Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)
175 Addison Road, PO Box 725
Windsor, CT 06095-0725

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS (NY)

Claimant: Read The Following Instructions Carefully

1. USE THIS FORM ONLY IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE CLAIM FORM DB-300 IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A - THE **"CLAIMANT'S STATEMENT"**, BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS, AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT".**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY. YOU MAY FAX THE COMPLETED FORM TO (781) 304-5599.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

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

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

1. My name is _____ (First / Middle / Last)
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 _____ 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 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. Day Yr.	Through Mo. Day Yr.	

9. My job is or was _____ (Occupation / Name of Union and Local No., 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 BELIEF 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 _____ (Date / Claimant's Signature)

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

_____ (Name and Address / Relationship)

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, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NEW YORK STATE WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY - MENANDS, ALBANY, N.Y. 12241.

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE SIDE

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 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:
   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.)

MONTH	DAY	YEAR

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 due to pregnancy, please enter estimated Delivery

I affirm that I am a	☐ Chiropractor ☐ Dentist	☐ Physician ☐ Podiatrist	☐ Psychologist ☐ Nurse-Midwife	Licensed in the state of	License Number

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

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-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.

EMPLOYER'S STATEMENT

Policy Number: _____

Employee's Full Name: _____ S.S. Number: _____

Employee's Address: _____ Date of Birth: _____

Employee's Occupation: _____ Date Employed _____ Full Time ☐ Part Time ☐

Is Employee a Union Member? ☐Yes ☐ No

Check Days Normally Worked

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

Date Employee Last Worked: _____

Date Employee's Wages Ceased: _____

Date Employee Returned To Work: _____

Wages Continued During Disability? _____

Is Reimbursement Requested? _____

Is Disability Due To Job? _____

If So, Has a Compensation Claim Been Filed? _____

Indicate Weekly Value of Board, Lodging, Tips $ _____

Employer's Name _____

Employer's Identification No. _____

Percentage of Weekly Disability Premium paid by Employer _____ %

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

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

MONTH	DAY	YEAR	NO. DAYS WORKED	AMOUNT
			TOTAL	

Is this employee currently covered by Social Security? ☐Yes ☐ No If No, state grounds for exemption.

Address _____

Date _____ Telephone No. _____

Signed _____ Title _____

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS - DISABILITY BENEFITS LAW

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of Disability Benefits to his/her employees.

2. Statutory Disability Benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.

3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or by contacting the Workers' Compensation Board. (See address and telephone number below.) **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**

4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.

5. Disability Benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.

6. **If your employer or the insurance carrier contends that you are not entitled to the payment of Disability Benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact the Workers' Compensation Board at the telephone number below.

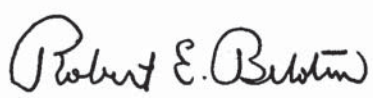
7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT**: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.

8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability Benefits Law. Your employer's disability benefits insurance carrier is:

Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481
800-247-6875



ROBERT E. BELOTEN
CHAIR

NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

Customer Service Toll-Free Line: 877-632-4996

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACION OBRERA
Robert E. Beloten, Presidente

DECLARACION DE DERECHOS - LEY DE BENEFICIOS POR INCAPACIDAD

SI USTED NO PUEDE TRABAJAR A CAUSA DE ENFERMEDAD O LESION NO RELACIONADA CON EL TRABAJO PUEDE TENER DERECHO A BENEFICIOS POR INCAPACIDAD

1. Su patrono está obligado por ley a proveer pagos de Beneficios por Incapacidad a sus empleados.

2. Beneficios por Incapacidad establecidos por ley son pagados por cualquier lesión o enfermedad no relacionada con el trabajo (incluyendo incapacidad debida a embarazo) comenzando a partir del octavo dia consecutivo de incapacidad. Los beneficios son pagados por 26 semanas. Los pagos de beneficios por incapacidad se basan en el promedio de su sueldo semanal durante las ocho semanas inmediatamente anteriores a su incapacidad y estan limitados al maximo permitido por ley el dia inicial de su incapacidad. Su patrono ó unión podran proveer en un plan o en un convenio beneficios diferentes que sean al menos tan favorables como los establecidos por ley.

3. PARA RECLAMAR BENEFICIOS **usted** deberá radicar una notificación y prueba de incapacidad (Formulario DB450) con su patrono ó con la compañia de seguros nombrada abajo dentro del plazo de 30 dias desde el primer dia de incapacidad o toda o parte de su reclamación podra ser rechazada. Bajo ninguna circunstancia usted debe esperar mas de 26 semanas desde esa fecha para radicar su reclamación. El formulario DB-450 lo puede conseguir a traves de su patrono, la compañia de seguros, el proveedor de servicios médicos o cualquier oficina de la Junta de Compensación Obrera.(Direcciones y telefonos mas abajo). **No** asuma que su patrono ha radicado la reclamación por usted. **La radicación de la reclamación es su responsabilidad.**

4. Usted tiene el derecho de ser atendido por cualquier médico, quiropractico, dentista, enfermera-partera, podiatra, o psicologo que usted seleccione. Contrario a como ocurre en compensación obrera sus cuentas médicas **no** seran pagadas por su patrono o su compañia de seguros a menos que el patrono y o la unión lo hayan dispuesto mediante un plan de beneficios o convenio.

5. Los beneficios por incapacidad le seran pagados a usted **directamente** por la compañia de seguros, **no a traves de su patrono,** salvo en los casos en que su patrono sea aprobado como auto asegurado.

6. Si su patrono ó la compañia de seguros reclama que usted no tiene derecho al pago de Beneficios por Incapacidad ellos tienen la obligación de enviarle un Aviso de Rechazo, dentro de los 45 dias siguientes ala radicación de su reclamación, explicandole las razones para no pagar los beneficios. Si usted no está de acuerdo con el rechazo, **tiene el derecho** de solicitar una revisión del mismo por la Junta de Compensación Obrera. **IMPORTANTE:** Si dentro del término de 45 dias de haber radicado su reclamación no recibe los beneficios ni tampoco recibe un Aviso de Rechazo (Formulario DB-451) comuniquese inmediatamente con cualquier oficina de la Junta de Compensación Obrera.

7. **Si su incapacidad es el resultado de un accidente automovilistico** y usted ha radicado una reclamación para beneficios por 'no-fault' tambien deberá radicar una reclamación (Formulario DB-450) para beneficios por incapacidad. **Si no radica reclamación para beneficios por incapacidad, la compañia de seguro podria reducir los pagos 'no fault' que le correspondan. IMPORTANTE:** en estos casos, si no tiene derecho a beneficios por incapacidad, avise inmediatamente a la compañia de seguros.

8. Su patrono no puede pedirle que renuncie a su derecho de recibir beneficios por incapacidad ni tampoco puede descontar mas de 60 centavos semanales (a menos que la contribución adicional sea parte de un acuerdo) de su paga para contribuir al pago de las primas de seguro para los beneficios por incapacidad. **Usted no puede ser despedido ni discriminado por radicar una reclamación de beneficios por incapacidad.**

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO, O TIENE CUALQUIER OTRO PROBLEMA ACERCA DE UNA LESION O ENFERMEDAD NO RELACIONADA CON EL TRABAJO COMUNIQUESE CON CUALQUIER OFICINA DE LA JUNTA DE COMPENSACIÓN OBRERA.

Este es un breve resumen de sus derechos como lo requiere la Sección 229 de la Ley de Beneficios por Incapacidad. La compañia de seguro de su patrono para beneficios por incapacidad es:

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