Standard Security Life Insurance Company
A Member of The IHC Group

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New York State
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

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. Employer must complete part C.

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

1. First Name: _____ Last 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. Workers' compensation for work-connected disability? ☐ Yes ☐ No
       2. Paid Family Leave? ☐ Yes ☐ No
       3. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No
       4. 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. 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 9. **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 #**

Part C - EMPLOYER'S STATEMENT

1. Employee's Name: _____ **2.** Soc. Sec. #: ☐☐☐ ☐☐ ☐☐☐☐

3. Employee's Address: _____
Number Street Apartment Number City / Town State Zip Code

4. Employee's Occupation: _____ **5.** Date of Hire: _____ **6.** Status: ☐ Full Time ☐ Part Time

7. Is the Claimant an: ☐ Employee ☐ Owner ☐ High School Student **7a.** Date of Birth _____

8. Indicate the employee's normal work schedule: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9. If the employee is no longer in your employ, explain why: ☐ Quit ☐ Fired ☐ Laid Off ☐ Other (explain) _____

10. Date Employee last worked: _____ **10a.** Do you expect to rehire him/her? ☐ YES ☐ NO

11. Date Employee returned to work: _____

12. Are you paying wages or sick time: ..... ☐ YES ☐ NO

a. If **YES,** time period paid: _____

b. Are you requesting reimbursement for this time period? ..... ☐ YES ☐ NO

13. Is Employee receiving or claiming Unemployment Ins? ..... ☐ YES ☐ NO

14. Is Employee receiving or claiming Workers' Comp. Ins? ..... ☐ YES ☐ NO

15. Did this Disability occur as a result of employment? ..... ☐ YES ☐ NO

16. Is Employee in a Union proving **MONETARY DISABILITY BENEFITS?** ..... ☐ YES ☐ NO

17. Are you aware of other employment claimant may have? ..... ☐ YES ☐ NO

18. Has the employee received DBL or PFL benefits within the past 52 weeks? ☐ YES ☐ NO

19. TAXABLE PERCENTAGE _____ %

POLICY NUMBER: _____

Weekly Wages 8 Weeks prior to Last Day Worked Before Disability
(include value of Board, Lodging, and Tips if any)

	Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		TOTAL	

EMPLOYER INFORMATION:

Employer Name: _____ Employer Address: _____

Phone: _____ Fax: _____ E-mail: _____

Print Name: _____ Sign: _____ Title: _____ Date: _____

After Parts A, B, & C are COMPLETED, Do one of the following: SSLICNY Phone: 800-477-0087 or 585-398-2340

Mail to: SSLICNY, P.O. Box 25339 Farmington, NY 14425 or Fax to: 585-398-2854 or E-mail to: claims@sslicny.com