Part A - Claimant's Statement

What is the DB450 Claim Form?

The DB450 Claim Form is the initial form used to file a disability benefits claim for individuals who have a non work-related injury or illness while employed, or within 4 weeks after termination of employment. If you are sick or disabled after being unemployed more than 4 weeks, you must use form DB300.

To ensure your claim is handled in a timely fashion, it is important that this claim form is legibly filled out in its entirety with all sections completed. **Missing, incomplete, or illegible information will result in a delay in processing your claim.**

Before submitting this Claim Form for processing, be sure each section is **fully completed**. There are 3 sections on the DB450:

- **Part A** is for the **Claimant (Employee)**
- **Part B** is for the treating **Physician/Medical Practitioner**
- **Part C** is for the **Employer**

Each Part must be fully completed, signed, and dated by the appropriate party.

Be sure to make a copy of the completed Claim Form and retain for your records. A detailed outline of each section is below.

Your privacy and security is important to us - none of your information is distributed to 3rd parties without your express consent.

In this section you will enter your First and Last Name, Social Security Number, Mailing Address and other details which will aid in processing this claim.

All information should be printed & legible.

EXAMPLE FORM

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

1. My name is ..... (First / Middle / Last) Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

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 ..... (Month / Day / Year) 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 Mo.	FROM Day	FROM Yr.	THROUGH Mo.	THROUGH Day	THROUGH 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 ..... (Date) to ..... (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 ..... (Date) To ..... (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 BELEIF 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 .... (Claimant's Signature) ..... (Claimant's Email Address)

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

Part A - Claimant's Statement

Question 1:
PRINT your full first and last name in the space provided and enter your nine digit social security number in the boxes provided. This information is required for tax reporting purposes.

Question 2:
PRINT your current mailing address (Street # and name, apartment #, City, State, Zip). We will use the address provided when mailing correspondence and/or benefit checks to you. An incomplete or incorrect address could result in returned or lost mail and delay in processing your claim.

Question 3 – Tel. No:
This is the contact phone where we may reach you, should there be any questions on your claim.

Question 4 – Date of Birth:
Enter the month, day, and year in which you were born.

Question 5 – Marital Status:
Enter "yes" if you are married and "no" if you are not.

Question 6:
Enter a brief description of your disability. If you were injured, please also provide details on when (date) and where (location of incident) the incident occurred, as well as how you came to be injured.

Question 7:
Enter the date you became disabled, whether or not you worked on that day, and if you have since worked for wages.

Question 8:
Enter your **Employer's information**, including business name, address, phone#, dates employed (when you started working through your last day worked prior to the disability) and your average weekly wages.

IMPORTANT: If you have more than one job, be sure to complete for ALL employers. Each employer will need to complete their own Part C.

Question 9:
Tell us your job title. If you are a member of a union that **provides DBL benefits**, please enter union name and local number.

Question 10 – Provide us additional detail on your disability:

a) After being disabled, have you received any wages, salary, or other pay? If so, enter YES. If your wages have ceased, enter NO.
b) Have you received OR claimed any other types of benefits? Check Yes or No where applicable
   (1) Workers Comp (On the Job Accident or Illness) Benefits
   (2) Unemployment Insurance Benefits
   (3) Damages for Personal Injury
   (4) Social Security Disability (Federal Long Term Disability Benefits)

*If you have marked YES to any of the options in question 10, you must also provide additional detail regarding the period of time in which you are receiving or claiming these benefits. *

Question 11:
Answer Yes or No to the question "Have you received disability benefits within the past year (52 week period)". If yes, provide from whom the benefit was collected, and the period of time during which you received benefits.

Part A must be signed by claimant and/or authorized representative. End of Part A.

Part B - Healthcare Provider's Statement

Instructions for the Claimant:

This section must be completed by your treating Healthcare provider or Practitioner, providing all details of your disabling condition. Be sure all questions are answered, the information is legible, and your provider/practitioner has signed and dated Part B. This section must be completed, signed and dated **after** the date you became disabled and stopped working.

Be sure your form is completed and signed by an authorized practitioner.

