Board will 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.state.ny.us](http://www.wcb.state.ny.us). It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

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 COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005
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**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 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".**

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 .....

Month	Day	Year

(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 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) .....

(If disability is pregnancy related, please enter estimated delivery)

I affirm that I am a	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Physician	<input type="checkbox"/> Psychologist	Licensed in the State of	License Number
	<input type="checkbox"/> Dentist	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Nurse-Midwife		

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD 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) ..... Tel.No. ....

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.

# GUÍA PARA LLENAR EL FORMULARIO DB-450, NOTIFICACIÓN Y CONSTANCIA DE LA SOLICITUD DE LOS BENEFICIOS POR INCAPACIDAD

(GUIDE TO COMPLETING FORM DB-450,  
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS)

Esta guía pretende ayudarles a las personas que hablan español como primer idioma a llenar el Formulario DB-450, que se usa con mayor frecuencia para solicitar los beneficios por incapacidad del Estado de Nueva York (por lesiones o enfermedades sufridas fuera del trabajo). Contiene una traducción de las instrucciones y preguntas que deberá responder en el formulario. Si puede, llene la Parte A del Formulario DB-450 en inglés y siga las instrucciones que se brindan a continuación para presentar la solicitud. El proveedor de servicios de salud que le brinde asistencia médica deberá llenar la Parte B ubicada al dorso del formulario antes de que usted lo presente. No presente esta guía junto con la solicitud.

## CLAIMANT'S INSTRUCTIONS / INSTRUCCIONES PARA EL RECLAMANTE

LEA ATENTAMENTE LAS SIGUIENTES INSTRUCCIONES.

1. USE ESTE FORMULARIO SI SE ENFERMA O QUEDA INCAPACITADO **MIENTRAS ESTÉ EMPLEADO O DENTRO DE LAS CUATRO (4) SEMANAS POSTERIORES AL CESE LABORAL**. USE EL FORMULARIO DB-300 SI SE ENFERMA O QUEDA INCAPACITADO **LUEGO DE HABER ESTADO DESEMPLEADO MÁS DE CUATRO (4) SEMANAS**.
2. DEBE LLENAR TODOS LOS PUNTOS DE LA PARTE A: LA "DECLARACIÓN DEL RECLAMANTE". SEA PRECISO. TODAS LAS FECHAS.
3. NO DEJE DE FECHAR NI FIRMAR SU SOLICITUD (CONSULTE EL PUNTO 12). SI NO PUEDE FIRMAR ESTE FORMULARIO DE SOLICITUD, SU REPRESENTANTE PUEDE HACERLO EN SU NOMBRE. EN TAL CASO, EL NOMBRE, LA DIRECCIÓN Y LA RELACIÓN CON EL REPRESENTANTE DEBERÁ ANOTARSE DEBAJO DE LA FIRMA.
4. **NO ENVÍE POR CORREO ESTA SOLICITUD ANTES DE QUE SU PROFESIONAL DE ASISTENCIA MÉDICA HAYA LLENADO Y FIRMADO LA PARTE B: LA "DECLARACIÓN DEL PROFESIONAL DE ASISTENCIA MÉDICA"**.
5. DEBERÁ ENVIAR LA SOLICITUD LLENA **DENTRO DE LOS TREINTA (30) DÍAS DE HABERSE ENFERMADO O HABER QUEDADO INCAPACITADO A SU ÚLTIMO EMPLEADOR O A LA ASEGURADORA DE SU ÚLTIMO EMPLEADOR**.
6. ANTES DE ENVIARLO, SÁQUELE UNA COPIA AL FORMULARIO LLENO PARA SU ARCHIVO.

## PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

**PARTE A: DECLARACIÓN DEL RECLAMANTE (escriba con letra de imprenta o a máquina). RESPONDA TODAS LAS PREGUNTAS**

1. *My name is.....(First).....(Middle).....(Last)*. Me llamo.....(Primer nombre).....(Segundo).....  
.....(Apellido). Escriba su número de seguro social en los recuadros ubicados al final de punto 1.
2. *Address.....(Number)....(Street)....(City or Town)....(State)....(Zip Code)....(Apartment No.)*  
Dirección.....(Número)....(Calle)....(Ciudad o Pueblo)....(Estado)....(Código postal)....(Nº de apartamento)
3. *Telephone Number.....* Número telefónico.....
4. *Date of Birth.....* Fecha de nacimiento.....
5. *Married (check one)*  Yes  No Casado (marque una opción)  Sí  No
6. *My disability is (if injury, also state how, when and where it occurred).....*  
La incapacidad que padezco es (si es una lesión, también indique cómo, cuándo y dónde ocurrió).....
7. *I became disabled on.....(month)....(day)....(year)*. Quedé incapacitado el.....(mes)....(día)....(año).  
7a. *I worked on that day*  Yes  No  
7a. Trabajé ese día  Sí  No  
7b. *I have since worked for wages or profit*  Yes  No *If "Yes," give dates.....*  
7b. Desde entonces he trabajado percibiendo un sueldo o ganancias  Sí  No Si responde "Sí,"  
indique las fechas.....

