

Use this form if you became disabled **while employed** or if you became disabled **within four (4) weeks after termination of employment** OR if you became disabled **after having been unemployed for more than four (4) weeks**. Please answer all questions in Part A and questions 1 through 3 in Part B. Read all instructions on this form carefully. Health care providers must complete Part B on page 2.

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

1. First Name: _____ MI: _____ Last Name: _____
 2. Mailing Address: _____ Line 2: _____
 City: _____ State: _____ Zip: _____ Country: _____
 3. Daytime Phone #: _____ 4. Email Address: _____
 5. Social Security #: _____ - _____ - _____ 6. Date of Birth: ____ - ____ - ____ 7. Gender: Male Female
 8. My disability is (if injury, also state how, when and where it occurred): _____

9. I became disabled or became ineligible for Unemployment Insurance because of this disability on: ____ / ____ / ____
 I worked on that day: Yes No
 Have you recovered from this disability? Yes No If Yes, what was the date you were able to work: ____ / ____ / ____
 Have you since worked for wages or profit? Yes No If Yes, list dates: _____

10. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER			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.	

11. My job is or was: _____ Occupation
 12. Union Member: Yes No If "Yes": _____ Name of Union or Local Number

13. 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: _____

14. 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 (check box): Yes No or personal injury involving third party (check box): 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 14, COMPLETE THE FOLLOWING:

I have: received claimed from: _____ for the period: ____ / ____ / ____ to: ____ / ____ / ____

15. In the year (52 weeks) **before** your disability began, have you received disability benefits for other periods of disability? Yes No
 If "Yes", fill in the following: Paid by: _____ from: ____ / ____ / ____ to: ____ / ____ / ____

16. In the year (52 weeks) **before** your disability began, have you received Paid Family Leave? Yes No
 If "Yes", fill in the following: Paid by: _____ from: ____ / ____ / ____ to: ____ / ____ / ____

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. If my disability began while I was unemployed, I certify that I had been unemployed for more than four (4) weeks. 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 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 <input type="checkbox"/> estimated delivery date OR <input type="checkbox"/> 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 _____ %

Weekly Wages 8 Weeks prior to Last Day Worked Before Disability			No. of Days Worked	GROSS WEEKLY WAGES
Month	Day	Year		
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
TOTAL				

POLICY NUMBER: _____

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