Please be advised **the following medical professionals are NOT Authorized** to complete and sign part B of the DB450 form:

- RN (Registered Nurse)
- CSW (Certified Social Worker)
- PT (Physical Therapist)
- LPN (Licensed Practical Nurse)

Instructions for the Health Care Provider:

IMPORTANT: Part B must be fully and legibly completed to process this claim in a timely fashion. In addition to providing the medical details necessary to examine the claim, **this statement MUST be signed by the treating practitioner and dated to be considered acceptable.**

You must select the appropriate professional degree, enter your license number and state in which you are licensed to practice. Finally, we must have your practice name and mailing address in case additional medical documentation is required.

EXAMPLE FORM

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 .....
   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 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					Licensed in the State of	License Number
	☐ Chiropractor	☐ Physician	☐ Psychologist			
	☐ Dentist	☐ Podiatrist	☐ Nurse-Midwife			

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELEIF 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, 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 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.

Part B - Healthcare Provider's Statement

Question 1:
Please PRINT the claimant's (Patient) First and Last Name.

Question 2:
Please enter the claimant's date of birth (month, day, year).

Question 3– Sex:
Please indicate whether the claimant is Male or Female.

Question 4:
Please indicate the symptoms and findings of the claimant's disabling condition. Be sure to include any complications which may have exacerbated the disabling condition and provide applicable diagnosis codes if possible.
If this is a pregnancy claim, please enter the estimated date of delivery in this section.
If claimant has already delivered, please provide actual delivery date and type.

Question 5:
Please indicate if the claimant was hospitalized. If hospitalized, provide the confinement dates (from/to).

Question 6:
Please indicate whether or not an operation was performed. If yes, provide type of surgery and the date it took place.

Question 7:

IMPORTANT: YOU MUST PROVIDE DATES for questions 7A through 7D.

a) Date of claimant's **FIRST (Initial)** treatment for their disability (print date in Month, Day, Year format in the boxes provided)

b) Date of claimant's **MOST RECENT** treatment for their disability (print date in Month, Day, Year format in the boxes provided)

c) Date claimant was medically **UNABLE TO WORK (ONSET DATE)** due to this disability (print date in Month, Day, Year format in the boxes provided). This is not necessarily a working day, but the actual day that you certified the claimant disabled.

d) Date claimant will be able to perform usual work **(PROGNOSIS)** (print date in Month, Day, Year format in the boxes provided). This may be an estimated date.

Question 8:
Please indicate whether or not this disabling condition may be WORK RELATED.
If Yes, indicate whether a C-4 Doctor's Initial Report has been filed with the Workers' Compensation Board.

Remarks: Please enter any additional comments needed.

Practitioner Information (Type of Practitioner, License State, License #, Signature, Date, Practice Name, Mailing address etc). **Please legibly print all information.**

End of Part B.

Part C - Employer's Statement

Instructions For the Claimant:

In this section **your Employer** will provide details of your employment. Be sure all questions are answered, the information is legible, and your employer has signed and dated Part C.

If you have more than 1 employer, be sure **each** employer completes their own Part C, and all pages are included with your claim submission.

Instructions For the Employer:

Part C must be **fully and legibly** completed to process this claim in a timely fashion. In addition to providing the employee's details of their employment necessary to examine the claim, **this statement MUST be signed, titled, and dated to be considered acceptable**. We must also have your business name and mailing address in case additional information is required.

PLEASE NOTE:

Part C cannot be completed or signed by the claimant. If you (the claimant) are the owner and sole employee, a Schedule C Form 1040 must be included with your claim submission, and Part C must be completed and signed by your bookkeeper or accountant.

EXAMPLE FORM

PART C - EMPLOYERS STATEMENT

1. Employee's Name: _____ **POLICY NUMBER: DBL-** _____
2. Employee's Occupation: _____ S.S. No.: _____ Age ____
3. Date Employee Last Worked: _____ DATE EMPLOYED: / /20 FULL TIME ☐ PART TIME ☐
4. Date Employee's Wages Ceased: _____ CHECK DAYS NORMALLY WORKED
5. Date Employee Returned To Work: _____