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

EMPLOYER'S			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include bonuses, tips, commissions, reasonable value of board, rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM	THROUGH	
			Month Day Year	Month Day Year	

Indique el nombre del último empleador. Si tuvo más de un empleador en las últimas ocho (8) semanas, menciónelos a todos los empleadores.

DATOS DEL EMPLEADOR			FECHAS DE TRABAJO		SALARIOS SEMANALES PROMEDIOS (incluya bonificaciones, propinas, comisiones, valor razonable de viáticos, renta, etc.)
NOMBRE DE LA EMPRESA	DIRECCIÓN DE LA EMPRESA	Nº TELEFÓNICO	DESDE	HASTA	
			Mes Día Año	Mes Día Año	

9. *My job is or was.....(occupation)..... Name of union and local number, if member.....*  
Mi trabajo consiste o consistía en.....(ocupación)..... Nombre del gremio sindical y número local, si integrara uno,.....

10. For the period of disability covered by this claim  
Durante el período de incapacidad que abarca esta solicitud

a. Are you receiving wages, salary or separation pay..... Yes  No  
a. ¿Está percibiendo sueldo, salario o indemnización por despido?..... Sí  No

b. Are you receiving or claiming:  
b. ¿Está percibiendo o solicitando

(1) Workers' compensation for work-connected disability..... Yes  No  
(1) Una Indemnización por accidentes de trabajo por incapacidad vinculada al trabajo?... Sí  No

(2) Unemployment Insurance benefits..... Yes  No  
(2) Los beneficios del seguro de desempleo?..... Sí  No

(3) Damages for personal injury..... Yes  No  
(3) Una indemnización por lesiones corporales..... Sí  No

(4) Benefits under the Federal Social Security Act for long-term disability..... Yes  No  
(4) Los beneficios otorgadas según la Ley Federal de Seguro Social por incapacidad prolongada?.....  
 Sí  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 .....(date)..... to ..... (date).....

SI MARCÓ "SÍ" EN LOS PUNTOS 10a O 10b, LLENE LO SIGUIENTE:

He  percibido  solicitado de.....desde.....(fecha)..... hasta ..... (fecha).....

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

He percibido beneficios por incapacidad que padecí durante otro/s período/s dentro de las 52 semanas inmediatamente anteriores al inicio de mi incapacidad actual..... Sí  No

If "Yes", fill in the following: I have been paid by ..... from....(date).... to ....(date)....

Si respondió "Sí," llene lo siguiente: ..... me ha pagado desde....(fecha).... hasta ....(fecha)....

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.

He leído las instrucciones anteriores. Por medio del presente documento, solicito los beneficios por Incapacidad y certifico que he padecido incapacidad durante el período que abarca esta solicitud y que las declaraciones anteriores, y también las que se adjuntan, son verdaderas y completas según mi leal saber y entender.

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.

CUALQUIER PERSONA QUE, A SABIENDAS Y CON EL PROPÓSITO DE DEFRAUDAR PRESENTE, ORDENE PRESENTAR O PREPARE INFORMACIÓN QUE CONTENGA DECLARACIONES FALSAS U OCULTE DATOS RELEVANTES, SABIENDO O CREYENDO QUE SERÁ ENTREGADA A UNA COMPAÑÍA DE SEGUROS, O AUTOASEGURADORA, O PRESENTADA POR LA MISMA, SERÁ CULPABLE DE UN DELITO Y ESTARÁ SUJETO A CONSIDERABLES MULTAS Y PRISIÓN.

Claim signed on.....(date).....(signature).....

La solicitud se firmó el .....(fecha).....(firma).....

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

Si la firma otra persona que no sea el solicitante, escriba a continuación: nombre, dirección y relación con el representante.

**Disclosure of Information:** The Board will 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.state.ny.us](http://www.wcb.state.ny.us). It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

**Divulgación De La Información:** La Junta No Divulgará Información Sobre Su Caso A Ninguna Parte No Autorizada Sin Su Consentimiento. Si Usted Decide Divulgar Tal Información A Una Parte No Autorizada, Deberá Presentar Ante La Junta Una Copia Original Firmada Del Formulario OC-110A, "Autorización Del Reclamante Para Divulgar Información De La Indemnización Laboral ", O Una Carta De Autorización Original, Firmada Y Certificada Ante Notario. Puede Llamar Por Teléfono A La Oficina Local De WCB (Del Inglés *Worker's Compensation Board*, Junta De Compensación Laboral) Para Solicitar Que Le Envíen El Formulario OC-110A O Lo Puede Descargar De Nuestra Página Electrónica, [www.wcb.state.ny.us](http://www.wcb.state.ny.us). Está Publicado Bajo El Título Formularios En Línea De Uso Habitual (Common Forms Online). Envíe Por Correo El Formulario O Carta De Autorización Llenos A La Dirección Que Se Brinda A Continuación.