Mutual of Omaha

c/o Maxon Administrators, Inc.
PO Box 606
Neversink, NY 12765

New York State
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Read instructions on page 2 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 2.

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: _____ First Name: _____ MI: ___
2. Mailing Address (Street & Apt. #): _____
   City: _____ State: _____ Zip: _____
3. Daytime Phone #: _____ Email Address: _____
4. Social Security #: _____ - _____ - _____ 5. Date of Birth: ____ / ____ / _____ 6. Gender: ☐ Male ☐ Female
7. Describe your disability (if injury, also state how, when and where it occurred): _____
   _____
8. Date you became disabled: ____ / ____ / _____ Did you work on that day?: ☐ Yes ☐ No
   Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: ____ / ____ / _____
   Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, list dates: _____
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)**
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

10. My job is or was: _____ (Occupation) 11. Union Member ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)
12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No
    If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: _____
    _____
    If you did receive unemployment benefits, provide all periods collected: _____
    _____
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. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
       3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
       4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No
       5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐ Yes ☐ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:
    I have: ☐ received ☐ claimed from: _____ for the period: ____ / ____ / _____ to: ____ / ____ / _____
14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____
15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's Signature **Date**

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of Claimant **Address** **Relationship to Claimant**

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name: _____ First Name: _____ MI: ___

2. Gender: ☐ Male ☐ Female 3. Date of Birth: ___ / ___ / _____

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	MONTH	DAY	YEAR
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 again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual 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 Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) Licensed or Certified in the State of License Number

_____ _____ _____
Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

_____ _____
Health Care Provider's Address **Phone #**

IMPORTANT NOTICE TO CLAIMANT - READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days of your first date of disability to your employer or your last employer's insurance carrier.** You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officer Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigation and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-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 insurance 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.

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 "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (**www.wcb.ny.gov**) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTATIONAL FINES AND IMPRISONMENT.

C/O Maxon Administrators, Inc.
PO Box 606
Neversink, NY 12765

Tel#: (800) 999-3309
Fax#: (845) 985-0238
Email: disability@maxonco.com

EMPLOYER'S STATEMENT (Please Print or Type)

Employer's Name: _____

Employer's Tax Identification No.: _____

Policy Number: _____

1. Employee's Full Name: _____ Social Security Number: _____
2. Employee's Address: _____
_____
3. Date of Birth: _____
4. Employee's Occupation: _____ Date of Hire: _____ Status: Full Time ☐ Part Time ☐
5. Is Claimant: an employee ☐ an owner ☐ a high school student ☐
6. Is Employee a Union Member: YES ☐ NO ☐ Check Days Normally Worked: Mon ☐ Tues ☐ Wed ☐ TH ☐ Fri ☐ Sat ☐ Sun ☐
7. Date Employee Last Worked: _____
8. Date Employee's Wage Ceased: _____
9. Date Employee Returned to Work: _____
10. Are you paying wages or sick time: YES ☐ NO ☐
    If yes, time period paid: _____ Is Reimbursement Requested: YES ☐ NO ☐
11. Is Disability due to job: YES ☐ NO ☐
    If so, has a compensation claim been filed: YES ☐ NO ☐
12. Reason if the employee is no longer employed: _____ Date terminated: _____
13. Is the Employee receiving or claiming unemployment insurance: YES ☐ NO ☐
14. Has the employee received DBL or PFL benefits within the past 52 weeks: YES ☐ NO ☐
    If yes, provide dates: _____

Percentage of weekly disability premium paid by employer: _____

If blank we assume the Employer pays 100% of the premium

EARNINGS FOR 8 WEEKS PRIOR TO LAST DAY WORKED				
MONTH	DAY	YEAR	# OF DAYS WORKED	GROSS AMOUNT
			TOTAL	$

CONTACT INFORMATION:

Employer Address: _____
_____

Phone: _____ Fax: _____ E-mail:_____

Print Name: _____ Sign: _____

Title: _____ Date: _____