

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 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 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 7-d, 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. Age _____

First Middle Last

3. <input type="checkbox"/> Male <input type="checkbox"/> Female

4. Diagnosis/Analysis: _____

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 be able to perform usual work			

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability a result of injury arising out of and in the course of employment or occupational disease? YES NO

If "Yes," has Form C-4/48 been filed with the Workers' Compensation Board? YES NO

Remarks (Attach additional sheet if necessary): _____

9. I affirm that I am a _____ Licensed or Certified in the State of _____ License No. _____
(Physician, Podiatrist, Chiropractor, Dentist or Nurse-Midwife)

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (Please Print) _____ Tel. No. _____

Office Address _____
Number Street City or Town State Zip Code

NEW YORK DISTRICT COUNCIL OF CARPENTERS
WELFARE FUND
395 HUDSON STREET
NEW YORK, N.Y. 10014
DISABILITY CLAIM DEPT.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.