Mon	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun

6. Wages Continued During Disability? _____
7. Is Reimbursement Requested? _____
8. Is Disability Due To Job? _____
9. Name of Workers' Compensation Carrier: _____
10. Indicate Weekly Value of Board, Lodging, Tips $ _____
11. Is Employee A Member of a Union Which Provides N.Y. State Disability Benefits? _____
12. If Employee is no longer in your employ, check reason
    Labor Dispute ☐ Lack of Work ☐ Discharged ☐ Quit ☐
    Explain _____
13. Is Claimant a ☐ Proprietor ☐ Owner ☐ Partner ☐ High School Student
14. Has Employee made a claim for Disability Benefits in the past 52 weeks?
    ☐ Yes ☐ No. If Yes, Date _____ 20 ____
15. Last Date Employee Received Unemployment Benefits: _____
16. Does Employee Work For Anyone Other Than You ☐ Yes ☐ No
17. Do Employees contribute toward their Disability premium? _____

EARNINGS 8 WEEKS PRIOR TO DISABILITY
(Including the week in which the disability began)

MONTH	DAY	YEAR	NO. DAYS WORKED	AMOUNT
			TOTAL	

EMPLOYER'S NAME: _____
ADDRESS: _____
DATE: _____ **TELEPHONE: ( )** _____
SIGNED BY: _____ **TITLE:** _____

MAIL COMPLETED FORMS TO:
ShelterPoint Life Insurance Company
600 Northern Blvd, Great Neck, NY 11021
by email: claimforms@shelterpoint.com
by fax: 516-504-6414

Question 1:

Please print the employee's first and last name.

Question 2:

Indicate the employee's job title.

Question 3:

Please enter the exact date the employee last worked (print date in Month, Day, Year format).

Part C - Employer's Statement

Question 4:
Please enter the exact date the employee's wages ceased. If wages are still being continued, enter "N/A". You will reaffirm this in question 6.

Question 5:
Please enter the date the employee returned to work, if applicable.

Question 6:
Please indicate if wages were continued during disability (Respond with YES or NO). Note, if wages were continued, we will need to know the type of wages (Sick Time, Vacation Time, PTO) and dates collected. You can provide a breakdown on a separate piece of paper to be submitted at same time.

Question 7:
Please indicate whether or not YOUR BUSINESS is requesting reimbursement for continued wages (sick time only).

Question 8:
Please indicate if the employee's disability is work related (respond with Yes or No).

Question 9:
Print the name of your Workers' Comp (on the Job Accident or Illness) insurer. ShelterPoint does not write Workers' Comp insurance.

Question 10:
If this employee receives additional remuneration in the form of tips, Board, Lodging, or Rent, indicate the average weekly amount here.

Question 11:
Please indicate if the employee is a member of a union that provides NYS Disability benefits (respond with Yes or No). If yes, provide the Union Name and Number.

Question 12:
If the employee no longer works for you, indicate **why** (check the applicable box) and provide detail on their termination/separation.

Question 13:
Select the appropriate employee designation.

Question 14:
Indicate whether the claimant has received or claimed Disability Benefits within the past 52 weeks. If yes, please provide dates of claim.

Question 15:
Enter the last date the employee received unemployment benefits, if applicable.

Question 16:
Indicate whether the employee works for anyone other than you. This is important as liability may be split amongst multiple employers.

Question 17:
Indicate whether the employee contributes to disability premium or not. (Respond with Yes or No). If yes, indicate the dollar amount of weekly contribution, or percentage of premium employee contributes.

Part C - Employer's Statement

Additional Required Info on Part C:

Policy Number:
Enter your current ShelterPoint Disability Benefits policy #. If you are completing this form as a concurrent employer, and are insured with another Carrier, you can enter your disability policy # and insurance carrier's name here.

SS No:
Print the employee's 9 digit social security number here.

Age:
Enter the employee's age.

Check Days Normally Worked:
Select boxes indicating which days the employee normally works. If employee's schedule varies, provide average days worked per week.

Wages Grid:
Enter the last 8 weeks GROSS (pre-tax) wages prior to the employee's last day worked in the boxes provided. You may also submit the same information as a separate page.

Employer's Name:
Print your Business name here.

Address:
Print your Business's mailing address here.

Date:
Enter the date you received and completed the form here.

Telephone:
Enter your phone number here, including area code.

Signed By:
Sign your name here

Title:
Print your job title here.

End of Part C.

Once the DB450 form is fully completed, make a copy for your records